



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

September 8, 2026

Licensee

Butterfly Bound Care

6219 Chowen Ave N

Brooklyn Center, MN 55429

RE: Denial of License Number 423281
Health Facility Identification Number (HFID) 41252
Initial survey; Project Number(s) SL41252015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on July 2, 2026 for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey(s), MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBLE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Jess Schoenecker, via email at: Jess.Schoenecker@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **09/11/2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Jess Schoenecker, Supervisor, at Jess.Schoenecker@state.mn.us. Jess Schoenecker can also be reached by office phone at 651-201-3789.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41252	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6219 CHOWEN AVE N 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 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: SL41252015-0 On June 29, 2026, through July 2, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one (1) resident; one receiving services under the Provisional 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 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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director/licensed practical nurse (LALD/LPN)-D was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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 the residents). The findings include: Prior to survey initiation on June 28, 2026, at 3:10 p.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/LPN-D currently held a LALD license effective through October 31, 2026; however, LALD/LPN-D's license did not list her as the Director of Record for the licensee. On June 29, 2026, at 10:38 a.m., during entrance conference, the surveyor showed LALD/LPN-D that she was not listed under the licensee on BELTSS. LALD/LPN-D stated she did not know	0 110			

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0 110	Continued From page 2 how to add herself as the Director of Record. The surveyor suggested she call BELTSS directly for more information on how to add herself. LALD/LPN-D later stated she needed to fill out an application which she said she would do. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (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 manner that complied with the Nurse Practice Act when the registered nurse (RN) and licensed practical nurse (LPN) changed provider's orders for insulin administration without obtaining an updated provider order for one of one resident (R1).	0 450			

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0 450	Continued From page 3 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: Minnesota Nurse Practice Act 148.171, subdivision 14, dated 2025, indicated the "practice of practical nursing" means the performance, with or without compensation, of those services that incorporates caring for individual patients in all settings through nursing standards recognized by the board at the direction of a registered nurse, advanced practice registered nurse, or other licensed health care provider and includes, but is not limited to: (1) conducting a focused assessment of the health status of an individual patient through the collection and comparison of data to normal findings and the individual patient's current health status, and reporting changes and responses to interventions in an ongoing manner to a registered nurse or the appropriate licensed health care provider for delegated or assigned tasks or activities; (2) participating with other health care providers in the development and modification of a plan of care; (3) determining and implementing appropriate interventions within a nursing plan of care or when delegated or assigned by a registered nurse; (4) implementing interventions that are delegated, ordered, or prescribed by a licensed health care	0 450			

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0 450	Continued From page 4 provider; (5) assigning nursing activities or tasks to other licensed practical nurses (LPNs); (6) assigning and monitoring nursing tasks or activities to unlicensed assistive personnel; (7) providing safe and effective nursing care delivery; (8) promoting a safe and therapeutic environment; (9) advocating for the best interests of individual patients; (10) assisting in the evaluation of responses to interventions; (11) collaborating and communicating with other health care providers; (12) providing health care information to individual patients; (13) providing input into the development of policies and procedures; and (14) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily expected of an individual who has completed an approved practical nursing education program described in section 148.211, subdivision 1. Minnesota Nurse Practice Act 148.171, subdivision 15, dated 2025, indicated the "practice of professional nursing" means the performance, with or without compensation, of those services that incorporates caring for all patients in all settings through nursing standards recognized by the board and includes, but is not limited to: (1) providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and	0 450			

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0 450	Continued From page 5 address changes in a patient's condition; (2) collaborating with the health care team to develop and coordinate an integrated plan of care; (3) developing nursing interventions to be integrated with the plan of care; (4) implementing nursing care through the execution of independent nursing interventions; (5) implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider; (6) delegating nursing tasks or assigning nursing activities to implement the plan of care; (7) providing safe and effective nursing care; (8) promoting a safe and therapeutic environment; (9) advocating for the best interests of individual patients; (10) evaluating responses to interventions and the effectiveness of the plan of care; (11) collaborating and coordinating with other health care professionals in the management and implementation of care within and across care settings and communities; (12) providing health promotion, disease prevention, care coordination, and case finding; (13) designing and implementing teaching plans based on patient need, and evaluating their effectiveness; (14) participating in the development of health care policies, procedures, and systems; (15) managing, supervising, and evaluating the practice of nursing; (16) teaching the theory and practice of nursing; and (17) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily	0 450			

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0 450	Continued From page 6 expected of an individual who has completed an approved professional nursing education program as described in section 148.211, subdivision 1. The Minnesota Nurse Practice Act definitions of practical and professional nursing did not include the ability to prescribe medication. R1 had diagnoses including schizophrenia, type 2 diabetes, binge eating disorder, generalized anxiety disorder, and congestive heart failure. R1's unsigned Service Plan - Waiver with effective date June 29, 2026, indicated unlicensed personnel (ULP) assisted with blood glucose (BG) checks three times daily and medication administration 12 times per day. R1's admission orders dated March 5, 2026, ordered the following: -Humulin R 500 units/milliliter (ml) Kwik pen (concentrated insulin for severe insulin resistance), inject 600 units subcutaneously (SQ) at breakfast and dinner, and inject 700 units SQ at lunch. The order did not provide any parameters on when to hold Humulin. R1's individualized medication management plan dated April 17, 2026, did not include resident specific instructions for holding insulin related to BG readings. On June 29, 2026, at 1:50 p.m., ULP-B stated R1's blood BG was 132, so Humulin was held, and said she waited for the BG to be "over 200 in order to give it." R1's record did not include an order to hold Humulin for later administration. On June 29, 2026, at 2:30 p.m., ULP-B stated a nurse trained her on medication administration.	0 450			

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0 450	Continued From page 7 When asked who told her to hold the Humulin if BG was below 200, ULP-B stated [name of RN-E] told her to hold it so that R1's "blood sugar does not drop to 70." R1's record did not include an order to hold Humulin. During interview on June 30, 2026, at 11:20 a.m., ULP-B stated R1's BG yesterday morning was 132 and she held the Humulin insulin. The surveyor asked why the Humulin was documented as given on the MAR, ULP-B stated it was a "mistake," and should have "declined it and written a note." ULP-B also stated if R1's BG was below 150, she held the Humulin (an earlier interview said she would hold it if BG was below 200), when asked who instructed her to do that, ULP-B stated RN-E did and also it was on "Educare (online training program)." R1's record did not include an order to hold Humulin. During observation on June 30, 2026, at 12:20 p.m., after checking R1's BG 223, ULP-B made a call on a cell phone. After the call, ULP-B stated she was going to administer 600 units of Humulin. The surveyor asked if she spoke with clinical nurse supervisor (CNS)-A, ULP-B stated no, that she spoke with LALD/LPN-D where she was told to give 600 units due to R1's BG being "lower." The surveyor observed ULP-B administer the first 300 units of Humulin, then re-dialed the pen and administered another 300 units for a total of 600 units. At 12:38 a.m., ULP-B opened R1's MAR and clicked on "setup," "verify," and "administered" then "completed." ULP-B did not make a notation in the notes section indicating 600 units were given or where the insulin was administered. R1's provider ordered 700 units of Humulin at lunch. During interview on June 30, 2026, at 1:50 p.m.,	0 450			

