DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 14, 2022

Administrator
The Sanctuary At Brooklyn Center
6121 Brooklyn Boulevard
Brooklyn Center, MN 55429

RE: Project Number(s) SL33772015

Dear Administrator:

On April 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on January 27, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the January 27, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on January 27, 2022, found not corrected at the time of the April 5, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

The details of the violations noted at the time of this follow-up evaluation completed on April 5, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier, Supervisor, at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	R 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL33772015 On April 5, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 27, 2022. At the time of the survey, there were 156 residents: 154 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	{0 480}		

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{0 480}	Continued From page 1 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{01760} SS=D	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	{01760}		

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{01760}	Continued From page 2	{01760}		

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 interview and record review, the licensee failed to ensure medications were administered and not administered as prescribed in order to meet the resident's needs for one of four residents (R11) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R11 admitted on May 18, 2021, with diagnoses of diabetes type 2 with diabetic neuropathy, atrial fibrillation, hypertension, and peripheral vascular disease.

R11's Service Agreement dated March 8, 2022, indicated R11 received medication management.

R11's Master Assessment 2.0 dated February 14, 2022, indicated R11 received insulin injections.

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{01760}	Continued From page 3 R11's Medication Sheet dated March 2022, indicated R11 received Humalog (fast acting) insulin via an insulin pen. The order read, "Inject 0 to 5 units subcutaneously three times daily before meals per sliding scale. 0-199 give 0 units, 200 and over give 5 units with meals." On March 3, 2022, for the 12:00 p.m. dose, unlicensed personnel (ULP)-I documented 6 units were administered. On March 8, 2022, for the 7:30 a.m. dose, ULP-I documented R11's blood sugar reading of 152, which based on prescribed order would indicate zero (0) insulin would be administered. ULP-I documented they administered 5 units. On March 15, 2022, for the 12:00 p.m. dose, ULP-I documented R11's blood sugar reading of 116, which based on prescribed order would indicate zero (0) insulin would be administered. ULP-I documented they administered 5 units. ULP-I's training record provided by executive director (ED)-A on April 5, 2022, indicated ULP-I had completed NEO AL - Medication Administration - RAs - Ebenezer, Medication and Treatment - Insulin, and Medication and Treatment - Insulin Pen between March 7 and March 8, 2022. On April 5, 2022, at approximately 1:30 p.m., registered nurse (RN)-D acknowledged R11 had received an overdose of insulin by ULP-I when blood sugar levels had indicated no insulin would be administered. RN-D stated ULP-I was currently out of the country and RN-D would not be able to verify with ULP-I if a medication error had occurred. RN-D indicated based on	{01760}		

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{01760}	Continued From page 4 documentation, the errors would have occurred. RN-D stated ULP-I would not be allowed to provide medication to any residents until they had returned to work and completed a remedial medication administration training program with supervision from the RN. The licensee's Medication Administration: Insulin Injection policy dated August 1, 2021, indicated employees would complete the "5 rights," checks in order to prevent medication errors. No further information provided.	{01760}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

Electronically Delivered

March 4, 2022

Administrator
The Sanctuary At Brooklyn Cent
6121 Brooklyn Boulevard
Brooklyn Center, MN 55429

RE: Project Number(s) SL33772015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33772015 On Janaury 24, 2022, through January 27, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 150 residents receiving services under the provider's Assisted Living/with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 24, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 485	Continued From page 2	0 485		
0 485 SS=D	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure meal substitutions were of similar nutritional value for one of six residents (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 485		

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0 485	Continued From page 3 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The posted menu for lunch on January 24, 2022, included soup, salad, chicken fajitas, refried beans and assorted desserts. The alternate noted a chef salad with dressing. On January 24, 2022, at 12:30 p.m. R2 sat in the dining room during lunch, drinking ice water (without thickener) and had a bowl of pureed brown food in front of her. R2 stated she did not like the meal and could not eat it. R2's prescriber orders, dated February 24, 2021, included diagnoses of dementia and aspiration pneumonia. The prescriber orders included honey thickened liquids, and a mechanical soft diet (foods that do not require much chewing and are soft on the mouth, ground meats with gravy, mashed potatoes and soft-cooked noodles). R2's assessment, dated November 9, 2021, indicated R2 was on a pureed diet (soft, pudding like texture). R2's service plan, dated February 2, 2021, included honey thickened liquids and free water in between meals. On January 24, 2022, at 12:40 p.m., memory care manager (MCM)-O served R2 a bowl of refried beans and chocolate pudding as an alternate. On January 24, 2022, at 12:45 p.m., R2 reported to the surveyor that she did not like refried beans, and could not eat it, however, she ate the	0 485		

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0 485	Continued From page 4 chocolate pudding. On January 27, 2022, at 9:00 a.m., chef (C)-L verified on January 24, 2022, R2 received an alternate lunch of refried beans. C-L stated another alternate that could have been served was hot dog and french fries, which was not provided. C-L verified that all the food was blended together (rice, beans and chicken) and served in one bowl. The licensee's Meal Program policy, dated August 2021, noted meal substitutions must be of similar nutritional value. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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0 510	Continued From page 5 review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards related to COVID-19. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 24, 2022, at approximately 4:00 p.m., the surveyor observed an individual exit the main floor dining room, and walk down the hall without any personal protective equipment (PPE), including a surgical mask and eye protection. The surveyor observed residents in the vicinity. The same individual exited a bathroom in the hallway several minutes later. The individual stated they were an employee in dietary and verified the lack of any PPE. The individual stated their name, however, the name was not identified on the employee roster. The individual then walked into the dining room and into the kitchen. On January 26, 2022, at approximately 12:00 p.m., three employees provided meals and cleaned the dining area, with multiple residents and visitors present, and did not wear eye protection. Each employee wore surgical face masks in the proper manner. On January 27, 2021, at 9:00 a.m., multiple residents were in the main floor dining room. Upon entering the dining room, chef (C)-L and	0 510		

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0 510	Continued From page 6 dietary aide (DA)-M and DA-N were observed wearing cloth masks instead of medical grade masks. The employees were not wearing eye protection. On January 24, 2027, at 11:25 a.m. registered nurse (RN)-D stated all staff should wear medical grade masks. On January 26, 2022, at 12:30 p.m. executive director (ED)-A stated they were short staffed in dietary because a "handful" of staff were out sick with COVID-19. ED-A stated employees were not instructed to wear eye protection while serving meals to residents. ED-A acknowledged there was a possibility employees would be in contact with residents and the dining area could be considered a resident care area. ED-A acknowledged eye protection should be required for all staff if resident contact may occur. On January 27, 2021, at 9:00 a.m. C-L verified the masks worn by C-L, DA-M and DA-N were not medical grade. On January 27, 2021, at approximately 9:05 a.m. DA-M stated she had COVID-19 several weeks ago, and that she wore a cloth mask while working and that none of the residents had contracted COVID-19. The licensee's PPE Using Masks and Eye Protection policy, dated November 11, 2021, indicated eye protection would be required when in contact with residents. The policy lacked information regarding the type of mask that should be worn. The Minnesota Department of Health (MDH) Covid-19 Personal Protective Equipment and	0 510		

