Electronically Delivered

February 3, 2025

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

RE: Project Number(s) SL33772016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 may be 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.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

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 _____	12/12/2024

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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0 000	Initial Comments 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: SL33772016-0 On December 9, 2024, through December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 142 residents; all of whom were receiving services under the Assisted Living facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related garbage removal and incontinence products for one of four staff, (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 10, 2024, from 7:34 a.m. through 8:02 a.m., the surveyor observed ULP-B came out of a resident's room and placed a garbage bag that was approximately half full of garbage including soiled incontinence products, next to resident's door. ULP-B asked for assistance from	0 510		

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0 510	Continued From page 2 another ULP, then picked up the half full garbage bag and entered R3's room and place the garbage bag down on the floor against R3's cabinet. ULP-B completed morning cares for R3. ULP-B removed a soiled incontinent product from R3 and placed it directly on the floor. ULP-B provided perineal (peri) care and applied a clean brief. ULP-B then proceeded to get R3 dressed from the waist up with the help of another ULP and assisted R3 into a wheelchair. ULP-B then took the soiled incontinent product from the floor and placed it into the garbage bag. On December 10, 2024, at 8:05 a.m., ULP-B stated, "We bring the garbage from room to room because otherwise we waste too much time running back and forth, when the bags get full, we will start a new bag and once we are done with rounds we throw them away. I put the garbage bag too far away so I couldn't reach it, but usually I put the dirty products right into the garbage bag." On December 10, 2024, at 11:37 a.m. clinical nurse supervisor (CNS)-D "They should be taking the soiled items to the soiled utility room immediately; they should not be sitting it down or taking it anywhere other than to the trash. No incontinence products should be put on the ground, but we are working on that." The licensee's Standard Infection Control Precautions policy, dated March 25, 2016, indicated, "Standard Precautions apply to all staff when working with all clients, regardless of the clients' diagnosis or presumed infection status. Application of Standard Precautions include appropriate hand washing, utilization of personal protective equipment, proper handling of contaminated equipment and soiled linens, use	0 510		

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0 510	Continued From page 3 and disposal of sharps, and devices used as an alternative to mouth-to-mouth resuscitation to reduce exposure to blood and other potentially infectious material." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 700		

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0 700	Continued From page 4 The findings include: On December 10, 2024, at 8:45 a.m., the surveyor observed the laptop on the memory care medication cart 3-4 to be left unattended while open and access to all resident charts unlocked. On December 10, 2024, at 11:34 a.m., clinical nurse supervisor (CNS)-D stated the medication cart should be locked anytime staff are going to move away from the cart and the computer screens shut or locked. The licensee's Client Record Confidentiality policy dated March 1, 2014, indicated, "Client records and client information will be kept confidential" as well as "All staff members are responsible to make sure confidentiality is maintained." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	0 780		

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0 780	Continued From page 5 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate and failed to maintain self-closing fire rated assembly. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2024, from 10:00 a.m. to 3:00 p.m., the surveyor toured the facility with director of environmental services (DES)-G and director of environmental services float (DESF)-F. The following was observed.	0 780		

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0 780	Continued From page 6 Smoke alarms: The surveyor asked DES-G and DESF-F to initiate a test of the smoke alarms in all resident rooms that were being surveyed. Upon testing, it was found that the smoke alarms were not interconnected within resident rooms: 330, 424, 413. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. Fire rated entry doors: The fire rated entry doors separating the resident rooms from the corridor on the following resident rooms would not close and latch on their own: 131, 227, and 219. Fire rated entry doors separating the resident rooms from the corridor are required to close and latch on their own. Fire rated ceiling assembly: In the fourth-floor electrical room the surveyor observed there was missing required fire stopping between the fourth-floor electrical closet and the attic space. The surveyor observed several pieces of fire stopping material laying on the floor. DES-G stated that they had more fire stopping material and would replace the missing fire stopping. Firestopping used to protect penetrations to resist the passage of smoke and fire shall be maintained. The firestopping shall be securely fastened or bonded to the opening being protected with no visible gaps.	0 780		

