DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 6, 2023

Licensee
The Sanctuary At St. Cloud
2410 20th Avenue Southeast
Saint Cloud, MN 56304

RE: Project Number(s) SL33613015

Dear Licensee:

On May 31, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 10, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

JMD

Electronically Delivered

April 28, 2023

Licensee
The Sanctuary At St Cloud
2410 20th Avenue Southeast
Saint Cloud, MN 56304

RE: Project Number(s) SL33613015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 10, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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 survey:

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for 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

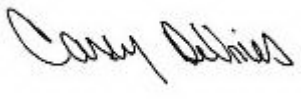
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH 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. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33613015-0 On March 6, 2023, through March 10, 2023, 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 90 residents, 89 of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on March 7, 2023, issued for SL33613015-0, tag identification 2310. On March 8, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G. An immediate correction order was identified on March 9, 2023, issued for SL33613015-0, tag identification 0830.	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.	

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0 000	Continued From page 1 On March 10, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained at a scope and level of I.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	0 470		

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0 470	Continued From page 2 Based on observation, interview, and record review, the licensee failed to ensure the daily staffing schedule was posted in a central location in the facility, accessible to staff, residents, volunteers, and the public as required, potentially affecting the licensee's current residents, staff, and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of 147 residents and had a current census of 90 residents. The licensee failed to post a daily staffing schedule in a central location of the facility. During a tour of the facility with licensed assisted living director (LALD)-B on March 6, 2023, at 10:43 a.m., the evaluators observed the facility layout included entrance to the facility, a large common area, and resident apartments on the first (main) floor, resident apartments on the second and third floors, and the memory care unit was located on the fourth floor. The evaluators observed an AL (Assisted Living) Daily Schedule posted on a bulletin board in the hallway, outside of the resident assistants' office on the second floor of the facility, dated March 6, 2023, and the	0 470		

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0 470	Continued From page 3 same document posted on a bulletin board behind the reception area in the memory care unit on the fourth floor. The licensee lacked a posted daily staffing schedule in a central location, accessible to all staff, residents, volunteers, and visitors to the facility. On March 6, 2023, at 1:20 p.m., LALD-B indicated the daily staffing schedule was not posted on the main level of the facility where the entrance and common area was located, and residents and visitors to the facility would not be aware of the location of the posting unless they visited the second or fourth floor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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: (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	0 480		

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0 480	Continued From page 4 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 March 6, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for three of three	0 510		

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0 510	Continued From page 5 employees (unlicensed personnel (ULP)-L, ULP-I, and ULP-E) observed to perform medication administration and blood glucose testing, and failed to ensure proper disposal of a used needle for one of three medication pens. 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: HAND HYGIENE On March 7, 2023, at 3:13 p.m., the evaluator observed ULP-L prepare to administer R17's nebulizer. ULP-L gathered supplies out of the medication cart, went to R17's room, knocked and entered. R17 was sitting in her chair. Without donning gloves, ULP-L picked up R17's nebulizer mouthpiece off the floor under R17's chair, brought it to the sink, and rinsed it out with water. ULP-L used a paper towel to wipe out and dry the mouthpiece and poured the Albuterol (used to treat wheezing and shortness of breath) solution into the chamber and handed the mouthpiece to R17. Without performing hand hygiene, ULP-L touched the kitchen counter and the door handle, and walked to the medication cart and applied hand sanitizer. On March 7, 2023, at 4:05 p.m., the evaluator observed while ULP-L prepared to administer R5's insulin. ULP-L gathered the supplies out of the medication cart and walked to R5's room. R5 was sitting in his motorized chair and reported his	0 510		