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0 510	Continued From page 7 Source Control Grids for Congregate Settings, dated December 7, 2021, noted cloth masks were intended primarily for source control in the community (versus congregate settings). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to report incidents of neglect of supervision to the Minnesota Adult Abuse Reporting Center (MAARC), for two of two residents (R8 and R9). 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	0 620		

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0 620	Continued From page 8 situation has occurred only occasionally). The findings include: On January 25, 2022, at 7:00 a.m., unlicensed personnel (ULP)-H exited R8's room and stated R8 was sleeping in R9's room. ULP-H then entered R9's room, R8 and R9 were in bed together. R8 was sleeping on her side, and was awoken and assisted up to a sitting position. ULP-H escorted R8 to her room via wheelchair for personal care assistance. R8's Global Deterioration Scale for Assessment of Primary Degenerative Dementia, dated November 23, 2021, noted moderate cognitive decline. R8's deficits included: decreased knowledge of current and recent events, may exhibit some deficit in memory of personal history, inability to perform complex tasks and denial is dominant defense mechanism. R8's assessment, dated November 23, 2021, noted assistance of one with transfers and getting in and out of bed. R8 was described as having difficulty using a call system. R8's assessment identified R8's daughter and son as powers of attorney. R8's Vulnerability: Safety and Risk assessment, dated November 23, 2021, noted R8 had word finding difficulty. The assessment noted R8 was not at risk of being sexually abused by others. R8's progress notes included the following: -December 1, 2021: Resident was enrolled in hospice for additional support and services. Notified daughter of resident's recent being close to a male resident in the facility. Daughter was happy she found a friend that will keep from	0 620		

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0 620	Continued From page 9	0 620		

isolating herself. Informed daughter that no sexual expression has been observed.
-January 1, 2022: Complained of pain in back and buttocks. Has scheduled acetaminophen and Morphine.
-January 5, 2022: Resident continues to be disoriented at all times. Resistant to ask for assistance. Weak due to changing physical condition.
-January 13, 2022: Resident more confused and weaker than previously due to poor appetite and pain. Resident unable to use pendant and staff must anticipate needs.

R9's Global Deterioration Scale for Assessment of Primary Degenerative Dementia, dated December 15, 2021, noted severe cognitive decline. R9's deficits included: may forget the name of the spouse upon whom they are entirely dependent for survival, will be largely unaware of all recent events and experiences in their lives, personality and emotional changes occur that can be variable and include: delusional behavior, obsessive symptoms, anxiety symptoms, agitation and even previously nonexistent violent behavior may occur.

R9's assessment, dated December 15, 2021, noted assistance of one with dressing, grooming and bathing.

R9's progress notes included the following:
-December 15, 2021: Resident up daily walking in halls. Recently his female companion passed away. He seems to be noticing another female resident but no evidence that he is confusing her with past female companion. Resistant to showers.

R9's Vulnerability: Safety and Risk assessment,

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0 620	Continued From page 10 dated September 23, 2021, noted R9 did not pose a potential risk to others, including verbal abuse, threatening behavior and inappropriate sexual behavior. On January 25, 2022, at 8:15 a.m., ULP-H indicated she did not usually work in the memory care unit, and she did not know if it was acceptable or not, if R8 and R9 slept in the same bed. ULP-H stated R9 "always has a woman." On January 25, 2022, at 8:15 a.m., ULP-G stated today (January 25) was the first day she noticed R8 in R9's room and indicated she did not routinely work on the unit. On January 25, 2022, at 10:00 a.m., ULP-J indicated she was aware R8 and R9 were sleeping together. On January 25, 2022, at 11:30 a.m., registered nurse (RN)-D started she was unaware R8 and R9 were sleeping together, and the licensee considered them consenting adults as long as the family members were aware. RN-D was unaware if the R8 and R9's family members were aware of them sleeping together. On January 25, 2022, at 11:50 a.m., RN-E verified she expected staff to report if residents in the memory care unit were sleeping together. RN-E indicated she did not think it was a good idea, because R8 had pain, and received hospice (end of life) services. RN-E stated she understood why it was not communicated, because if they were both consenting, that was acceptable. RN-E indicated R8 and R9's family members were aware they were spending time together and verified she did not think they were aware they were sleeping together.	0 620		

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0 620	Continued From page 11 On January 26, 2022, at 11:00 a.m., clinical director (CD)-B verified the incident was not reported to MAARC. CD-B stated the licensee did not have an obligation to inform R8 and R9's family members they were sleeping together, because R8 and R9's relationship appeared consensual. CD-B verified the registered nurse was not aware of the behaviors, and the situation should have been assessed, as well as a plan developed for ongoing monitoring. The licensee's Vulnerable Adult Chart-Abuse, Neglect and Financial Exploitation policy, dated December 2, 2020, defined neglect as failure or omission to supply care or services, including supervision. The policy defined the timing of the report as "immediately" which means as soon as possible, but no longer than 24 hours. The licensee's Vulnerable Adult Reporting and Investigation policy, dated December 2, 2020, noted any staff person who witnesses or suspects any form of resident-to-resident abuse must report the abuse immediately. According to the policy the DHS (acronym not identified) or executive director were responsible for investigating reported incidents and completed the Vulnerable Adult Internal Investigation of Suspected Maltreatment form for any incident of suspected maltreatment. As part of the internal investigation, interview witnesseses or persons who may have information concerning the incident. Document the witness statements. Review the resident's care plan and relevant chart, including the individual abuse protection plan and agency policies. Review, revise and implement service plan revisions and care plan interventions.	0 620		

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0 620	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement an individual abuse prevention plan that included and individualized assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse for three of eight (R8, R9 and R4) residents with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 630		

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0 630	Continued From page 13	0 630		

cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On January 25, 2022, at 7:00 a.m. unlicensed personnel (ULP)-H exited R8's room and stated R8 was sleeping in R9's room. ULP-H then entered R9's room, R8 and R9 were observed in bed together. R8 was sleeping her side, and was awoken and assisted up to a sitting position. ULP-H escorted R8 to her room via wheelchair for personal care assistance.

On January 25, 2022, at 10:00 a.m. ULP-J indicated she was aware R8 and R9 were sleeping together.

On January 25, 2022, at 11:50 a.m. RN-E verified she expected staff to report if residents in the memory care unit were sleeping together. RN-E indicated she did not think it was a good idea, because R8 had pain, and received hospice (end of life) services. RN-E stated she understood why it was not communicated, because if they were both consenting that was acceptable. RN-E indicated R8 and R9's family members were aware they were spending time together.

R8
R4 admitted on July 9, 2019.