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0 450	Continued From page 8 ULP-B stated if R1's BG was between 150-250, she would call the nurse and the nurse would ask ULP-B what the last BG was to determine next steps. If it was 300 or over, ULP-B stated she would give the prescribed dose without calling a nurse. If it was below 150, she would hold it (an earlier interview said she would hold it if BG was below 200). During interview on June 30, 2026, at 2:20 p.m., LALD/LPN-D stated there was no order to hold Humulin, but would instruct staff to hold Humulin if the BG was 70 or below. LALD/LPN-D stated she would not instruct the staff to hold Humulin if the BG was below 150 because they did not have an order to do that. When asked if a different dose of Humulin was instructed to be given, LALD/LPN-D denied instructing ULP-B to give the 600 units out of 700 units prescribed. During observation on June 30, 2026, at 2:55 p.m., R1 asked ULP-B to check her BG, which was 58. R1 was able to recognize symptoms of low BG and notified the staff. While LALD/LPN-D was searching for BG glucose tablets (help raise BG quickly), ULP-B provided R1 a banana and juice. During interview on June 30, 2026, at 3:30 p.m., LALD/LPN-D stated staff had been instructed to hold the Humulin, let the resident eat, then recheck it and give the Humulin but there was no documentation to support that statement. LALD/LPN-D stated they had told R1's provider about the BG fluctuation but the provider would not give them parameters to follow. R1's record lacked documentation to support that statement. During phone interview on June 30, 2026, at 3:51 p.m., CNS-A stated she was responsible for	0 450			

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0 450	Continued From page 9 tracking BGs and monitoring the MAR. CNS-A stated staff contacted her if R1's BG numbers were high and would follow the insulin parameter order, which she thought for Humulin, hold if it was below 150, but when the surveyor stated there were no orders to hold Humulin, CNS-A stated she did not realize it was only for Lantus then said she did not have the orders in front of her. CNS-A stated staff called daily due to high BG numbers and had instructed staff to hold the Humulin if it was below 150, and stated R1 would refuse the insulin because she knew her body. The nurse had told her how much to give if it wasn't the prescribed amount but that did not happen often. During phone interview on June 30, 2026, at 4:36 p.m., ULP-H stated R1's BG was high most of the time so she received 600/700 units of Humulin. When R1's BG was low, she would call CNS-A, if no answer, would call LALD/LPN-D. During phone interview on July 1, 2026, at 3:00 p.m., CNS-A stated she could not provide documentation of her attempts to obtain parameters for Humulin with R1's provider. During phone interview on July 2, 2026, at 9:13 a.m., medical assistant (MA)-K from R1's specialty clinic stated the provider and his nursing staff were out of the office but read in R1's notes that the provider only had parameters for Lantus, not Humulin. MA-K was unable to locate any discussion with the licensee regarding parameters or when to hold Humulin. The licensee's Medication Orders policy dated August 1, 2021, indicated licensee would administer medications as prescribed by the authorized prescriber.	0 450			

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0 450	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480			

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0 480	Continued From page 11 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 480			

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0 480	Continued From page 12 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 29, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the name, telephone number, and email contact information for the individuals	0 550			

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0 550	Continued From page 13 who were responsible for handling resident grievances. This had the potential to affect the licensee's current resident, 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 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: During posting review on June 29, 2026, at 12:33 p.m., the surveyor observed a one level rambler style home with a basement. The living room/dining room on the main floor had multiple postings. The surveyor was unable to locate information about the facilities' grievance procedure and contact information for the Office of Ombudsmen for Mental Health and Developmental Disabilities (OOMHDD). On June 29, 2026, at 2:51 p.m., the surveyor asked licensed assisted living director/licensed practical nurse (LALD/LPN)-D where the facility's grievance procedure could be located, and LALD/LPN-D grabbed an accordion style folder off the table within the living room and could only locate the form where a complaint could be written. LALD/LPN-D then found the grievance procedure inside one of the binders which listed registered nurse (RN)-E as the contact person. LALD/LPN-D stated the information was not correct and would need to be updated prior to posting it. LALD/LPN-D stated she could not locate contact information for OOMHDD as	0 550			

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0 550	Continued From page 14 required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of	0 650			

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0 650	Continued From page 15 one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During entrance conference on June 29, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated they were aware of the required contents of the employee records. ULP-B was hired under the licensee's comprehensive license on April 10, 2020, and began providing assisted living services on August 1, 2021. Between June 29, 2026, and July 1, 2026, at various times, the surveyor observed ULP-B administer medications to R1 (oral and injections). ULP-B's training record lacked documentation of completed training and competency evaluation by a registered nurse on medication setup for an unplanned leave of absence. On July 2, 2026, at 10:22 a.m., CNS-A stated staff had been trained how to set up medications for unplanned time away at sister facilities but did not have documentation of training or demonstrated competencies for any staff. CNS-A	0 650			

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0 650	Continued From page 16 stated staff had hands on training and completed demonstrations in the past. The licensee's undated Unplanned Time Away Medication Set Up Policy indicated this policy applied to all staff responsible for medication administration and management. The licensee would maintain a roster of trained staff available to cover unplanned absences to ensure compliance and safety. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660			

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0 660	Continued From page 17 licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptom screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees (clinical nurse supervisor (CNS)-A). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated January 2, 2026, indicated the facility was at a low risk for TB transmission. CNS-A was hired on March 28, 2025, to provide direct nursing care for residents and supervision of staff. On June 29, 2026, at approximately 1:45 p.m., during CNS-A's record review, the surveyor was unable to locate TB screening for CNS-A and informed licensed assisted living director/licensed practical nurse (LALD/LPN)-D where she said she would try to locate the missing record. On June 30, 2026, at 10:18 a.m., LALD/LPN-D	0 660			