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0 510	Continued From page 6 blood sugar results to ULP-L. ULP-L donned gloves, cleansed an area on R5's abdomen with an alcohol pad and administered R5's NovoLog (short acting) insulin. ULP-L removed the gloves, held them in her hand, and without performing hand hygiene, touched R5's door handle to exit the room. ULP-L walked to the medication cart, disposed of the gloves in the attached garbage bin, put the disposable needle into the sharps container, opened the computer and touched the keyboard to document the insulin administration. ULP-L then performed hand hygiene with hand sanitizer on the medication cart. When interviewed on March 7, 2023, at 4:13 p.m., ULP-L indicated she should wear gloves when cleaning a soiled nebulizer mouthpiece and should perform hand hygiene after removing gloves and before leaving a resident's room or touching surfaces. On March 8, 2023, at 8:45 a.m., the evaluator observed as ULP-I prepared oral medications and supplies to perform a blood glucose check for R15. At 8:51 a.m., ULP-I knocked and entered R15's room, donned gloves, and offered R15 his medications. R15 stated he only wanted to take the Tylenol (pain reliever) and ULP-I assisted to take the two tablets of Tylenol out of the medication cup. Still gloved, ULP-I performed R15's blood glucose check by cleansing a finger with an alcohol pad and poking with the lancet to obtain a drop of blood which she applied to the testing strip in the glucometer (device used to test blood glucose level). ULP-I announced the blood glucose level of 128. With the same gloves still on, ULP-I handed R15's Flonase (allergy relief) nasal spray to him, and applied hydrocortisone cream (anti-itch) to an area on the left side of R15's neck with her left gloved hand. ULP-I	0 510		

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0 510	Continued From page 7	0 510		

removed her left glove, straightened R15's bed linens, gathered supplies and garbage, and removed the right glove. Without performing hand hygiene, ULP-I touched the door handle to exit R15's room, pulled up her jeans, pulled her phone from her pocket and looked at the screen, walked to the medication cart, threw garbage into the attached garbage bin, placed the lancet into the sharps container, pulled her keys out of her pocket and unlocked the medication cart, put supplies into the cart, and touched the keyboard to document the medication administration. Without performing hand hygiene, ULP-I announced that she needed to go to the second floor medication storage room to grab insulin for R18, locked the medication cart, and left.

On March 8, 2023, at 8:55 a.m., the evaluator observed ULP-E prepare medications for R19, gather supplies, and enter R19's room with gloves on. ULP-E administered the oral medications, wiped R19's finger with an alcohol wipe, poked it with a lancet, wiped the finger with a tissue, and placed blood on the test strip. After the result was obtained, ULP-E wiped the lower left quadrant of R19's abdomen with an alcohol wipe and administered 2 units of Lispro Kwikpen insulin. ULP-E then gathered her supplies, left the resident's room, and returned to the medication cart, where she placed a cap on the insulin pen, grabbed the keys to open the medication cart, with the glove on her right hand removed the test strip from the glucometer, and removed the glove and disposed of it. ULP-E then opened the top drawer and placed the items inside, put a new glove on her right hand to remove trash from the cup, and tossed the glove, touched the iPad, and marked medications as administered. At this time, ULP-E stated she was done and would move on to the next resident. When asked when

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0 510	Continued From page 8 she would perform hand hygiene, ULP-E stated she should have done it when returning to the medication cart. On March 8, 2023 at 9:32 a.m., ULP-I prepared to administer R18's insulin, gathering supplies from the medication cart as well as a medication cup marked with R18's name that held medications she stated she had set up earlier and attempted to deliver, but R18 was unavailable. ULP-I entered R18's room after knocking and asked R18 what his blood glucose results were. R18 stated, "255". ULP-I donned gloves, cleansed an area on R18's abdomen with an alcohol pad, and administered Lispro (short acting) insulin pen 12 units and Lantus (long acting) insulin pen 40 units. Without removing the gloves, ULP-I handed R18 the oral medications in the medication cup, which he took with juice, and gathered the supplies and garbage. ULP-I removed the gloves as she walked to the door, and without performing hand hygiene, touched the door handle, exited the room, and walked to the medication cart. Without performing hand hygiene, ULP-I removed her glasses and set them on the medication cart, donned one glove to remove the disposable needle from the insulin pens and placed them into the sharps container, doffed the glove and threw it into the garbage bin. Still without performing hand hygiene, ULP-I pulled her keys out of her front pocket and unlocked the medication cart, opened the top drawer, and placed the insulin pens inside, touched the keyboard on the computer to document medication administration, and pulled her phone out of her back pocket to look at the screen. On March 8, 2023, at 9:42 a.m., ULP-I stated hand hygiene should have been performed when	0 510		

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0 510	Continued From page 9	0 510		

removing soiled gloves and before touching surfaces, door handle, phone, and computer. ULP-I stated it wasn't convenient to perform hand hygiene at this facility because hand sanitizer was only on the medication carts and by the elevators, not near resident rooms.