R8's Vulnerability, Safety and Risk assessment dated November 23, 2021, lacked an individualized asssessment and statements to minimize the risk of abuse pertaining to the

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0 630	Continued From page 14 behaviors of sleeping with R9. R8's diagnoses included dementia. R8's Global Deterioration Scale for Assessment of Primary Degenerative Dementia, dated November 23, 2021, noted moderate cognitive decline. According to the assessment, deficits included decreased knowledge of current and recent events. May exhibit some deficit in memory of ones personal history. Inability to perform complex tasks. Denial is dominant defense mechanism. R8's assessment dated November 23, 2021, noted assistance of one with transfers and getting in and out of bed. The resident was described as having difficulty using call system. R8 was described as having difficulty with communication, but could make needs known. R8's Vulnerability: Safety and Risk assessment dated November 23, 2021, noted the resident had word finding difficulty. The assessment noted the resident was not at risk of being sexually abused by others. R9 R9 admitted on March 1, 2019. R9's Vulnerability, Safety and Risk assessment dated September 23, 2021, lacked an individualized asssessment and statements to minimize the risk of abuse pertaining to the behaviors of sleeping with R8. R9's diagnoses included dementia. R9's Global Deterioration Scale for Assessment of Primary Degenerative Dementia, dated December 15, 2021, noted severe cognitive decline. May forget the name of the spouse upon	0 630		

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0 630	Continued From page 15 whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their livers. Personality and emotional changes occur that can be variable and include: delusional behavior, obsessive symptoms, anxiety symptoms, agitation and even previously nonexistent violent behavior may occur. R9's assessment dated December 15, 2021, noted assistance of one with dressing, grooming and bathing. R9's Vulnerability: Safety and Risk assessment dated September 23, 2021, noted the resident did not pose a potential risk to others, including verbal abuse, threatening behavior and inappropriate sexual behavior. On January 26, 2022, at 11:00 a.m. clinical director (CD)-B stated the licensee did not have an obligation to inform R8 and R9's family members they were sleeping together, because R8 and R9's relationship appeared consensual. CD-B verified the registered nurse was not aware of the behaviors, and the situation was not assessed in order to determine if either resident was at risk for abuse. CD-B verified the situation should have been assessed, as well as a plan for ongoing monitoring. On January 27, 2022, at 12:30 p.m. RN-E stated R8 and R9 were sleeping together "on and off." RN-E verified R8 and R9's individual abuse prevention plans lacked identification of the behavior, as well as specific measures to minimize the risk of abuse. RN-E verified she would modify the plans to include ongoing observations and verbalizes if either resident was not comfortable sleeping together. RN-E stated	0 630		

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0 630	Continued From page 16 R8 was suppose to have assistance with transfers, but indicated R8 self transferred into R9's bed. R4 R4 admitted on March 1, 2019. R4's record included a Master Assessment 2.0 dated January 20, 2022, identified by clinical director (CD)-B to include R4's individual abuse prevention plan (IAPP). CD-B indicated areas labeled with, "(Potential Vulnerability)," would be part of R4's IAPP. R4's assessed areas of potential vulnerability included financial, vision, hearing, mobility, mental health, and assistance needs in case of an emergency. R4's IAPP lacked specific measures to be taken by licensee to minimize risk of abuse in identified areas of potential vulnerability. On January 25, 2022, at approximately 11:00 a.m., CD-B acknowledged R4's IAPP lacked specific measures to be taken by the licensee to minimize the risk of abuse to R4. CD-B stated licensee was in the process of developing a single assessment to include specific interventions but had not implemented the assessment. The licensee's Assessment of Clients - Initial and Ongoing policy dated August 1, 2021, indicated the licensee would develop an IAPP based on the registered nurse's assessment and would include specific measures to minimize the risk of abuse. No further information provided.	0 630		

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0 630	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 facility failed to establish and maintain a comprehensive tuberculosis (TB) infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC). In addition, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-G) with records reviewed completed baseline TB screening. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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0 660	Continued From page 18 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-G had hire date of December 2, 2019. ULP-G-s TB history and symptom screen, dated November 22, 2019, included a past positive tuberculin skin test (TST) or blood test. ULP-G's employee record included a "positive abnormal" TB blood test dated June 19, 2019, and a chest X-ray dated June 26, 2019, which noted the lungs were clear with no evidence of consolidation (airspaces with fluid) or effusion (fluid). ULP-G's employee record lacked documentation of a medical evaluation following past positive TST or blood test. On January 27, 2022, at approximately 11:00 a.m., the surveyor requested clinical director (CD)-C provide evidence of a medical evaluation following the positive blood test and chest X-ray, however nothing further was provided. CD-C did not specifiy if a medical evaluation was not completed, or if it could not be located. The licensee's TB Screening and Prevention policy, dated November 30, 2020, noted if employees do not have written documentation (past positive) they must receive a chest radiograph and medical evaluation to exclude a diagnosis of infectious TB disease before having direct client contact. No further information was provided.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 660	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 25, 2022, between 10:40 a.m. and 12:00 p.m., survey staff toured the facility with the executive director (ED)-A. During the facility tour, survey staff observed the following: The trash chute access doors were open on the	0 800		

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0 800	Continued From page 20 second and third floors. During the facility tour interview with ED-A, it was confirmed that these doors were open and should be self-closing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	0 950		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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0 950	Continued From page 21 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included designation of representatives in writing, with the required statutory language for six of six residents (R1, R2, R3, R4, R5, and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's Master Assisted Living Resident Agreement, dated August 1, 2021, identified by executive director (ED)-A as R1's assisted living contract. R1's assisted living contract indicated R1 had identified a designated representative, but the contract lacked the required verbatim notice. R2's Master Assisted Living Resident Agreement, dated August 1, 2021, identified by ED-A as R2's assisted living contract. R2's assisted living contract indicated R2 had identified a designated representative, but the contract lacked the required verbatim notice. R3's Master Assisted Living Resident Agreement, dated September 30, 2021, identified by ED-A as R3's assisted living contract. R3's assisted living	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 22 contract indicated R3 had identified a designated representative, but the contract lacked the required verbatim notice. R4's Master Assisted Living Resident Agreement, dated August 1, 2021, identified by ED-A as R4's assisted living contract. R4's assisted living contract indicated R4 had identified a designated representative, but the contract lacked the required verbatim notice. R5's Master Assisted Living Resident Agreement, dated August 1, 2021, identified by ED-A as R5's assisted living contract. R5's assisted living contract indicated R5 had identified a designated representative, but the contract lacked the required verbatim notice. R6's Master Assisted Living Resident Agreement, dated August 1, 2021, identified by ED-A as R6's assisted living contract. R6's assisted living contract indicated R6 had identified a designated representative, but the contract lacked the required verbatim notice. On January 27, 2022, at approximately 10:00 a.m., ED-A acknowledged the contracts for the residents lacked the required verbatim notice per statute. ED-A stated a new contract would need to be developed to include the required notice for all residents receiving services from the licensee. No policy was provided by licensee for the required notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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01620	Continued From page 23	01620		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident reassessment and monitoring was conducted as needed based on changes in the resident's condition, and failed to ensure reassessment and monitoring did not exceed 90 days from the last date of the assessment for two of six residents (R1 and R6) with records reviewed.	01620		