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0 660	Continued From page 18 provided the surveyor CNS-A's chest x-ray (CXR). At 10:30 a.m., the surveyor asked LALD/LPN-D who was responsible for collecting TB screening records, LALD/LPN-D stated office manager (OM)-F was. CNS-A's CXR completed on November 8, 2018, did not indicate CNS-A was free of TB. CNS-A's employee record lacked documentation of a positive two-step TST or Interferon-Gamma Release Assay (IGRA) test completed prior to the CXR and provider evaluation or lacked documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. On June 30, 2026, at 10:32 a.m., via telephone, OM-F stated she was responsible for TB screening records and made sure TB screening were in the employee's record prior to working with residents. OM-F stated when CNS-A was hired, she was told CNS-A would email her the TB screening and failed to follow-up on that record. OM-F also stated she was not aware of the required documentation to go with the CXR. The surveyor referred OM-F to the Minnesota Department of Health's (MDH) website for more information. On June 30, 2026, at 11:50 a.m., OM-F arrived at the facility. The surveyor requested CNS-A's completed TB symptom and history form, so OM-F looked through CNS-A's binder then stated her process was to put the TB test with the symptom and history form together so that made sense why it was not in the binder. OM-F stated she would have CNS-A complete the form right away.	0 660			

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0 660	Continued From page 19 On July 2, 2026, at 10:22 a.m., via telephone, CNS-A stated the CXR provided was to screen TB, and said it was not recommended to get a CXR annually and refused to get the two-step TST because she had the TB vaccine. CNS-A could not recall if she completed the TB history and symptom form. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC. The policy also stated new staff with a verbal, but undocumented history of a previous positive TST or blood test would undergo the same screening process as those without previous positive tests. Staff would also complete a baseline screening to include an assessment for TB history and current TB symptoms. The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 5, 2026, indicated a CXR alone was not acceptable documentation. Staff either need to provide documentation of the following: -a positive two-step TST or IGRA test along with a CXR with provider evaluation after that date; or -documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 20 (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 cause serious injury, impairment, or death), and	0 680			

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0 680	Continued From page 21 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 held a provisional assisted living licensure issued on January 2, 2026, and set to expire on January 1, 2027. The licensee's EPP binder titled Emergency Management Plan dated June 20, 2026, lacked evidence of the following required and/or updated content: -quarterly missing resident review; -hazard vulnerability assessment completed on August 26, 2022, for a different facility; -indicated licensee had a generator which they did not; -customized disaster plan for fire (instructed to pull the nearest fire alarm pull station which did not exist); -indicated facility's house number was 6212 (should have been 6219); -evacuation procedures indicated high rise buildings, use of elevators, and emergency assembly areas not related to licensee; -facility's role under a section 1135 waiver declared by secretary; -use of volunteers; and -resident population. On July 1, 2026, at 12:07 p.m., house manager (HM)-C brought a binder to the facility, so the surveyor asked if the binder was stored outside of the facility, HM-C stated the reason it was out of the facility was because some updates were being completed. HM-C stated office manager (OM)-F and licensed assisted living	0 680			

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0 680	Continued From page 22 director/licensed practical nurse (LALD/LPN)-D were responsible for maintaining the EPP. On July 1, 2026, at 3:53 p.m., during EPP review with LALD/LPN-D, she stated the hazard vulnerability assessment was for a different facility and the current facility did not have one completed. LALD/LPN-D acknowledged the EPP contained an address for a different facility and the resident capacity was not correct. LALD/LPN-D stated the facility would not use volunteers, so she thought it was not necessary to include it and was not aware of the 1135 waiver. LALD/LPN-D stated she was not aware the missing resident plan needed to be reviewed every 90 days. 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 residents and staff during periods of an emergency or disaster that disrupts services. The intent was the plan would be aligned with the Centers for Medicare and Medicaid services State Operation Manual Appendix Z. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedures would be reviewed by the director and clinical nurse supervisor at least quarterly. Changes to the plan would be documented. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications,	0 680			

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0 680	Continued From page 23 methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810			

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0 810	Continued From page 25 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 810			

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0 810	Continued From page 26 or a violation that had the potential to cause more than minimal harm? to the resident) 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 document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has	0 900			

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0 900	Continued From page 27 been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the Office of Ombudsman for Long-Term Care (OOLTC) with a complete unsigned copy of the assisted living contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that will cause only 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: The licensee held a provisional assisted living license effective January 1, 2026, and set to expire on January 2, 2027. The licensee's Notice of Providing Assisted Living Services (NPALS) indicated they began providing services on March 3, 2026.	0 900			

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0 900	Continued From page 28 On July 1, 2026, at 3:49 p.m., via email, the regional ombudsman indicated OOLTC did not receive an assisted living contract for the specific address on file. On July 2, 2026, at 2:12 p.m., the surveyor asked licensed assisted living director/licensed practical nurse (LALD/LPN)-D if a blank contract with all attachments was sent to OOLTC. LALD/LPN-D stated she did not send a copy of their contract to OOLTC but was aware of the requirement and had it on her list to complete. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
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 a staff member 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	01290			

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01290	Continued From page 29 by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was affiliated to the current health facility identification (HFID) number for seven (7) of ten (10) employees (clinical nurse supervisor (CNS)-A, house manager (HM)-C, unlicensed personnel (ULP)-B, ULP-G, ULP-H, ULP-I, ULP-J) shown to have worked with licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee held a provisional assisted living license issued January 2, 2026, and set to expire on January 1, 2027. The licensee admitted their first resident (R1) on March 3, 2026. According to The Minnesota Board of Nursing website, CNS-A became an active certified nurse practitioner on January 28, 2015, therefore was required to have a BGS completed by the licensee. Throughout the survey between June 29, 2026, and July 1, 2026, the surveyor observed ULP-B work with R1 all three days. CNS-A and HM-C came in at various times.	01290			

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01290	Continued From page 30 The licensee's undated NETStudy 2.0 Roster (web-based system for submitting background study requests to the Department of Human Services (DHS)) listed all HFIDs the licensee owner held (32914, 35716, 35717, 37241, 37324, 41252). The roster did not show CNS-A, HM-C, ULP-B, ULP-G, ULP-H, ULP-I, and ULP-J were affiliated to HFID 41252, but all were affiliated to another HFID owned by the same owner. The licensee's two-week staff schedule dated June 28, 2026, through July 11, 2026, indicated the following 12-hour shifts (day-7:00 a.m. to 7:00 p.m.) or (night-7:00 p.m. to 7:00 a.m.): -ULP-B worked three (3) day shifts during week 1 and week 2; -ULP-G worked three (3) night shifts during week 1 and week 2; -ULP-H worked one (1) night shift and two (2) day shifts during week 1 and two (2) day shifts and one (1) night shift during week 2; -ULP-I worked three (3) night shifts during week 1 and week 2; and -ULP-J worked two (2) day shifts during week 1, and week 2. On June 29, 2026, at 1:35 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D provided their NETStudy 2.0 Roster and stated only three staff were affiliated to HFID 41252, and that office manager (OM)-F was responsible for completing BGS and affiliations. On June 29, 2026, at 2:21 p.m., LALD/LPN-D provided the surveyor their updated NETStudy 2.0 Roster showing all seven (7) staff were affiliated to HFID 41252 on June 29, 2026.	01290			