On March 10, 2023, at 8:43 a.m., clinical nurse supervisor (CNS)-A stated hand hygiene should be performed before donning gloves and promptly when removing gloves and before touching other surfaces. CNS-A stated she was working on a plan to have hand sanitizer more available for staff.

SHARPS SAFETY
On March 8, 2023, at 8:45 a.m., the evaluator observed the medication storage room that included the medication refrigerator with CNS-A. The evaluator observed the contents of the medication refrigerator included an injectable medication, Ozempic, with a pen needle still attached to the injectable pen, being stored on top of another medication box. CNS-A removed the injectable pen out of the refrigerator and took the pen to the nursing office. The pen cap of the injectable medication came off as CNS-A placed the pen in the office and the evaluator observed the safety cap had covered the needle, which indicated the needle had been used.

On March 8, 2023, at 8:55 a.m., CNS-A stated that the injectable medication pen should not be stored in the medication refrigerator with a needle still attached, especially since it was a used needle.

The licensee's Standard Infection Control Precautions policy, reviewed August 1, 2022, directed proper hand washing was the most

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0 510	Continued From page 10 important way to break the chain of infection and staff should wash hands before putting on gloves and immediately after gloves were removed. In addition, the policy directed gloves should be changed between tasks and procedures on the same resident and removed promptly after use and before touching non-contaminated items, environmental surfaces, self or other residents, and hands should be washed after removing gloves. In addition, the policy directed staff will use "sharps" precautions to prevent injury from needles, scalpels, and other sharp-edge instruments. Sharps containers will be used by staff for disposal of any sharps used in the provision of client [resident] care that may be exposed to blood of other body fluid. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (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 interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of five residents (R1).	0 620		

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0 620	Continued From page 11 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 entrance conference on March 6, 2023, at approximately 9:55 a.m., a request was made to licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A to review all vulnerable adult reports the licensee had made to MAARC in the last six months. R1's diagnoses included type II diabetes, heart failure, and history of traumatic brain injury. R1's Service Plan Agreement signed on January 30, 2023, noted R1 received services including orientation for moderate confusion, grooming, toileting, and medication administration. A MAARC report submitted September 12, 2022, at 2:28 p.m., indicated on September 10, 2022, at 9:16 p.m., R1 was standing near her closet when she fell to the floor hitting her head. Unlicensed personnel (ULP)-M was in the room at the time and had just set the medication on the dresser, and when she turned around, resident fell. ULP-M was unable to stop the fall. ULP-M called the nurse, who instructed to call 911. When the paramedics arrived, R1 said she had fallen and hit her head, and she also stated she was pushed.	0 620		

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0 620	Continued From page 12 On March 10, 2023, at approximately 9:20 a.m., CNS-A stated although she was not employed with the licensee at the time of the report, their policy is to report immediately, no later than within the first 24 hours. The ULP would notify the nurse on-call, who would notify the CNS to report the incident if needed. The licensee's Vulnerable Adult Reporting and Investigation policy dated reviewed December 2, 2020, noted as soon as the resident was safe, the staff witnessing the maltreatment or CNS would notify the common entry point. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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.	0 660		

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0 660	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of a completed health history and symptom screening for one of four employees (registered nurse(RN)-G). 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 licensee's facility risk assessment dated February 10, 2023, indicated the facility was a low risk. RN-G, employed by a staffing agency, began providing assisted living services for the licensee on August 23, 2022. RN-G's employee record contained a negative Quantiferon TB Gold Plus test dated August 24, 2022. However, it lacked documentation of a completed health history and symptom screening. On March 9, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-A stated the employee file was kept with the agency, and she would check for	0 660		

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0 660	Continued From page 14 the history and symptom screen. However, documentation was not provided. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated baseline TB screening should be documented in the employee's record. The licensee's TB Screening and Prevention policy dated revised August 1, 2021, noted at the time of hire the RN would review TB symptoms and history with each new employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 15 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to prominently post the facility's emergency disaster plan. This had the potential to affect all 90 residents, staff, and visitors of the licensee. 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). Findings include: During a tour of the facility with licensed assisted living director (LALD)-B on March 6, 2023, at 10:43 a.m., the evaluators observed the facility layout included entrance to the facility, a large common area, and resident apartments on the first (main) floor, resident apartments on the second and third floors, and the memory care was located on the fourth floor. The evaluators observed there was no information regarding the licensee's disaster plan posted in a prominent area or elsewhere in the facility.	0 680		