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01620	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 On January 25, 2022, at approximately 7:15 a.m., R1 sat on a sofa in her room, across the room from her bed, with pants at her ankles. When teh surveyor asked where her call pendant was, neither R1 or unlicensed personnel (ULP)-G could locate the call pendant. ULP-G retrieved R1's walker, which was not within reach, and the call pendant was attached to the walker. ULP-G assisted R1 to the bathroom using her walker. When ULP-G completed cares, R1 was not reminded to call for assistance and use the pendant. R1's Master Assessment 2.0, dated November 9, 2021, noted falls as a significant medical concern since the previous assessment. R1 requires assistance of one with ambulation, transferring and toileting. The assessment identified 1-2 falls a month/quarter. The assessment stated R1 had "some difficulty" using call system and needs were met by the service plan. The assessment indicated R1 had both short and long term memory impairment. R1's medical record included the following falls: -December 23, 2021: R1's family called to report R1 was on the floor in her room at 11:00 a.m. R1	01620		

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01620	Continued From page 25	01620		

did not have shoes on, and the call pendant was on her night stand, and not within reach. The fall lacked a reassessment by a registered nurse (RN) for causal factors.
-January 15, 2021, at 5:30 p.m.: R1 was found on the floor. R1 stated she found herself laying on the floor in her blanket. The follow-up assessment was completed by a RN on December 16, 2021. The follow-up assessment noted R1 could not remember how she ended up on the floor. R1's new interventions included that she is encouraged to have pendant on at all times to call for help.
-January 19, 2021, at 11:00 a.m.: R1 was found lying on her left side on the dining room floor. R1 had difficulty picking up feet while walking and tends to keep walker away from body. R1 has unsteady gait and easily fatigues. R1's new interventsion included services changed so that R1 will use the wheelchair when outside her apartment.

On January 26, 2022, at approximately 3:30 p.m., RN-D and RN-E verified an assessment was not completed by a RN following the fall on December 23, 2021. RN-D indicated R1 could not use a pendant consistently because of memory impairment, and RN-E stated R1 did use the pendant to call for assistance. RN-E verified more fall interventions could be implemented regarding pendant use. RN-D and RN-E verified the fall assessments lacked causal/contributing factors, including but not limited to; what the resident was doing prior to the fall; when the resident was last toileted and checked on; how long the resident was on the floor, prior to being discovered, or if the pendant was in reach or if it was used.

The licensee's Fall Protocol policy, dated December 2, 2020, noted the nursing

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01620	Continued From page 26 assessment could be in person or by phone triage. A focused fall follow-up will be completed to determine if there are any additional interventions needed. R6 R6 admitted to the licensee on November 20, 2019. R6's Master Assessment 2.0, dated August 23, 2021, was identified by clinical director (CD)-B as R6's most recent assessment. R6's assessment would have needed to be completed by November 21, 2021, to be completed within the 90 calendar days required time period. On January 26, 2022, at approximately 12:00 p.m., CD-B stated R6's assessment was marked completed by a nurse but may have been completed on paper instead of the computer. CD-B stated the licensee was reaching out to the nurse to see if paperwork could be located but were unsuccessful. CD-B acknowledged R6's assessment was overdue and should have been completed within in 90 calendar days of the previous assessment. The licensee's Assessment of Clients - Initial and Ongoing policy, dated August 1, 2021, indicated assessments were not to exceed 90 calendar days from the previous assessment. In addition, the policy noted on-going assessments of clients were completed based on needs of the resident, including a change in condition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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01640	Continued From page 27	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure services were provided according to the service plan for two of six residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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01640	Continued From page 28	01640		

was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's service plan, dated March 13, 2021, included showers on Tuesday and Fridays.

R1's Service Checkoff List (documentation of services provided), dated January 2022, lacked documentation shower assistance was provided on January 11, 14, and 18, 2022. According to documentation dated January 11, 2022, shower assistance was completed by "another" [no specification as to another]. There was a lack of documentation why shower assistance was not provided on January 14, 2022. Documentation dated January 18, 2022, noted R1 "refused."

On January 25, 2022, at 8:00 a.m., unlicensed personnel (ULP)-K entered R2's room, who was sleeping in bed with clothes on. ULP-K stated ULPs just give her meds and assist on shower days. ULP-K stated R2 did not receive any personnel care assistance. ULP-K reminded R2 of breakfast.

R2's service plan, dated February 6, 2021, included cues and assistance with grooming and dressing.

R2's Service Checkoff List, dated January 2022, included documentation dressing/undressing assistance was provided daily. The Service Checkoff List indicated staff are to provide cues and assistance to ensure that R2 is dressed in clean and appropriate clothing. The Service Checkoff List included documentation assistance

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01640	Continued From page 29 with grooming was provided daily, including give clues and assistance. On January 26, 2022, at approximately 3:30 p.m., registered nurse (RN)-E verified services should be completed as directed on the service plans. The licensee's Service Plan Agreement Development and Revision policy, dated December 2, 2020, noted all assisted living services were provided in accordance with a suitable and up-to-date written service plan, based on the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

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01650	Continued From page 30 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for three of six residents (R4, R5 and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 admitted to the licensee on March 1, 2019. R4's Service Plan Agreement, dated January 1, 2021, indicated R4 received activities of daily living (ADL) assistance, housekeeping, medication management, and treatment management services. R4's service plan lacked the schedule and method of monitoring staff that provided services to resident.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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01650	Continued From page 31 R5 admitted to the licensee on December 3, 2020. R5's Service Plan Agreement, dated March 14, 2021, indicated R5 received activities of daily living (ADL) assistance, housekeeping, medication management, and treatment management services. R5's service plan lacked the schedule and method of monitoring staff that provided services to resident. R6 admitted to the licensee on November 20, 2019. R6's Service Plan Agreement, dated February 25, 2021, indicated R6 received activities of daily living (ADL) assistance, housekeeping, medication management, and treatment management services. R6's service plan lacked the schedule and method of monitoring staff that provided services to resident. On January 25, 2022, at approximately 11:00 a.m., clinical director (CD)-B acknowledged residents' service plans lacked the schedule and method of monitoring for employees that provided services to the residents. CD-B stated the licensee had developed new service plans that contained all required content but had not provided them to the residents or residents representatives for signature and they would not be included in the residents' records. The licensee's Service Plan Agreement Content policy, dated December 2, 2020, indicated all required content related to resident service plans. No further information provided.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions 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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 33 reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the individual medication management plan included the required content for one of six residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 25, 2022, at 7:30 a.m., unlicensed personnel (ULP)-G administered oral medications and insulin to R1. ULP-G retrieved a Novolog insulin pen, placed a needle on the pen, and dialed the pen to 5 units without priming the needle. ULP-G was prepared to administer the insulin and the surveyor questioned if the needle was primed. ULP-G verified it was not and then primed the needle. ULP-G verified the R1's record lacked instructions to prime the needle prior to administration.	01730		