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01290	Continued From page 31 During phone interview on June 30, 2026, at 10:32 p.m., office manager (OM)-F stated she was the sensitive information person (SIP) and responsible for completing BGS on staff and completing affiliations. Upon hire, she would collect the necessary identification required and utilized a checklist. When completed, the BGS went in the employee's file. OM-F stated the licensee closed another facility owned by the same owner and staff moved to the current facility to began to work when R1 was admitted and missed completing the affiliations. OM-F stated she had a process in place and felt this was a unique situation. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors that worked with the licensee. The policy lacked instruction regarding affiliating staff to more than one HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730			

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01730	Continued From page 32 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be 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	01730			

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01730	Continued From page 33 review, the licensee failed to maintain a current individualized medication management plan to include instructions for administering highly concentrated insulin, storing insulin in the medication refrigerator, documenting where on the body insulin was administered, and assisting with inhaler administration for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on June 29, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the licensee provided medication management services to the licensees' one resident. R1 had diagnoses including schizophrenia, type 2 diabetes, binge eating disorder, generalized anxiety disorder, and congestive heart failure. R1's unsigned Service Plan - Waiver effective date June 29, 2026, indicated R1 received assistance with blood glucose checks and medication administration 12 times per day. R1's Individualized Medication Management Plan (IMMP) dated April 17, 2026, indicated self-administration was not applicable and	01730			

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01730	Continued From page 34 required full medication management. Uncontrolled medications would be secured in a locked medication room, and controlled medications would be secured in a locked medication box. R1's admission orders dated March 5, 2026, ordered the following diabetic medication: -Humulin R 500 units/milliliter (ml) Kwik pen (concentrated insulin for severe insulin resistance), inject 600 units subcutaneously (SQ) at breakfast and dinner, and inject 700 units SQ at lunch; -Lantus Solostar 100 units/ml flex pen (long-acting insulin), inject 100 units SQ at bedtime, hold if blood glucose was less than 150; -Ozempic 2 milligrams (mg)/3 ml pen (receptor agonist for type 2 diabetes), inject 0.25 mg SQ once weekly; and -fluticasone 220 micrograms (mcg), inhale two (2) puffs twice a day for asthma. During observation on June 29, 2026, at 11:45 a.m., the surveyor observed a locked dorm sized medication refrigerator on the floor of the dining room. The surveyor asked LALD/LPN-D to open the refrigerator and observed the following contents: -Humulin R 500 unit/ml Kwik pen-15 Kwik pens; -Lantus Solostar 100 units/ml flex pen-1 flex pen; and -Ozempic 2 mg/3 ml pen-1 pen. During observation on June 30, 2026, at 8:30 a.m., unlicensed personnel (ULP)-B assisted R1 with checking her blood glucose which was 447 (normal blood glucose levels are 80-130). ULP-B primed the Humulin Kwik pen by dialing two clicks (wasted 10 units of insulin to ensure the pen was working properly) then dialed the pen to the	01730			

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01730	Continued From page 35 maximum dose possible-300 units. ULP-B injected the insulin into the top mid-section of R1's abdomen. While the needle was still in the abdomen, ULP-B dialed it to another 300 units, and injected it. R1's abdomen was round, firm, and extended that showed pigmentation across the top of the abdomen from the injections. On June 30, 2026, at 12:38 p.m., the surveyor observed ULP-B document the Humulin administration on R1's medication administration record (MAR) with a few clicks indicating the medication was "set up/verified, administered, and completed." No notes were written as to where the insulin was administered. During interview on July 1, 2026, at 12:18 p.m., ULP-B stated she was trained to give insulin at another job but stated all "nurses" trained her on how to administer R1's Humulin. R1 stated some staff would administer how ULP-B did, others would remove the needle from the abdomen, redial, then re-inject. R1's Med Admin Summary - Actual - Month dated June 2026, indicated R1 received the following: -Humulin U-500, inject 600 units at breakfast and dinner, and inject 700 units at lunch time "Prime the insulin pen before administering insulin"; and -self-administered the fluticasone 220 mcg, inhale 2 puffs twice a day, so there was no documentation by staff as being administered (no initials and left blank). R1's IMMP lacked the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions (lacked instructions for refrigerated medications and where inhaler should be stored);	01730			

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01730	Continued From page 36 - documentation of specific resident instructions relating to the administration of medications (how to administer insulin requiring more than one dial up); and - any resident-specific requirements relating to documenting medication administration (documenting where insulin was administered). During interview on July 1, 2026, at 3:00 p.m., CNS-A stated R1 required supervision when self-administering the inhaler, so it was not full self-administration. CNS-A stated R1 kept the inhaler at her bedside table, or it was kept locked up with R1's other medications. CNS-A stated she trained staff to document in the notes section of the MAR where they administered the insulin. CNS-A was not aware staff were not documenting as required. The manufacturer's instructions for Lantus Solostar dated August 2022, indicated rotating injection sites with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. The manufacturer's instructions for Humulin R-500 revised February 2024, indicated rotating injection sites within the area chosen for reach dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The licensee's Assessment of Medications policy dated August 1, 2021, indicated based on the results of the assessment, the registered nurse (RN) would document an individualized medication management plan, to include the following missing content: - a description of storage of medications based	01730			

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01730	Continued From page 37 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; and - any resident-specific requirements relating to documenting medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that prior to delegating the task of medication administration, the registered nurse (RN) had instructed the unlicensed personnel (ULP) in the proper methods to administer insulin, and the ULP had demonstrated the ability to competently follow the procedures, specified, in writing, specific	01750			

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01750	Continued From page 38 instructions for each resident and documented those instructions in the resident's records; and communicated with the ULP about the individual needs of the resident for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 had diagnoses including schizophrenia, type 2 diabetes, binge eating disorder, generalized anxiety disorder, and congestive heart failure. R1's unsigned Service Plan - Waiver effective date June 29, 2026, indicated R1 received assistance with blood glucose checks and medication administration 12 times per day. R1's medication assessment, dated September 4, 2025, indicated, "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of medication." The assessment further indicated R1 was unable to correctly state what medications were to be taken, what each medication was for, or the proper dosage of medications. R1's most recent nursing assessment, completed by clinical nurse supervisor (CNS)-A on April 17,	01750			