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0 680	Continued From page 16 On March 6, 2023, at 1:20 p.m., LALD-B indicated the emergency preparedness information was in binders, located behind the receptionist's desk, in the LALD's office, in the nursing and resident assistants' office, and on the fourth floor in the memory care unit behind the nurse's desk. LALD-B stated she thought there might be some emergency preparedness information in the library on the second floor of the facility, but stated it wasn't "together" and stated there was nothing posted or available regarding the facility's emergency preparedness plan for residents or visitors to the facility. The licensee's Emergency Operations Program Plan, undated, lacked direction to post the emergency plan prominently, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730		

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0 730	Continued From page 17 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged	0 730		

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0 730	Continued From page 18 residents (R8), all records of communications pertinent to the resident's services for one of five residents (R6), and current prescriber orders for three of nine residents (R6, R15, and R16). 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: DISCHARGE SUMMARY R8 R8 admitted to the facility on July 11, 2019, and discharged to another assisted living facility on November 1, 2022. R8's Discharge Summary dated November 1, 2022, included diagnoses, course of illnesses, allergies, treatments or therapies. However, it lacked a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On March 10, 2023, at 8:58 a.m., clinical nurse supervisor (CNS)-A stated the discharge summary for R8 lacked a final summary, and she was not aware of the requirement to have this. The licensee's Client [resident] Record policy dated revised August 1, 2021, noted the record	0 730		

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0 730	Continued From page 19 would include orders or prescriptions for medications, all records of communications pertinent to the resident's assisted living services, and a discharge summary. RECORDS OF COMMUNICATION R6's diagnoses included type 2 diabetes, inflammatory polyarthropathy (pain and inflammation in five or more joints), anxiety, major depressive disorder, asthma, and glaucoma. R6's Service Plan Agreement, signed January 30, 2023, indicated R6 received services including diabetic management, bathing assistance, compression stockings, weekly weight monitoring, monthly vital monitoring, blood glucose monitoring, topical medication administration, insulin administration, and medication administration. R6's record included Resident Incident Report, dated December 23, 2022, indicating R6 self-reported a fall in her apartment, when she became weak and lost her balance when trying to put her pants on and fell into the corner of the wall. R6 was found sitting on the floor in her bedroom with blood on her face and nose. The report indicated R6 was taken to the emergency room (ER) by emergency medical services (EMS) for treatment. R6's Progress Notes, dated December 23, 2022, at 8:35 a.m., indicated R6 had an unwitnessed fall at 7:03 a.m., and the on-call nurse was called. R6 was bleeding heavily from her nose and on-call nurse directed staff to call 911. At 12:40 p.m., the progress notes indicated a fall follow up by the registered nurse (RN) and noted R6 returned from hospital, had bruising under both eyes, and sustained two lacerations across the	0 730		

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0 730	Continued From page 20 bridge of her nose. Also noted, PT (physical therapy)/OT (occupational therapy) referral was obtained and R6 was eager to start therapy. When interviewed on March 10, 2023, at 10:10 a.m., CNS-A stated R6 returned from the ER after treatment to a laceration on her nose and a referral was initiated for PT/OT to assess R6. CNS-A stated she wasn't sure if R6 was still receiving services from PT/OT. When asked to review the communication notes from PT/OT, CNS-A stated they didn't always receive written communication from outside agencies that provided services for their residents. CNS-A stated she was working hard to improve the communication with agencies coming into the facility to provide services for the residents; however, that wasn't always happening. CURRENT PRESCRIBER ORDERS R6 R6's Medication Sheet, dated March 2023, indicated R6 received the following: - Aspercreme Lidocaine Creme 2.7 ounces, apply to lower back twice daily and both shoulders three times daily for pain; and - Dandruff Shampoo 1% shampoo (pyrithione zinc), wash hair with dandruff shampoo in shower every Wednesday for pain. R6's Medical Information which included medication orders, dated June 15, 2022, and signed by R6's medical provider on June 27, 2022, lacked orders for the above. R15 On March 8, 2023, at 8:45 a.m., the evaluator observed while unlicensed personnel (ULP)-I prepared to administer R15's medications. ULP-I	0 730		