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01730	Continued From page 34 On January 25, 2022, at approximately 11:00 a.m., the surveyor observed the refrigerator in the nurse's office contained recently delivered and unopened insulin. R1's individual medication management plan (date not specified) lacked: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and -documentation of specific resident instructions relating to the administration of medications. On January 25, 2022, at approximately 11:00 a.m., licensed practical nurse (LPN)-P verified insulin was stored in refrigerator. On January 26, 2022, at 3:30 p.m., registered nurse (RN)-D and RN-E verified R1's individual medication management plan lacked the required content. Manufactures' directions for Novolog insulin, dated June 2021, included: before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing, turn the dose selector to select 2 units and remove the air. Manufactures' directions for storage of unopened insulin noted between 36 and 40 degrees Fahrenheit. The licensee's Development of Individualized Medication Management Plan policy, dated December 2, 2020, noted the plan included a description of how medications were stored, and identification of specific client instructions regarding medications administered by staff.	01730		

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01730	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	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 ensure medications were administered as prescribed, and when not administered as prescribed, documentation included any follow-up procedures provided in order to meet the resident's needs for two of six residents (R1 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

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01760	Continued From page 36	01760		

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:

On January 25, 2022, at 7:30 a.m., unlicensed personnel (ULP)-G administered oral medications and insulin to R1. ULP-G retrieved a Novolog (fast acting insulin) insulin pen, placed a needle on the end of the pen, and dialed the pen to 5 units without priming the needle. ULP-G was prepared to administer the insulin and the surveyor questioned if the needle was primed. ULP-G verified it was not and then primed the needle. ULP-G verified the R1's record lacked instructions to prime the needle prior to administration. ULP-G did not administer the Diclofenac gel (non-steroid anti-inflammatory) or Clotrimazole cream (anti-fungal). ULP-G indicated she would administer the topical ointments and creams after R1's shower.

On January 25, 2022, from 9:30 a.m. to 10:00 a.m., ULP-G assisted R1 with a shower. After the shower, ULP-G assisted R1 with dressing, and but did not apply the Diclofenac gel and Clotirmazole cream. Following the shower, R1 stated she was tired and rested on the sofa in her room.

R1's prescriber orders, dated October 14, 2021, included Diclofenac gel 1% apply topically to knees twice a day.

R1's prescriber orders, dated October 28, 2021, included Novolog insulin 5 units 15 minutes before breakfast, lunch and dinner.

R1's prescriber orders, dated December 16,

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01760	Continued From page 37 2021, included Clotrimazole 1% cream to rash on buttocks, twice a day. R1's medication administration record (MAR), dated January 2022, included: -January 5, at 4:00 p.m., Novolog insulin was not administered with notation it was "too late." At 8:00p.m., R1's blood glucose was 402. -January 11, 2022, at 8:00 a.m., Novolog insulin was not administered because "low blood sugar." R1's blood glucose was 52 (normal blood glucose/sugar typically 70-120). -January 12, at 8:00 a.m. and 11:00 a.m., R1's Novolog insulin was administered. R1's blood glucose was 49. -January 25, 2022 at 8:00 a.m., Diclofenac gel and Clotrimazole cream were applied (though they were not observed to be administered by ULP-G). On January 26, 2022, at 3:30 p.m., registered nurse (RN)-D and RN-E verified R1's MAR lacked instructions for priming the insulin needles and verified needles should be primed before dialing the insulin dose. RN-E did not know why the insulin was not administered on January 11, 2022, or what "too late" meant. RN-D and RN-E verified the nurse should be notified if and when insulin was not administered as prescribed. RN-D and RN-E verified a lack of documentation by licensed nurse, regarding the insulin that was not administered. Manufactures' directions for Novolog insulin, dated June 2021, included: before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing, turn the dose selector to select 2 units and remove the air.	01760		

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01760	Continued From page 38 R3's prescriber orders, dated December 16, 2022, indicated Tylenol (non-steriodal anti-inflammatory pain medication) extra strength one tablet four times a day. R3's MAR. dated January 2022, included instructions for Tylenol extra strength one tablet three times a day. On January 26, 2022, at 9:00 a.m., clinical director (CD)-B verified an error occurred, and R3 had been receiving Tylenol three times a day, versus the prescribed four times a day. The licensee's Medication Errors policy, dated November 2020, noted medication errors were promptly reported to the RN. Medication errors included incorrect dose, medications skipped or administered at the wrong time, or not administered consistent with the prescription. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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:	01940		

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01940	Continued From page 39 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment plan with the required contents for two of two residents (R2 and R1) who received treatments/therapies. 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 the survey, dated January 24, 2022,	01940		

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01940	Continued From page 40 through January 27, 2022, clinical director (CD)-B stated the licensee's individual treatment/therapy plans consisted of multiple documents including the service plan, the medication/treatment record, and the service checkoff list (documentation of services). R2 On January 24, 2022, at 12:30 p.m., R2 sat in the dining room during lunch, drinking ice water (without thickening) with a bowl of pureed brown food in front of her. R2 coughed occasionally. On January 24, 2022, at 12:50 p.m., unlicensed personnel (ULP)-R verified R2 was drinking water, not thickened, during her meal and that was acceptable. On January 25, 2022, at 8:30 a.m., R2 drank juice without thickening. On January 25, 2022, at 8:45 a.m., R2 ate a biscuit (chopped) with gravy and an entire Danish roll. R2 coughed occasionally. R2's service plan, dated February 2, 2021, included assistance with a pureed diet (soft, pudding-like consistency). R2's service plan included free water during non-meal times. R2's prescriber orders, dated February 24, 2021, included honey thickened liquids and a mechanical soft diet (foods that do not require much chewing and are soft on the mouth, ground meats with gravy, mashed potatoes and soft-cooked noodles). R2's prescriber orders included diagnoses of dementia and aspiration pneumonia. R2's Service Checkoff list, dated January 22,	01940		