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NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6219 CHOWEN AVE N 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
01750	Continued From page 39 2026, indicated R1 needed help with medication administration including insulin injections per provider orders. R1's admission orders dated March 5, 2026, ordered the following diabetic medication: -Humulin R 500 units/milliliter (ml) Kwik pen (concentrated insulin for severe insulin resistance), inject 600 units subcutaneously (SQ) at breakfast and dinner, and inject 700 units SQ at lunch; and -Lantus Solostar 100 units/ml flex pen (long-acting insulin), inject 100 units SQ at bedtime, hold if blood glucose was less than 150. During observation on June 30, 2026, at 8:30 a.m., ULP-B assisted R1 with checking her blood glucose which was 447 (normal blood glucose levels are 80-130). ULP-B primed the Humulin Kwik pen by dialing two clicks (wasted 10 units of insulin to ensure the pen was working properly) then dialed the pen to the maximum dose possible-300 units. ULP-B injected the insulin into the top mid-section of R1's abdomen. While the needle was still in the abdomen, ULP-B dialed it to another 300 units, and injected it. R1's abdomen was round, firm, and extended that showed pigmentation across the top of the abdomen from the injections. During observation and interview on July 1, 2026, at 12:18 p.m., ULP-B primed the Humulin Kwik pen then dialed it to 300 units, injected the insulin, then while needle was still in abdomen, ULP-B dialed it to 130 units (what was remaining of that pen) and injected the insulin and removed the pen/needle. ULP-B grabbed a new pen, placed a new needle, primed the pen, and dialed it to 270 units (remaining amount required to equal 700 units total as ordered) and administered the	01750			

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01750	Continued From page 40 insulin. ULP-B stated she was trained to give insulin at another job but stated all "nurses" trained her on how to administer R1's Humulin. R1 stated some staff would administer how ULP-B did, others would remove the needle, redial, then re-inject. R1's medical record included instructions on priming the pen but lacked instructions on how to administer high levels of insulin requiring a re-dial. During interview on July 1, 2026, at 3:00 p.m., CNS-A stated she trained staff to dial per orders, rotate sites, clean the site before administering insulin. Once they injected the first 300 units, staff were trained to remove the pen, re-dial to the amount needed then "re-inject using the same needle as long as it was done right away." CNS-A stated R1's insurance would not cover additional needles for them to change each time. The manufacturer's instructions for Humulin R-500 revised February 2024, indicated to always use a new needle for each injection to help prevent infections and blocked needles. Additionally, if the dose was more than 300 units, more than one injection was needed and must use a new needle for each injection and repeat the priming step. The licensee's Medication Administration policy dated August 1, 2021, indicated the RN may delegate medication administration to a ULP according to the following protocol: a. All ULPs have passed a competency evaluation with respect to all medication routes to be administered; b. The RN had prepared written instructions for the ULP in the proper methods to administer	01750			

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01750	Continued From page 41 medications with respect to each resident; and c. The RN had communicated with/provided orientation to the ULP regarding the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days		01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document why the medications were not administered as prescribed, and failed to transcribe medication orders for one of one resident (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or		01760		

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01760	Continued From page 42 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: During entrance conference on June 29, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the licensee provided medication management services to the licensees' one resident. R1 had diagnoses including schizophrenia, type 2 diabetes, binge eating disorder, generalized anxiety disorder, and congestive heart failure. R1's unsigned Service Plan - Waiver with effective date June 29, 2026, indicated R1 received assistance with blood glucose (BG) checks and medication administration 12 times per day. R1's lab result dated June 14, 2026, indicated R1's HA1C (hemoglobin A1C-percentage of hemoglobin in red blood cells that has glucose attached to it that provided a long-term view of blood glucose sugar control) was 10.4% (normal is below 5.7%, prediabetes is 5.7%-6.4%, diabetes is 6.5% or higher). R1's admission orders dated March 5, 2026, ordered the following medications: -Humulin R 500 units/milliliter (ml) Kwik pen (concentrated insulin for severe insulin resistance), inject 600 units subcutaneously (SQ)	01760			

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01760	Continued From page 43 at breakfast and dinner, and inject 700 units SQ at lunch; -Lantus Solostar 100 units/ml flex pen (long-acting insulin), inject 100 units SQ at bedtime, hold if BG was less than 150; and -Cymbalta (duloxetine) 60 milligrams (mg), one capsule by mouth every day at 5:00 a.m. for anxiety; and -multiple vitamins, chew one gummy by mouth once daily at 5:00 a.m. DOCUMENTATION ERROR R1's Med Admin Summary - Actual - Month dated June 1 through 28, 2026, included the following documentation for Humulin: -June 6, unlicensed personnel (ULP)-H documented not given for midday (noon) (BG was 234) and PM (dinnertime) (BG was 149) Humulin should have been given for both occurrences per provider order; -June 9, ULP-H documented not given for midday (BG was 136), and PM (BG was 200) Humulin should have been given for both occurrences per provider order; -June 19, ULP-H documented not given for midday (BG was 129) Humulin should have been given per provider order; -June 20, ULP-H documented not given for midday (BG was 254), and PM (BG was 120) Humulin should have been given for both occurrences per provider order; -June 23, ULP-H documented not given for midday (BG was 65), and held for PM (BG was 187) Humulin should have been given for PM per provider order; and -June 24, ULP-H documented not given for AM (breakfast) (BG was 257) and PM (BG was 141) Humulin should have been given for both occurrences per provider order.	01760			

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01760	Continued From page 44 During interview on June 30, 2026, at 11:20 a.m., ULP-B stated R1's BG yesterday morning was 132 and they held the Humulin insulin. The surveyor asked why the insulin was documented as given (initialed) on the medication administration record (MAR), ULP-B stated it was a "mistake," and should have "declined it and written a note." ULP-B also stated if R1's BG was below 150, she held the insulin, when asked who instructed her to do that, ULP-B stated registered nurse (RN)-E did and also it was on "Educare (online training program)." It was unknown whether ULP-B had been documenting Humulin was given when it was held. During observation on June 30, 2026, at 12:20 p.m., after checking R1's BG (223), ULP-B administered 600 units (700 units was prescribed) of Humulin as instructed by LALD/LPN-D. At 12:38 a.m., ULP-B opened R1's MAR and clicked on "setup," "verify," and "administered" then "completed." ULP-B did not make a notation in the notes section indicating 600 units were given or where the insulin was administered. It was unknown if a different dose was given than what was documented outside of this occurrence. During interview on June 30, 2026, at 3:30 p.m., LALD/LPN-D and the surveyor observed R1's June MAR. LALD/LPN-D stated the red circled initials meant the medication was either declined or held and she expected staff to document the reason why. LALD/LPN-D stated staff had been instructed to hold the Humulin, let the resident eat, then recheck it and give the Humulin but there was no documentation of staff doing that. During phone interview on June 30, 2026, at 3:51 p.m., CNS-A stated she was responsible for tracking BGs and monitoring the MAR. CNS-A	01760			