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0 730	Continued From page 21 placed medications into a clear, plastic medication cup as she punched each one from a pharmacy labeled medication punch card, which included the following: - ASA (aspirin) 81 mg (milligrams) orally daily; - diltiazem (treat high blood pressure) 120 mg ER (extended release) orally daily; - duloxetine (antidepressant/antianxiety) 20 mg one tab orally daily; - Eliquis (prevents blood clots) 2.5 mg one twice daily; - furosemide (decrease fluid overload) 20 mg one tab daily; - gabapentin (treat nerve pain) 300 mg one three times daily; - acetaminophen (pain reliever) 500 mg two tablets twice daily; - tamsulosin (treat enlarged prostate) 0.4 mg one daily; and - vitamin D3 (supplement) 25 (MCG) micrograms two tablets daily. ULP-I brought the medication cup to R15's apartment and observed while he swallowed the medications with water. R15's diagnoses included type 2 diabetes, weakness, pulmonary edema, prostate cancer high blood pressure, anxiety, vitamin D deficiency, depression, age related cognitive decline, and lung cancer. R15's Service Plan Agreement, signed January 31, 2023, indicated R15 received services including diabetic management, bathing assistance, meal reminders, cues during dressing, monthly vital monitoring, blood glucose monitoring, insulin administration, and medication administration. R15's record included prescriber orders, dated	0 730		

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0 730	Continued From page 22 November 7, 2022; however, lacked orders for the following administered medications: - diltiazem 120 mg ER orally daily; - duloxetine 20 mg one tab orally daily; and - Eliquis 2.5 mg one twice daily. R16 On March 8, 2023, at 9:10 a.m., the evaluator observed while ULP-L prepared to administer R16's medications. ULP-L placed medications into a clear, plastic medication cup as she punched each one from a pharmacy labeled medication punch card, which included the following: - acetaminophen 325 mg two tablets twice daily; - isosorbide monotrate (prevents chest pain) ER 30 mg one orally daily; - losartan potassium (treat high blood pressure) 50 mg one orally daily; - memantine HCl (hydrochloride) (treat symptoms of Alzheimer's Disease) 10 mg one orally daily; - omeprazole (treat acid reflux) 20 mg one capsule orally twice daily; - verapamil (prevent chest pain) HCl 180 mg one daily: and - metoprolol succinate (treat high blood pressure) 50 mg two tablets daily. ULP-L brought the medication cup to R16's apartment and observed while R16 swallowed the medications with water. R16's diagnoses included type 2 diabetes, dementia, high blood pressure, gastroesophageal reflux (heartburn), Alzheimer's Disease, anxiety, chronic obstructive pulmonary disease, tachycardia (fast heart rate) and cerebral vascular accident (stroke). R16's Service Plan Agreement, signed January 30, 2023, indicated R16 received services	0 730		

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0 730	Continued From page 23 including bathing assistance, orientation to time and place, meal reminders, assist with setting out clothing, reminders for grooming, oral care assistance, blood glucose monitoring, and routine safety checks. R16's record included prescriber orders, dated June 27, 2022; however, lacked orders for the following administered medications: - verapamil HCl 180 mg one daily: and - metoprolol succinate 50 mg two tablets daily. On March 10, 2023, at 8:15 a.m., CNS-A provided separate order sheets for the above missing medication orders and stated she was unable to locate some of the orders due to large piles of documents that had not been filed in residents' records, so she had printed the orders from the provider's portal or called the pharmacy for a copy of the original order. CNS-A indicated the residents' record should include the prescriber orders for the medications being managed by the licensee and was unable to explain why documents were in a pile and not filed in the residents' records. The licensee's Medication Prescriptions, Refills, Supplies-Request & Delivery policy, dated as reviewed November 30, 2020, indicated the RN was responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications, alcohol, and dietary supplements to be managed by the licensee's staff, were kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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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, 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). Findings include: On a facility tour on March 08, 2023, at approximately 10:00 am to 2:00 p.m. with the licensed assisted living director (LALD)-B and the director of maintenance (DM)-D it was observed that the trash chute doors on floors 2, 3, and 4 did	0 800		