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0 780	Continued From page 7 Exit obstruction: The surveyor observed three or more plastic carts per floor placed directly in front of the handrail in the corridor. The surveyor did not observe anyone using the carts, or the carts being moved while surveying the facility. The surveyor asked DES-G and DESF-F what the carts are used for. Both indicated that the carts are used to store medication. The surveyor asked DES-G and DESF-F if the med carts are normally stored in the corridor, or if they are stored in a different area and brought into the corridor when in use. DES-G and DESF-F both stated that the med carts are always stored in the corridor. The corridor shall be maintained free of obstructions and combustible materials storage. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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0 800	Continued From page 8 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2024, from 10:00 a.m. to 3:00 p.m., the surveyor toured the facility with director of environmental services (DES)-G and director of environmental services float (DESF)-F. The following was observed. In resident room 407 there was missing interior trim on the side of the entry door. DES-G stated it was from the resident's mobility scooter catching the trim when entering the unit. In resident room 314 there was missing trim on the side of the bathroom door. DES-G stated it was from the resident's mobility scooter catching the trim when entering and exiting the bathroom. Interior trim shall be maintained as approved at time of construction. When the unit door to resident room 435 was opened by DES-G during survey there was a strong ammonia smell inside of the room that	0 800		

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0 800	Continued From page 9 caused the surveyor to begin coughing and made the surveyors eyes water. DES-G and DESF-F both entered the resident room and stated that they believed that the smell was due to soiled incontinence garments not being removed from the resident room and a dry sewer drain trap. Resident rooms shall be maintained in a manner that will not cause eye or respiratory irritation. The carpeting in resident room 131 had multiple brown stains on the carpeted area. DES-G stated that they believed the stains were from chocolate. The surveyor asked DES-G if they had a plan to address the stained carpeting. DES-G stated they would prefer to replace the carpeting with a more easily cleanable flooring. Resident rooms shall have flooring that is maintained reasonably free from stains in a sanitary condition. Resident room 428 had an excessive amount of belongings causing there to be restrictive paths throughout the room making it difficult for staff and emergency responders to safely access the resident room. All resident rooms shall have a storage configuration that allows safe access to the room for the resident, staff, and emergency responders. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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01820	Continued From page 10 recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R6). 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: R6 admitted to the licensee and began receiving services on November 21, 2023. R6 had diagnoses to include peripheral vascular disease, type 2 diabetes mellitus, hypertension, major depressive disorder, anxiety disorder, spinal stenosis, and metabolic encephalopathy. R6's signed Service Plan Agreement dated November 21, 2024, indicated R6 received medication administration, daily temperature check, monthly vital sign check, blood glucose monitoring, bathing assistance four times per week, dressing, grooming, apply/remove/wash compression stockings, personal laundry, linens, housekeeping, transfer, and toileting assistance.	01820		

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01820	Continued From page 11 R6's Medication Administration Record (MAR) dated December 1, 2024, through December 31, 2024, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that R6 received Duloxetine 60mg two times daily through December 7, 2024. R6's record lacked a signed order to discontinue Duloxetine 60mg two times daily on December 7, 2024. On December 11, 2024, at 12:52 p.m., clinical nurse supervisor (CNS)-D indicated that the nurse who processed R6's medication orders followed the initial signed orders from the transitional care unit along with printed orders from the day R6 discharged back to [licensee] and there is not an official order to discontinue the Duloxetine 60mg twice daily. A fax has been sent to the provider for clarification and to request that discontinue order. The licensee's Medication Prescriptions, Refills, Supplies- Request & Delivery policy dated March 1, 2014, last revised August 1, 2021, indicated "1) The RN is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications, alcohol, and dietary supplements, to be managed by our staff are kept in the client's record and that changes in orders are addressed in the client's care plan, service plan and Medication Administration Record (MAR)/Electronic Medical Record (EMAR), and are communicated on a timely manner to appropriate staff. 2) It is the responsibility of the nurse to obtain signed orders from the prescriber	01820		

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 _____	12/12/2024

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
01820	Continued From page 12 - When new medication prescriptions are sent directly to the pharmacy by the prescriber or client, the nurse will request a copy of the prescription from the prescriber or from the pharmacy. - When medication prescriptions are initiated by another health care provider, such as home care or hospice, the nurse will request a copy of the prescription signed by a prescriber - Should the pharmacy or another health care provider not be able to provide a signed order, the nurse will obtain an order from the known prescriber (sic)" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of one residents (R3). 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	01880		

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 _____	12/12/2024

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

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01880	Continued From page 13 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: R3 was admitted to the licensee on November 3, 2020, and began recieving assisted living services on August 1, 2021. R3's Service Plan dated November 22, 2024, indicated R3's services included diabetic management, bathing, behavior monitoring, TEDS, Dressing, grooming, nail care, vitals, daily blood pressure monitoring, housekeeping, laundry, medication administration, assist of two transfers, and toileting. On December 10, 2024, at 8:29 a.m., unlicensed personnel (ULP)-B unlocked the memory care 3/4 medication cart, and then walked away to another area of the facility to get paper towels and speak to another staff, at the time there were four residents sitting in the commons area by the unlocked medication cart. At 8:30 a.m., ULP-B came back to the unlocked medication cart to obtain blood glucose monitoring for R3. On December 10, 2024, at 8:33 a.m., ULP-B took R3 down the hall to the bathroom leaving the memory care 3/4 medication cart unlocked and R3's medications including two insulin pens sitting out, at the time there were three residents sitting in the commons area by the medications and the unlocked medication cart. After placing R3 in the bathroom ULP-B came back to the medication cart and grabbed one insulin pen, leaving the memory care 3/4 medication cart unlocked and R3's medications and one lantus insulin pen out	01880		