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01940	Continued From page 41 2022, included documentation a mechanical soft diet was provided. On January 25, 2022, at 2:00 p.m., registered nurse (RN)-E stated R2's son wanted R2 on a pureed diet, but R2 did not like it. RN-E indicated a past swallow evaluation recommendation included a pureed diet (date not specified, and RN-E was unable to locate the evaluation). RN-E indicated R2 used to receive hospice services (end of life), but no longer received the services. RN-E indicated the mechanical soft was initiated around that time, however, R2 had difficulty with some foods on the mechanical soft diet and the diet was changed back to pureed. RN-E could not locate current prescriber orders for the pureed diet. RN-E was informed of the observations, and verified R2 should receive thickened liquids and should not eat a Danish roll. On January 25, 2022, at approximately 2:30 p.m., licensed practical nurse (LPN)-P attempted to locate the prescriber orders for the diet, but was unable to do so. On January 25, 2022, at approximately 2:45 p.m., LPN-P called R2's physician assistant (PA) to question the diet order. R2's PA could not locate any orders, and subsequently ordered a pureed diet with honey thickened liquids. The PA stated R2 should have another swallow evaluation. R1 R1's assessment, dated November 9, 2021, included diagnoses of diabetes. R1's service plan, dated March 13, 2021, lacked a statement of the type of services provided regarding blood glucose monitoring, including	01940		

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01940	Continued From page 42 identification of treatment or therapy tasks delegated to unlicensed personnel. In addition, R1's service plan lacked ongoing monitoring of the treatment/therapy to prevent complications or adverse reactions. R1's prescriber orders, dated October 15, 2021, indicated blood glucose monitoring four times a day. R1's specific directions noted; notify the nurse for a blood glucose/sugar less than 70 or greater than 250. A review of the medication administration record dated January 2022, included at least 56 occasions of 96 opportunities, where the blood glucose was not in the identified range, and the record lacked documentation of ongoing monitoring of the treatment. R1's medication administration record (MAR), dated January 2022, indicated to notify the nurse for a blood glucose/sugar less than 70 or greater than 250. R1's MAR included 56 occasions of 96 opportunities, where the blood glucose was not in the identified range, and the record lacked documentation of ongoing monitoring of the treatment. R1's MAR noted on January 11, 2022, at 8:00 a.m., Novolog (fast acting) insulin was not administered because "low blood sugar" which was documented as 52 (normal blood glucose/sugar typically 70-120). However, on January 12, at 8:00 a.m. and 11:00 a.m., R1's Novolog insulin was administered with blood glucose level of 49. On January 26, 2022, at 3:30 p.m. RN-D and RN-E verified a lack of documentation a nurse was contacted regarding the blood glucose levels, and indicated they were not aware. RN-D	01940		

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01940	Continued From page 43 and RN-E did not verify the individual treatment/therapy plan lacked a statement on the service plan, and identification of treatment or therapy tasks that were delegated to unlicensed personnel. The licensee's Development of Individualized Treatment Management Plan policy, dated December 2, 2020, noted the RN obtained prescriptions for all treatments the agency managed. The policy noted the RN ensured the individual treatment management plan was up to date and consistent with prescriber orders. In addition, the policy noted the licensee verified that all treatments were administered as prescribed and monitoring of treatments to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960		

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01960	Continued From page 44 by: Based on observation, interview, and record review, the licensee failed to ensure each treatment or therapy was documented, and when not documented as prescribed, the provider must document the reason why and any follow-up procedures that were provided to meet the resident's needs for two of two residents (R1 and R2) who received treatments/therapies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 On January 25, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-G assisted R1 with morning cares. A sign was posted in R1's room with directions for application of calf compression wraps (to reduce swelling), however ULP-G did not apply R1's compression wraps. R1's lower calves appeared large but were nonpitting (does not respond to pressure or cause any sort of indentation when pressed). R1's feet did not appear edematous (swollen). On January 25, 2022, at approximately 7:45 a.m. ULP-G stated R1 "sometimes" wore the compression wraps. ULP-G was unable to locate the compression wraps. On January 25, 2022, from 9:30 a.m. to 10:00	01960		

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01960	Continued From page 45 a.m. ULP-G assisted R1 with a shower. After the shower, ULP-G did not apply R1's compression wraps. On January 26, 2022, at 12:00 p.m., R1 was not wearing the calf compression wraps. R1's prescriber orders, dated December 7, 2020, indicated calf compression wraps. R1's Service Checkoff (documentation of services provided), dated January 2022, included compression stockings/wraps with specific instructions for the application. The Service Checkoff, dated January 26, 2022, indicated the wraps were applied (however, they were not observed on). The Service Checkoff indicated the wraps were not applied on four days in January 2022. On January 26, 2022, at 3:30 p.m., registered nurse (RN)-D and RN-E verified R1's wraps were to be applied. When informed ULP-G could not locate the compression wraps, RN-D and RN-E stated they would locate the wraps. RN-E stated R1 was admitted to a long-term care facility in October 2021, and RN-E thought possibly the compression wraps did not return with R1. On January 27, 2022, at approximately 1:00 p.m., RN-E verified the compression wraps were not located, and it was undeterminable how long they were missing. R2 R2's service plan, dated February 2, 2021, included assistance with a pureed diet (soft, pudding-like consistency). R2's service plan included free water during non-meal times.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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01960	Continued From page 46 R2's prescriber orders, dated February 24, 2021, included honey thickened liquids and a mechanical soft diet (foods that do not require much chewing and are soft on the mouth, ground meats with gravy, mashed potatoes, and soft-cooked noodles). R2's Service Checkoff, dated January 22, 2022, included documentation of a mechanical soft diet at meals. On January 24, 2022, at 12:30 p.m., R2 sat in the dining room during lunch, drinking ice water (without thickening) with a bowl of pureed brown food in front of her. R2 coughed occasionally. On January 24, 2022, at 12:50 p.m., unlicensed personnel (ULP)-R verified R2 was drinking water, not thickened, during her meal and that was acceptable. On January 25, 2022, at 8:30 a.m., R2 drank juice without thickening. On January 25, 2022, at 8:45 a.m., R2 ate a biscuit (chopped) with gravy and an entire Danish roll. R2 coughed occasionally. On January 25, 2022, at 2:00 p.m., registered nurse (RN)-E stated R2's son wanted R2 on a pureed diet, but R2 did not like it. RN-E indicated a past swallow evaluation recommendation included a pureed diet (date not specified, and RN-E was unable to locate the evaluation). RN-E indicated R2 used to receive hospice services (end of life), but no longer received the services. RN-E indicated the mechanical soft was initiated around that time, however, R2 had difficulty with some foods on the mechanical soft diet and the diet was changed back to pureed. RN-E could not	01960		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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01960	Continued From page 47 locate current prescriber orders for the pureed diet. RN-E was informed of the observations and verified R2 should receive thickened liquids and should not eat a Danish roll. On January 25, 2022, at approximately 2:30 p.m. licensed practical nurse (LPN)-P attempted to locate the prescriber orders for the diet but was unable to do so. On January 25, 2022, at approximately 2:45 p.m., LPN-P called R2's physician assistant (PA) to question the diet order. R2's PA could not locate any orders, and subsequently ordered a pureed diet with honey thickened liquids. The PA stated R2 should have another swallow evaluation. The licensee's Development of Individualized Treatment Management Plan policy, dated December 2, 2020, stated each treatment was documented as indicated by the service plan. If a treatment was not completed for any reason, staff were to notify a nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