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0 800	Continued From page 25 not shut or latch on their own. The door to the fire suppression system for the trash chute, located on the 4th floor, did not close or latch on its own. It was also observed that the fusible link was missing on the hatch at the bottom of the trash chute and the hatch had been disabled. The trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. LALD-B and DM-D visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 26 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This 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). Findings include: A record review and interview were conducted on March 08, 2023, at approximately 2:30 p.m. with the licensed assisted living director (LALD)-B and the director of maintenance (DM)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the	0 810		

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0 810	Continued From page 27 facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, DM-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. LALD-B stated they were doing training for staff at the same time they were conducting evacuation drills but had not completed a full training of the fire safety and evacuation plans and procedure. During interview, DM-D stated the licensee did not have any documented training or a policy on training employees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one	0 830		

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0 830	Continued From page 28 of one resident (R9). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 8, 2023, at 12:40 p.m., the engineering evaluator reported to the evaluator team that during her tour with licensed assisted living director (LALD)-B and director of maintenance (DM)-D at approximately 11:30 a.m., on the third floor, she entered room 320 with DM-D. The engineering evaluator stated she smelled smoke and entered the resident's bathroom. The bathroom had a strong smoke odor, and the engineering evaluator observed the ceiling fan covered with an orange-colored stain and lint. When asked if the resident was a smoker, DM-D said yes. DM-D observed the fan and said the fan was covered with a nicotine stain and added the resident definitely smoked in the bathroom. When the engineering evaluator opened the apartment door to exit to the hallway, the odor followed into the hallway. LALD-B was in the hallway at this time, and said yes, we have a problem with that. On March 8, 2023, at 1:40 p.m., the evaluators observed the third-floor hallway. Four apartments had signs on or around the door that stated oxygen in use. Unlicensed personnel (ULP)-I was on the third floor, and said she did not smell smoke when asked, but smelled cleaner, and	0 830		

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0 830	Continued From page 29 added someone had just come through with a cleaner. On March 8, 2023, at 3:23 p.m., the evaluators knocked on R9's door three times, and it took R9 approximately one and a half minutes before she answered the door. The evaluators entered the apartment with R9's permission, and immediately smelled a fresh, thick cigarette odor. The evaluator asked R9 if she had been smoking, and R9 said "no." R9's bathroom door was closed at this time. R9 R9 admitted to the facility on September 25, 2020. R9's diagnoses included Parkinson's disease, type II diabetes, spinal stenosis, sleep apnea, osteoarthritis of the hip, polyneuropathy, major depressive disorder, generalized osteoarthrosis, and essential tremor. R9's Basic Assessment ULP (unlicensed personnel) Services form dated December 27, 2022, was identified as a change of condition assessment, for resumption of care after a hospital visit and diagnosis of hypoxia and lingular pneumonia. The assessment noted housekeeping was provided weekly. R9's Comprehensive Assessment / Licensed Services form dated December 27, 2023, noted the resident was a smoker, and resident had tremors related to Parkinson's disease. Under the smoking, alcohol and recreational drug use section, it noted the following: - resident was a current smoker, with approximately 15 cigarettes a day; - no safety concerns posing a risk to the resident;	0 830		

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0 830	Continued From page 30 - no safety concerns posing a risk to others; and - resident had a history of marijuana use. R9's Service Plan Agreement dated January 30, 2023, indicated R9 received services including diabetic management, blood pressure monitoring, monthly vital signs, housekeeping, bed making, trash removal, laundry, medication administration, blood glucose monitoring, and routine safety checks twice per day. On March 8, 2023, at 3:29 p.m., housekeeper (H)-H stated she cleaned R9's apartment every Tuesday, and sometimes when she goes in to clean, she can hardly breathe because of the smoke smell and having asthma. H-H stated she had not observed R9 smoking in her apartment but has observed ashes on the sink and on the floor in the bathroom. H-H denied seeing any burn marks or holes on the resident or flooring in the bathroom. In addition, H-H stated she had heard others mention another resident down the hall was occasionally smoking in her apartment. However, she had not observed or smelled a smoke odor coming from this resident's apartment. At 3:51 p.m., the evaluators knocked on this resident's door several times, however, there was no answer. There was a sign on the left side of the door frame on the wall that said "Oxygen in Use." On March 8, 2023, at 4:26 p.m., LALD-B stated she did smell smoke coming from R9's room today when DM-D and the engineering evaluator exited the room, and she was in the hallway. LALD-B stated it was very evident through the face mask the resident had been smoking in the apartment. LALD-B stated she brought this to the attention of her supervisor for direction. LALD-B stated there were a couple of residents she had	0 830		