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01760	Continued From page 45 stated staff contacted her if R1's BG numbers were high and would follow the insulin parameter order, which she thought for Humulin, hold if it was below 150, but when the surveyor stated there were no orders to hold Humulin, CNS-A stated she did not realize it was only for Lantus then said she did not have the orders in front of her. CNS-A stated staff called daily due to high BG numbers and had instructed staff to hold the Humulin if it was below 150, and stated R1 would refuse the insulin because she knew her body. CNS-A stated she expected staff to document the reason why it was held and was surprised it was not being documented. During phone interview on June 30, 2026, at 4:36 p.m., ULP-H stated R1's BG was high most of the time so she got 600/700 units of insulin. When R1's BG was low, she would call CNS-A, if no answer, would call LALD/LPN-D. ULP-H would hold Humulin insulin and try to raise the BG by providing a beverage or food then would document on R1's MAR "not given" and may recheck the BG and report the result to the nurse. The surveyor asked ULP-H what was considered a low BG, ULP-H stated she would be worried if the BG was 125, but would be really worried if it was 50 or 60. ULP-H then stated her overall procedure would be to call the nurse if the BG was below 150, put "hold or not given" on the MAR, gave food then rechecked it and may be instructed to give the insulin but would not be able to change the documentation on the MAR. ULP-H stated she would write a note in R1's progress notes or in the communication book used between staff. ULP-H then stated she accompanied R1 at her last doctor's visit and was told by the provider they did not have to give the full 700 units depending on the BG. The nurse had told her how much to give if it wasn't the	01760			

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01760	Continued From page 46 prescribed amount but that did not happen often. R1's Resident Notes - One Resident dated March 2, 2026, through June 29, 2026, lacked documented reason why Humulin was held or not given on the above days in June. TRANSCRIPTION ERROR R1's E-Script New Prescription Request (provided by the pharmacy) dated June 26, 2026, ordered duloxetine 30 mg delayed release capsule, one capsule to be given with 60 mg capsule for a total of 90 mg every morning for depression. R1's MAR dated June 1-30, 2026, documented R1 took the following medications: -Cymbalta (duloxetine) 60 mg capsule, one capsule by mouth every day at 5:00 a.m. (duplicate transcription that was documented on daily by staff); -duloxetine (Cymbalta) 60 mg capsule, one capsule daily by mouth (documented as given daily from June 1-26, 2026, then it was stopped); -duloxetine (Cymbalta) 60 mg capsule, give 60 mg with 30 mg for total of 90 mg by mouth daily (started on June 27, 2026); -the MAR lacked children's multivitamin chewable. On July 1, 2026, at 2:30 p.m., during medication review with LALD/LPN-D, R1's pre-filled pharmacy pack indicated the morning pack included children's multivitamin chewable and duloxetine 60 mg capsule. It was unknown if duloxetine 30 mg was being given from a pharmacy bottle since it was not in the pre-filled pharmacy pack. After observing both duloxetine and Cymbalta listed on the MAR, LALD/LPN-D stated it was a duplicate and staff had been incorrectly documenting on Cymbalta and staff	01760			

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01760	Continued From page 47 should have been reviewing the pre-filled pharmacy pack medication contents against the MAR. LALD/LPN-D stated when she was updating the MAR, she noticed Cymbalta was listed on the MAR as a duplicate so she updated the "Medication List" but did not know why it did not update on the MAR. LALD/LPN-D confirmed the multivitamin was in R1's pharmacy pre-filled pack and stated she was not aware that children's multivitamin was not listed on the MAR and stated both herself and CNS-A were responsible for transcribing orders. The licensee's Medication Documentation policy dated August 1, 2021, indicated documentation would be complete, accurate, and legible. If administration of one or more medications were not completed, staff would document the following: -the reason why the medication was not administered; -follow up procedures to mee the resident's needs in compliance with the medication management plan; -appropriate notification to RN supervisor or other persons as instructed regarding missed dosages; and -medication error report, if appropriate. The licensee's Medication Management Program (MMP) policy dated 2021, indicated admission to the MMP was at the discretion of the RN and based on a professional face-to-face nursing assessment that included medication reconciliation to include duplicate drug therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been	01790			

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01790	Continued From page 49 provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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).	01790			

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01790	Continued From page 50 The findings include: During entrance conference on June 29, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the licensee provided medication management services to the licensees' one resident. The licensee's undated Unplanned Time Away Medication Set Up Policy lacked written procedures including: -the type of container or containers to be used for the medications appropriate to the provider's medication system; -how the container or containers must be labeled; -written information about the medications to be provided; -how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; -how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; -a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and -how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned	01790			