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	33772	A. BUILDING: _____ B. WING _____	12/12/2024

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

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01880	Continued From page 14 by the unlocked medication cart. At 8:35 a.m., ULP-B came back to the unlocked medication cart and put the insulin pens back in the cart and locked the cart. On December 10, 2024, at 8:36 a.m., ULP-B stated, "I should have locked that, I forgot. The med cart should be locked any time we leave the cart." On December 10, 2024, at 11:34 a.m., clinical nurse supervisor (CNS)-D stated, "The med cart should be locked anytime they are going to move away from the cart." The licensee's Storage of Medication and Key Security policy, dated September 27, 2021, indicated, "Secured Storage of medications is defined as medications stored in a locked cabinet/box or refrigerator the client's apartment. All medications administered by staff will generally be kept in the secured storage area." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910		

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	33772	A. BUILDING: _____ B. WING _____	12/12/2024

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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01910	Continued From page 15 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the prescription number, strength, and quantity in the disposition for one of two discharged residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was discharged from the licensee to another assisted living facility on December 2, 2024. R2's records included a Medication List that included a handwritten note that read, "Extra bottles of meds family provides	01910		

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 _____	12/12/2024

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

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01910	Continued From page 16 Vit D3 - X5 bottles Melatonin - X5 bottles Acetaminophen 500mg - 1 full bottle + 1/2 bottle Medication released to family" R2's record lacked a medication disposition to include the strength, prescription number as applicable, and quantity involved in the disposition of all of R2's medications. On December 10, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-D stated, "So, we had to call the pharmacy to get the prescription numbers for [R2] because we didn't have them, we normally do the disposition of meds on the disposition form but for some reason on his we didn't, we have it for anyone else you would look at." The Licensee's Disposition of Medication/Legend and Controlled Substances policy, dated March 1, 2014, indicated, "Documentation of the medication destruction must be kept in the client's record. The documentation includes, but is not limited to; name of the client, date, quantity, name of drug, prescription number, and signature of person destroying the medication." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights	02290		

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	33772	A. BUILDING: _____ B. WING _____	12/12/2024

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02290	Continued From page 17 at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee established a facility contract and service plan agreement that used language which limited the rights for one of one resident (R3). This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 10, 2024, at 10:47 a.m., while reviewing R3's resident file, the surveyor observed the licensee's Resident Agreement signed by R1 on May 1, 2024. The Resident Agreement read, "[Licensee] only allows installation of the HALO on a "homestyle" bed or bed mobile device(s) that are FDA approved for a hospital bed." On December 11, 2024, the licensed assisted living director (LALD)-C stated, "We do a bedrail assessment, and we do the measurement, and we only use the Halo brand bedrails, and most of our residents are on waivered services and that will cover the cost of them, so we actually have some in stock that we let them use until theirs is covered and comes in."	02290		

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02290	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/09/24*
Time: 13:30:00
Report: 1025241256

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: Yes

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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Butter
Temperature: 41 Degrees Fahrenheit - Location: Upright cooler
Violation Issued: No

Process/Item: Ham
Temperature: 40 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Beef, pkg
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Discussed deliming and testing for the dish machine, food for quarantine and highly susceptible populations, cooling TCS foods, sink usage for dining area, dipper well usage

Inspector irreverable temp strip turned melted halfway, repeat test with yellow TMD puck and adjust/service the dishwasher if necessary. Rinse @ 185, PSI at 20
3 compartment sink and sanitizer available, use if the dish machine fails to reach 160 deg F contact temperature minimum

Reusables and compostables grant (this is at least similar to what I'm familiar with on the Ramsey/Washington side of things) https://www.hennepin.us/en/business/work-with-henn-co/community-zero-waste-grants
Ramsey Co: https://bizrecycling.com/

Type: Full
Date: *12/09/24*
Time: 13:30:00
Report: 1025241256
The Sanctuary At Brooklyn Cent

Food and Beverage Establishment Inspection Report

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 1025241256 of 12/09/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241256

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 12/09/24
Time In 13:30:00
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
Surpervision							
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		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:** 12/09/24

Inspector (Signature) Gary King