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0 830	Continued From page 31 to talk to and give lease violations since she started here. R10 had many lease violations before LALD-B started here, and she gave R10 one last fall due to a marijuana odor coming from the apartment. LALD-B stated she was not aware of any concerns since then with this resident. In addition, LALD-B stated a verbal warning was given to R11 approximately one month ago. LALD-B was unsure about R11's oxygen need. However, when the current resident roster was reviewed with her, she said oxygen was marked as a service. LALD-B stated oxygen is very flammable. LALD-B stated the licensee did not have a policy related to smoking, just the information in the resident handbook. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. The U.S. Food & Drug Administration (FDA) Pulse Oximeters and Oxygen Concentrators: What to Know About At-Home Oxygen Therapy dated February 19, 2021, instructed when using an oxygen concentrator - do not use the concentrator, or any oxygen product, near an open flame or while smoking. Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state	0 830		

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0 830	Continued From page 32 and federal laws. The Resident Handbook dated March 2022, on page 24 of 30, in the section titled smoking, e-cigarettes, vaping and other inhalants, indicated the facility was a smoke-free and tobacco free building and campus. The handbook noted smoking any substance by any means, the use of e-cigarettes, vaping, and the use of any tobacco products in any form were all considered "smoking" and not permitted in any apartment, common area, or outside grounds. The handbook also included smoking in inappropriate locations was considered a Resident Agreement violation which may lead to termination of the agreement. The licensee's Safe Oxygen Use and Storage policy dated revised October 1, 2021, noted smoking was not allowed in rooms where oxygen is in use. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 10, 2023, the immediacy of correction order 0830 was removed as confirmed by evaluator observations and supervisor review, however non-compliance remained at a scope and level of I.	0 830		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 33 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 34 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for two of four employees (clinical nurse supervisor (CNS)-A, registered nurse (RN)-G). 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: CNS-A CNS-A began providing supervision of staff and direct care to residents on October 3, 2022. CNS-A's employee record lacked documented evidence of the following: - a review of the provider's policies and procedures.	01470		

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01470	Continued From page 35 RN-G RN-G, employed by a staffing agency, began providing assisted living services for the licensee on August 23, 2022. RN-G's employee record contained a transcript which indicated the Guide to Assisted Living course was completed on August 22, 2022, and included the basic orientation requirements; however, RN-G's record contained an Orientation Checklist - Nurse, which included an introduction and review of policies and procedures related to assisted living, electronically signed by RN-G on December 13, 2022, nearly four months after her start date. On March 9, 2023, at 10:13 a.m., corporate director of education (CDE)-K stated the policy and procedure training was completed with the training provided onsite, not through the training provided at the corporate office. On March 10, 2023, at 9:05 a.m., CNS-A stated she provides the onsite training, and did not recall seeing anything related to policy and procedure in her part of the training. In addition, CNS-A stated she has not included policy and procedure training since she started training on orientation or annual training. The licensee's Orientation and Training: Employee policy dated August 1, 2021, noted orientation to assisted living would include an introduction and review of the licensee's policies and procedures related to the providing of services. No further information was provided.	01470		

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01470	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

(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
01500	Continued From page 37 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of four employees (unlicensed personnel (ULP)-J). 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).	01500		

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01500	Continued From page 38 The findings include: ULP-J started employment on August 10, 2020, under the licensee's former comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-J's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On March 9, 2023, at 10:13 a.m., corporate director of education (CDE)-K stated the policy and procedure training was completed with the training provided onsite, not through the training provided at the corporate office. On March 10, 2023, at 9:05 a.m., clinical nurse supervisor (CNS)-A stated she provides the onsite training, and did not recall seeing anything related to policy and procedure in her part of the training. In addition, CNS-A stated she has not included policy and procedure training since she started training on orientation or annual training. The licensee's Orientation and Training: Employee policy dated August 1, 2021, lacked information on annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01620	Continued From page 39	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 90 days after the last assessment for two of five residents (R1 and R5). 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	01620		

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01620	Continued From page 40	01620		

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
R1's diagnoses included type II diabetes, heart failure, and history of traumatic brain injury.