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01970	Continued From page 48 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an up-to-date order included a description of the treatment/therapy, and other information needed to administer the treatment or therapy was obtained for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 24, 2022, at 12:30 p.m., R2 sat in the dining room during lunch, drinking ice water (without thickening) with a bowl of pureed brown food in front of her. R2's service plan, dated February 2, 2021, included a pureed diet. R2's prescriber orders, dated February 24, 2021, included honey thickened liquids, and a mechanical soft diet (foods that do not require much chewing and are soft on the mouth, ground meats with gravy, mashed potatoes and soft-cooked noodles). R2's Service Checkoff (documentation of	01970		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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01970	Continued From page 49 services provided), dated January 2022, noted honey thick liquids, and a mechanical soft diet were administered daily. On January 25, 2022, at 2:00 p.m., registered nurse (RN)-E stated R2's son wanted her on a pureed diet, but R2 did not like it (pureed). RN-E indicated a past swallow evaluation had recommended a pureed diet. RN-E indicated R2 received hospice services (end of life), but no longer received the services. RN-E indicated the mechanical soft was initiated around that time, however, R2 had difficulty with some foods on the mechanical soft diet and the diet was changed to pureed. RN-E could not locate a current prescriber order for the pureed diet. On January 25, 2022, at approximately 2:30 p.m. licensed practical nurse (LPN)-P attempted to locate the prescriber orders for the diet, but was unable to do so. On January 25, 2022, at approximately 2:45 p.m., LPN-P called R2's physician assistant (PA) to question the diet order. R2's PA could not locate any orders, and subsequently ordered a pureed diet with honey thickened liquids. The licensee's Development of Individualized Treatment Management Plan policy, dated December 2, 2020, noted the RN obtained prescriptions for all treatments the agency managed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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02040	Continued From page 50	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to affect all dementia care residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 25, 2022, at 12:00 p.m., documents were provided for review by the executive director, (ED)-A. The Ebenezer Hazard Vulnerability Assessment Tool was included. On January 25, 2022, between 12:00 p.m. and	02040		

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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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02040	Continued From page 51 12:55 p.m., documents were reviewed by survey staff. The hazard vulnerability assessment did not identify hazards on and around the property. On January 25, 2022, between 12:55 p.m. and 1:05 p.m., the ED-A confirmed during the exit interview that the licensee failed to identify hazards or safety risks on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices	02160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02160	Continued From page 52 for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident choice and dignity for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The posted menu for lunch on January 24, 2022, included soup, salad, chicken fajitas, refried beans and assorted desserts. The alternate noted a chef salad with dressing. On January 24, 2022, at 12:30 p.m., R2 sat in the dining room during lunch, drinking ice water (without thickening) with a bowl of pureed (soft, pudding like texture) brown food in front of her. R2 stated she did not like the meal and could not eat the meal. On January 24, 2022, at 12:40 p.m., memory care manager (MCM)-O served R2 a bowl of refried beans and chocolate pudding. R2's prescriber orders, dated February 24, 2022,	02160		

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02160	Continued From page 53 included diagnoses of dementia and aspiration pneumonia. The prescriber orders included honey thickened liquids, and a mechanical soft diet (foods that do not require much chewing and are soft on the mouth, ground meats with gravy, mashed potatoes and soft-cooked noodles). R2's assessment, dated November 9, 2021, identified R2 on a pureed diet. R2's service plan, dated February 2, 2021, included honey thickened liquids and free water in between meals. On January 24, 2022, at 12:45 p.m., R2 reported to the surveyor that she did not like refried beans, and could not eat it, however, ate the chocolate pudding. On January 27, 2022, at 9:00 a.m., chef (C)-L verified on January 24, 2022, R2 received an alternate lunch of refried beans. C-L stated another alternate that could have been served was hot dog and french fries, which was not provided. C-L verified that all the food was blended together (rice, beans and chicken) and served in one bowl. A policy and procedure regarding person-centered care was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02160		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services	02310		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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02310	Continued From page 54 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure assisted living services were provided based on the resident's needs and according to an up-to-date service plan an accepted health care standards for one of six residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: BED RAIL On January 25, 2022, at 7:30 a.m., the surveyor observed bilateral bed rails on R1's bed. R1's bed (right side) was observed against the wall, with the bed rail in the up position. The left bed rail was in the down position. The bed rails were close to the mattress, and without gaps. The openings within the rails appeared less than 4 3/4 inches width. R1's assessment, dated November 9, 2021, included assistance with ambulation, transfers	02310		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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02310	Continued From page 55 and toileting. R1's Global Scale Assessment of Primary Degenerative Dementia, dated November 9, 2021, noted moderate/severe cognitive decline. R1's medical record lacked an assessment of the bed rail, as well as evidence the risks of bed rail use was reviewed with R1's representative. On January 25, 2022, at 7:30 a.m., unlicensed personnel (ULP)-G stated she thought the bed rail was raised when R1 was in bed, but wasn't sure. R1 stated she did not think the bed rail was ever raised (left side) but said she wasn't sure. On January 26, 2022, at 3:30 p.m., registered nurse (RN)-D and RN-E verified they could not locate the bed rail assessment. The bed rail was removed following the interview on the same day. TRANSFER BELT On January 25, 2022, at approximately 9:15 a.m., ULP-G provided ambulation assistance from the dining room to R1's room, with a walker and without use of transfer belt. R1 ambulated very slowly and then stopped and reached out and grabbed the hall hand rail, and appeared to begin to lower herself down. ULP-G summoned ULP-H to obtain a wheelchair for R1. R1 was subsequently transferred to the wheelchair. On January 25, 2022, at approximately 9:30 a.m., ULP-G assisteded R1 with a shower. ULP-G assisted with a transfer to the shower stool. R1 had difficulty following directions and moving into the shower and sitting on the stool. ULP-G stated "do you want me to get a transfer belt?" R1 did not respond. ULP-J arrived following assistance with shower, and assisted with dressing. R1 was	02310		

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	33772	A. BUILDING: _____ B. WING _____	01/27/2022

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02310	Continued From page 56 sitting in the wheelchair and had difficulty rising to a standing position. ULP-G and ULP-J assisted with coaxing the resident and guiding, under the arms. ULP-J verified a transfer belt should have been used with R1. On January 26, 2022, at 11:30 a.m., RN-D verified a transfer belt should have been used when ambulating and transferring R1. The licensee's Assessment of The Safety of Side Rails policy, dated December 2, 2020, noted the RN assessed and evaluated client's needs to determine if the client can appropriately utilize the side rails. In addition, the RN provided education regarding side rail safety and risks. A policy regarding the use of transfer belts was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	03000		

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03000	Continued From page 57 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record	03000		

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03000	Continued From page 58	03000		

review, the licensee failed to report incidents of neglect of supervision to the Minnesota Adult Abuse Reporting Center (MAARC), for two of two residents (R8 and R9).