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01790	Continued From page 51 medication. On July 2, 2026, at 10:22 a.m., via telephone, CNS-A stated she did not know if there were written procedures and would discuss this topic at the following meeting that Monday. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
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, record review, and interview, the licensee failed to ensure diabetic medications were stored according to manufacturer's instructions within the medication refrigerator and failed to store controlled substances in a separately locked compartment per their policy for one of one resident (R1) receiving medication management services. 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	01880			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 52 a large portion or all the residents). The findings include: During entrance conference on June 29, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the licensee provided medication management services to the licensee's one resident. R1 had diagnoses including schizophrenia, type 2 diabetes, binge eating disorder, generalized anxiety disorder, and congestive heart failure. R1's unsigned Service Plan - Waiver effective date June 29, 2026, indicated R1 received assistance with blood glucose checks and medication administration 12 times per day. MEDICATION REFRIGERATOR R1's admission orders dated March 5, 2026, ordered the following diabetic medication: -Humulin R 500 units/milliliter (ml) Kwik pen (concentrated insulin for severe insulin resistance), inject 600 units subcutaneously (SQ) at breakfast and dinner, and inject 700 units SQ at lunch; -Lantus Solostar 100 units/ml flex pen (long-acting insulin), inject 100 units SQ at bedtime, hold if blood glucose was less than 150; and -Ozempic 2 milligrams (mg)/3 ml pen (receptor agonist for type 2 diabetes), inject 0.25 mg SQ once weekly. During observation and interview on June 29, 2026, at 11:45 a.m., the surveyor observed the medication refrigerator on the floor of the dining room with a metal exterior lock requiring a key to	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41252	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2026
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01880	Continued From page 53 open it. The surveyor asked LALD/LPN-D to open the refrigerator and observed three different types of insulin on the middle shelf along with an analog thermometer (non-digital) that read 32 degrees Fahrenheit (F) and showed LALD/LPN-D. Above that shelf to the right was a freezer component. The surveyor asked LALD/LPN-D what temperature range insulin typically needed to be within, she responded "40?" The surveyor informed LALD/LPN-D the range was typically 36-46 degrees F. LALD/LPN-D stated she would adjust the temperature control inside the refrigerator, and the surveyor observed the dial to be set on "Max." The refrigerator contained the following medications for R1: -Humulin R 500 unit/ml Kwik pen-15 Kwik pens; -Lantus Solostar 100 units/ml flex pen-1 flex pen; and -Ozempic 2 mg/3 ml pen-1 pen. The Temperature Log dated June 1-29, 2026, indicated critical limits of freezer was 0 degrees and refrigerator 40 degrees. The log also indicated the following documented temperatures: -one out of 29 days was blank (no temperature recorded); -25 out of 28 days recorded temperatures of 32 degrees F (freezing point for insulin); -two out of 28 days recorded temperatures of 35 degrees F; and -one out of 28 days recorded a temperature of 36 degrees F. During observation and interview on June 29, 2026, at 1:50 p.m., the surveyor asked unlicensed personnel (ULP)-B to open the medication refrigerator and the thermometer read 39 degrees F (within acceptable range). The surveyor asked ULP-B at what temperatures staff	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41252	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2026
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01880	Continued From page 54 should contact the registered nurse (RN)? ULP-B stated the temperatures had never been high or low but would contact the RN if the temperature reached 0 degrees. During phone interview on June 30, 2026, at 3:51 p.m., CNS-A stated staff were not trained when to notify the nurse regarding medication refrigerator temperatures. CNS-A stated she was not aware the temperatures were 32 degrees F and CNS-A stated she would get all staff trained. The manufacturer's instructions for Lantus Solostar dated August 2022, indicated to store unused pens in the refrigerator between 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Humulin R-500 revised February 2024, indicated to store unused pens in the refrigerator between 36 degrees F to 46 degrees F. Do not use if it has been frozen. The manufacturer's instructions for Ozempic dated April 2026, indicated to store unused pens in the refrigerator between 36 degrees F to 46 degrees F. CONTROLLED SUBSTANCE STORAGE R1's Visit Summary signed May 26, 2026, ordered the following controlled medications: -hydromorphone 2 mg, one tablet four times per day for pain; and -morphine sulfate extended release 15 mg, one tablet twice a day for pain. On July 1, 2026, at 2:30 p.m., LALD/LPN-D opened the locked medication cabinet and the surveyor observed a small metal safe (narcotic	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41252	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6219 CHOWEN AVE N 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
01880	Continued From page 55 box) with the key inside the keyhole. The surveyor asked LALD/LPN-D if staff left the key in the safe, she stated the cabinet door was always locked but stated it wouldn't be considered double locked and staff should keep the narcotic key on their person. The narcotic box contained R1's hydromorphone and morphine. The licensee's Storage/Control of Medications policy dated August 1, 2022, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or separated from foods. Temperature is maintained at 35-40 degrees. The policy also indicated schedule II controlled substances are stored in a separately locked compartment. Only authorized personnel have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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; (2) documentation of specific resident instructions	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41252	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2026
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01940	Continued From page 56 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 observation, interview, and record review, the licensee failed to develop and implement an individualized treatment or therapy management plan (ITTMP) including all required content for one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on June 29, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41252	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2026
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01940	Continued From page 57 stated they created the service plan on the electronic health record program (Residex), went over the service plan with the resident, then signed it. If there were changes to the service plan, they would complete the same process. R1 was admitted on March 3, 2026, and began receiving assisted living services. R1 had diagnoses including schizophrenia, type 2 diabetes, binge eating disorder, generalized anxiety disorder, and congestive heart failure. R1's unsigned Service Plan - Waiver effective date (printed date) June 29, 2026, indicated R1 received assistance with blood glucose checks three times per day, medication administration 12 times per day, monthly supervision: oxygen (O2) management by the registered nurse (RN), bathing assistance, bedmaking, grooming, housekeeping, manage behavior (agitation, anxiety, other mental health need, property destruction, repetitive behavior, verbal aggression), and toileting. R1's Assessment (30-day nursing assessment) dated April 17, 2026, indicated staff would assist R1 with O2 equipment when needed. R1's Medications-Current with as of date June 29, 2026, instructed staff to administer two (2) liters (L) of O2 via nasal cannula (NC-tubing that delivers oxygen to nostrils) to keep O2 saturation above 90%. R1's provider orders dated March 5, 2026, ordered to administer 2 L of O2 via NC as needed to keep O2 saturation above 90%. During facility tour on June 29, 2026, at 11:36 a.m., the surveyor observed an O2 concentrator	01940			

Minnesota Department of Health

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01940	Continued From page 58 (pulls ambient air, removes nitrogen to deliver higher concentration of oxygen) next to R1's bed with NC attached. CNS-A stated R1 should be using oxygen but R1 refused to use it. R1's ITTMP lacked the following required information: -statement of the type of service (O2 administration) that would be provided; -identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP); and -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapies. On July 1, 2026, at 4:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated she normally did not have the resident sign an updated service plan, only when they moved in. LALD/LPN-D stated O2 administration was not included on R1's current service plan. The licensee's Treatment and Therapy Management policy dated August 1, 2022, indicated the RN would prepare an ITTMP for each resident receiving ordered or prescribed treatments or therapy services, which addressed: -type of service to be provided; -procedures for documenting treatment therapies; -procedures for monitoring treatments to prevent possible complications or adverse reactions; -identification of treatment tasks delegated to ULP; and -procedures for notifying the RN when a problem arises related to the treatment service. No further information was provided.	01940			

Minnesota Department of Health

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01940	Continued From page 59	01940			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-B performed appropriate insulin administration procedures for one of one ULP observed performing insulin administration. 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 was hired to provide comprehensive home care services on April 10, 2020, and began providing assisted living services on August 1, 2021.	02320			

Minnesota Department of Health

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02320	Continued From page 60 ULP-B's Medication and Treatment - Insulin Administration Skill Competency dated November 15, 2023, indicated ULP-B had been deemed competent by the registered nurse (RN) to administer insulin. R1's Med Admin Summary - Actual - Month dated June 2026, indicated R1 received Humulin U-500 insulin (concentrated insulin for severe insulin resistance), inject 600 units at breakfast and dinner, then inject 700 units for lunch. "Prime the insulin pen before administering insulin." During observation on June 30, 2026, at 8:30 a.m., unlicensed personnel (ULP)-B assisted R1 with checking her blood glucose which was 447 (normal blood glucose levels are 80-130). ULP-B primed the Humulin Kwik pen by dialing two clicks (wasted 10 units of insulin to ensure the pen was working properly) then dialed the pen to the maximum dose possible-300 units. ULP-B injected the insulin into the top mid-section of R1's abdomen. While the needle was still in the abdomen, ULP-B dialed it to another 300 units, and injected it. During interview on July 1, 2026, at 12:18 p.m., ULP-B stated she was trained to give insulin at another job but stated all "nurses" trained her on how to administer R1's Humulin. R1 stated some staff would administer how ULP-B did, others would remove the needle from the abdomen, redial, then re-inject. During interview on July 1, 2026, at 3:00 p.m., clinical nurse supervisor (CNS)-A was not aware ULP-B was administering insulin that way and stated she trained staff to dial the pen per orders, rotate sites, and clean the site before administering insulin. Once they injected the first	02320			