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:

On January 25, 2022, at 7:00 a.m., unlicensed personnel (ULP)-H exited R8's room and stated R8 was sleeping in R9's room. ULP-H then entered R9's room, R8 and R9 were in bed together. R8 was sleeping on her side, and was awoken and assisted up to a sitting position. ULP-H escorted R8 to her room via wheelchair for personal care assistance.

R8's Global Deterioration Scale for Assessment of Primary Degenerative Dementia, dated November 23, 2021, noted moderate cognitive decline. R8's deficits included: decreased knowledge of current and recent events, may exhibit some deficit in memory of personal history, inability to perform complex tasks and denial is dominant defense mechanism.

R8's assessment, dated November 23, 2021, noted assistance of one with transfers and getting in and out of bed. R8 was described as having difficulty using a call system. R8's assessment identified R8's daughter and son as powers of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD 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
03000	Continued From page 59 attorney. R8's Vulnerability: Safety and Risk assessment, dated November 23, 2021, noted R8 had word finding difficulty. The assessment noted R8 was not at risk of being sexually abused by others. R8's progress notes included the following: -December 1, 2021: Resident was enrolled in hospice for additional support and services. Notified daughter of resident's recent being close to a male resident in the facility. Daughter was happy she found a friend that will keep from isolating herself. Informed daughter that no sexual expression has been observed. -January 1, 2022: Complained of pain in back and buttocks. Has scheduled acetaminophen and Morphine. -January 5, 2022: Resident continues to be disoriented at all times. Resistant to ask for assistance. Weak due to changing physical condition. -January 13, 2022: Resident more confused and weaker than previously due to poor appetite and pain. Resident unable to use pendant and staff must anticipate needs. R9's Global Deterioration Scale for Assessment of Primary Degenerative Dementia, dated December 15, 2021, noted severe cognitive decline. R9's deficits included: may forget the name of the spouse upon whom they are entirely dependent for survival, will be largely unaware of all recent events and experiences in their lives, personality and emotional changes occur that can be variable and include: delusional behavior, obsessive symptoms, anxiety symptoms, agitation and even previously nonexistent violent behavior may occur.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD 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
03000	Continued From page 60 R9's assessment, dated December 15, 2021, noted assistance of one with dressing, grooming and bathing. R9's progress notes included the following: -December 15, 2021: Resident up daily walking in halls. Recently his female companion passed away. He seems to be noticing another female resident but no evidence that he is confusing her with past female companion. Resistant to showers. R9's Vulnerability: Safety and Risk assessment, dated September 23, 2021, noted R9 did not pose a potential risk to others, including verbal abuse, threatening behavior and inappropriate sexual behavior. On January 25, 2022, at 8:15 a.m., ULP-H indicated she did not usually work in the memory care unit, and she did not know if it was acceptable or not, if R8 and R9 slept in the same bed. ULP-H stated R9 "always has a woman." On January 25, 2022, at 8:15 a.m., ULP-G stated today (January 25) was the first day she noticed R8 in R9's room and indicated she did not routinely work on the unit. On January 25, 2022, at 10:00 a.m., ULP-J indicated she was aware R8 and R9 were sleeping together. On January 25, 2022, at 11:30 a.m., registered nurse (RN)-D started she was unaware R8 and R9 were sleeping together, and the licensee considered them consenting adults as long as the family members were aware. RN-D was unaware if the R8 and R9's family members were aware of them sleeping together.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33772	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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03000	Continued From page 61 On January 25, 2022, at 11:50 a.m., RN-E verified she expected staff to report if residents in the memory care unit were sleeping together. RN-E indicated she did not think it was a good idea, because R8 had pain, and received hospice (end of life) services. RN-E stated she understood why it was not communicated, because if they were both consenting, that was acceptable. RN-E indicated R8 and R9's family members were aware they were spending time together and verified she did not think they were aware they were sleeping together. On January 26, 2022, at 11:00 a.m., clinical director (CD)-B verified the incident was not reported to MAARC. CD-B stated the licensee did not have an obligation to inform R8 and R9's family members they were sleeping together, because R8 and R9's relationship appeared consensual. CD-B verified the registered nurse was not aware of the behaviors, and the situation should have been assessed, as well as a plan developed for ongoing monitoring. The licensee's Vulnerable Adult Chart-Abuse, Neglect and Financial Exploitation policy, dated December 2, 2020, defined neglect as failure or omission to supply care or services, including supervision. The policy defined the timing of the report as "immediately" which means as soon as possible, but no longer than 24 hours. The licensee's Vulnerable Adult Reporting and Investigation policy, dated December 2, 2020, noted any staff person who witnesses or suspects any form of resident-to-resident abuse must report the abuse immediately. According to the policy the DHS (acronym not identified) or executive director were responsible for	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SANCTUARY AT BROOKLYN CENT	6121 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55429

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03000	Continued From page 62 investigating reported incidents and completed the Vulnerable Adult Internal Investigation of Suspected Maltreatment form for any incident of suspected maltreatment. As part of the internal investigation, interview witnesseses or persons who may have information concerning the incident. Document the witness statements. Review the resident's care plan and relevant chart, including the individual abuse protection plan and agency policies. Review, revise and implement service plan revisions and care plan interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *01/24/22*
Time: 13:18:19
Report: 7994221017

Food and Beverage Establishment Inspection Report

Location:
The Sanctuary At Brooklyn Cent
6121 Brooklyn Boulevard
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038902
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635046700
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.11A ** Priority 1 **

MN Rule 4626.0270A Do not allow food to contact surfaces of equipment and utensils that are not cleaned and sanitized.

KNIFE FOUND STORED BETWEEN THE HOT WELLS AND THE PREP TABLE. STORE KNIVES IN AN APPROVED WAY (ON A CLEAN SURFACE/IN RUNNING WATER/ETC) AND FULLY CLEAN EVERY 4 HOURS.

Comply By: 01/24/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO CURRENT TEMPERATURE MEASURING DEVICE WAS FOUND ON SITE.

Comply By: 01/24/22

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM WAS FOUND ON SITE. THE CURRENT KITCHEN MANAGER WILL BE TAKING THE SERVE SAFE CLASS NEXT WEEK.

Comply By: 01/24/22

Type: Full
Date: *01/24/22*
Time: 13:18:19
Report: 7994221017
The Sanctuary At Brooklyn Cent

Food and Beverage Establishment Inspection Report

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

thermometer
cfpm
knife

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994221017 of 01/24/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994221017

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	01/24/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	13:18:19
Legal Authority MN Rules Chapter 4626		**Time Out**	

The Sanctuary At Brooklyn Cent	**Address** 6121 Brooklyn Boulevard	**City/State** Brooklyn Center, MN	**Zip Code** 55429	**Telephone** 7635046700
License/Permit # 0038902	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/24/22

Inspector (Signature) Crystal Elva