Minnesota Department of Health

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02320	Continued From page 61 300 units, staff were trained to remove the needle from the skin, re-dial to the amount needed then "re-inject using the same needle as long as it was done right away." CNS-A stated R1's insurance would not cover additional needles for them to change each time. The manufacturer's instructions for Humulin R-500 revised February 2024, indicated to always use a new needle for each injection to help prevent infections and blocked needles. Additionally, if the dose was more than 300 units, more than one injection was needed and must use a new needle for each injection and repeat the priming step. The licensee's Medication Administration policy dated August 1, 2021, indicated the RN may delegate medication administration to a ULP according to the following protocol: a. All ULPs have passed a competency evaluation with respect to all medication routes to be administered; b. The RN had prepared written instructions for the ULP in the proper methods to administer medications with respect to each resident; and c. The RN had communicated with/provided orientation to the ULP regarding the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

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Establishment Info

Butterfly Bound Care
6219 Chowen Ave N
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41252

Risk:
License:
Expires on:
CFPM: MARTHA ISANKA
CFPM #: 60548; Exp: 8-5-2028

Inspection Info

Report Number: F1062261137
Inspection Type: Full - Single
Date: 6/29/2026 Time: 11:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

COMMENT: NO ILLNESS RECORD AVAILABLE FOR REVIEW DURING INSPECTION.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED RAW CHICKEN STORED ON REFRIGERATOR SHELF ABOVE CUT WATERMELON AT TIME OF INSPECTION. ENSURE RAW ANIMAL PROTEINS ARE STORED IN SUCH A WAY THAT RISK OF CONTAMINATION TO READY-TO EAT FOODS IS MINIMIZED.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

New Order: 3-500A Microbial Control: cooling

3-501.13ABC Priority Level: Priority 3 CFP#: 35

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

COMMENT: OBSERVED GROUND SAUSAGE BEING THAWED IN STANDING WATER DURING INSPECTION. ENSURE TCS FOODS ARE THAWED IN AN APPROVED MANNER. IN THIS CASE, WATER SHOULD BE RUNNING.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

New Order: 3-500C Microbial Control: date marking

3-501.17A Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

COMMENT: OBSERVED CUT WATERMELON IN REFRIGERATOR WITH NO INDICATION OF WHEN IT WAS PREPARED.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

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

COMMENT: IRREVERSIBLE REGISTERING THERMOMETER FOR TESTING DISH MACHINE WAS NOT AVAILABLE AT FACILITY DURING INSPECTION.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B *Priority Level: Priority 1 CFP#: 16*

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

COMMENT: HOT WATER SANITIZING DISHWASHER FAILED TO CAUSE TEMPERATURE SENSITIVE ELEMENTS OF THERMOLABEL TO CHANGE COLOR, INDICATING THE SURFACE TEMP OF THE WARES INSIDE THE MACHINE DID NOT REACH 160F. COMPLY WITH RULE ABOVE.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

Food & Beverage General Comment

INSPECTION COMPLETED ON BEHALF OF ANNA BOHNEN (HRD).

DRYWALL, WOOD PANEL FLOORS, LAMINATE COUNTERS

DISCUSSED HOT WATER SANITIZING, ILLNESS RECORDING, THAWING METHODS, AND FOOD STORAGE.

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 Metro District Office inspection report number F1062261137 from 6/29/2026

MARTHA ISANKA
CFPM


Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Butterfly Bound Care
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261137
Inspection Type: Full
Date: 6/29/2026
Time: 11:00 am

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: Refrigerator at 50 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** WATERMELON SLICE; **Temperature Process:** Cold-Holding

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Butterfly Bound Care
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261137
Inspection Type: Full
Date: 6/29/2026
Time: 11:00 am

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Less Than** 150 Degrees F.
Comment:
Violation Issued?: Yes



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Butterfly Bound Care
6219 Chowen Ave N
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41252

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1062261138
Inspection Type: Follow-up - Single
Date: 6/30/2026 Time: 2:18:39 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery:

! Previous Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED RAW CHICKEN STORED ON REFRIGERATOR SHELF ABOVE CUT WATERMELON AT TIME OF INSPECTION. ENSURE RAW ANIMAL PROTEINS ARE STORED IN SUCH A WAY THAT RISK OF CONTAMINATION TO READY-TO EAT FOODS IS MINIMIZED.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

Previous Order: 3-500C Microbial Control: date marking

3-501.17A Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

COMMENT: OBSERVED CUT WATERMELON IN REFRIGERATOR WITH NO INDICATION OF WHEN IT WAS PREPARED.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

Previous Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

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

COMMENT: IRREVERSIBLE REGISTERING THERMOMETER FOR TESTING DISH MACHINE WAS NOT AVAILABLE AT FACILITY DURING INSPECTION.

Comply By: 6/29/2026 Originally Issued On: 6/29/2026

Food & Beverage General Comment

ON SITE FOLLOW UP.

EMPLOYEE ILLNESS LOG PRINTED AND AVAILABLE ON SITE, REFRIGERATOR ADJUSTED TO KEEP CONTENTS AT 41 OR BELOW, DISH MACHINE RINSE RAISING SURFACE TEMPS OF UTENSILS/WARES TO 160F OR GREATER, VOMIT CLEAN-UP KIT AND PROCEDURES ASSEMBLED FOR STAFF.

NO FURTHER FOLLOW-UP NEEDED.

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 Metro District Office inspection report number F1062261138 from 6/30/2026



Establishment Representative

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Butterfly Bound Care
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261138
Inspection Type: Follow-up
Date: 6/30/2026
Time: 2:18:39 PM

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: Refrigerator at 36 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Butterfly Bound Care
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261138
Inspection Type: Follow-up
Date: 6/30/2026
Time: 2:18:39 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41252015-0	Date: 6/30/2026
Facility Name: BUTTERFLY BOUND CARE	
Facility Address: 6219 Chowen Ave N, Brooklyn Center, MN 55429	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: Licensed assisted living director (LALD)-D tested the smoke alarms for interconnection. The alarms located in the basement did not sound when tested. Housing manager (HM)-C was able to reconnect the alarms in the basement to the other alarms throughout the facility. Test was reinitiated and all alarms were interconnected.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP lacked any plans or diagrams showing the location and number of resident sleeping rooms.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. Policy was for residents of a high-rise apartment complex to follow.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Documentation provided was from a different facility that LALD-D also provided services for.

5. 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Training", indicated evacuation drills were conducted in May 2026. The documentation was also not labeled for the specific facility. LALD-D stated that all the training done is used for multiple facilities.