R1's Service Plan Agreement signed on January 30, 2023, noted R1 received services including orientation for moderate confusion, grooming, toileting, and medication administration.

R1's record contained a Comprehensive Assessment/Licensed Services dated September 14, 2022, and December 29, 2022 (106 days after the last assessment).

On March 10, 2023, at approximately 9:20 a.m., clinical nurse supervisor (CNS)-A stated the assessment in December was late, and she had approximately 120 assessments she was trying to catch up on when she started in October 2022. CNS-A stated the expectation was the assessments are every 90 days or less.
R5
R5's diagnoses included type II diabetes, chronic kidney disease, hypertension (high blood pressure), and depression.

R5's Service Plan Agreement signed on January 30, 2023, noted R5 received services including diabetic management, catheter care, insulin administration, and bathing.

R5's record contained a Master Assessment

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01620	Continued From page 41 dated May 5, 2022, and Comprehensive Assessment/Licensed Services dated August 10, 2022 (97 days after the last assessment), and September 28, 2022, and January 26, 2023 (120 days after the last assessment). The licensee's Assessment of Clients [residents] - Initial and Ongoing policy dated reviewed May 23, 2022, noted the RN would determine the frequency of reassessments based on the needs of the resident, not to exceed 90 days from the date of the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

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01760	Continued From page 42	01760		

review, the licensee failed to ensure the registered nurse (RN) reviewed two of three residents (R1 and R6) with medication errors, for causative factors to determine interventions to reduce the risk of reoccurring, and failed to ensure medications with time sensitive dates were not expired, for one of three residents (R22) reviewed during observation of medication storage. In addition, the licensee failed to ensure prescriber orders were transcribed as ordered for one of three 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 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:

MEDICATION ERROR REPORTS

R1
R1's diagnoses included type II diabetes, heart failure, and history of traumatic brain injury.

R1's Service Plan Agreement signed on January 30, 2023, noted R1 received services including orientation for moderate confusion, grooming, toileting, and medication administration.

On March 6, 2023, at 2:40 p.m., the evaluator observed R1 in her apartment. R1 invited the evaluator in after knocking on her door, and was seated in her wheelchair at the end of the bed next to a dresser. R1 stated staff help her with her medications and with getting dressed.

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01760	Continued From page 43 R1's record contained Medication Incident Reports as follows: - October 13, 2022, at 7:29 p.m., Jantoven (blood thinner) 2.5 milligram (mg) was documented as given but found in the medi-set (plastic container labeled for pre setup medications). The report noted the name of the staff involved, INR (blood test used to indicate how well the blood is able to clot) was checked and prescriber (MD) notified, and resident assessed for adverse effects; however, it lacked a description of the investigation and actions taken to prevent further incident; - November 16, 2022, at 8:00 p.m., Jantoven 2.5 mg not given or documented. It noted the MD was notified and resident was assessed for adverse effects; however, it lacked the name of the staff involved, the name of the person completing the form, and a description of the investigation and actions taken to prevent further incident; - November 26, 2022, at 8:00 a.m., R1's Lidocaine (pain relief) 5% patch was not removed as ordered. The report noted the name of the staff involved, MD was notified, and staff were instructed to notify the nurse with any change in condition; however, a description of the investigation and actions taken to prevent further incident; - December 22, 2022, at 12:00 p.m., R1's Lidocaine 5% patch was not removed as ordered. The report lacked the name of the staff involved, the name of the person completing the form, and a description of the investigation and actions taken to prevent further incident; - January 7, 2023, at 8:00 a.m., R1's Lidocaine 5% patch was not removed as ordered. The report noted the MD was notified and R1 was assessed; however, it lacked the name of the	01760		

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01760	Continued From page 44 staff involved, the name of the person completing the form, and a description of the investigation and actions taken to prevent further incident; - January 7, 2023, at 12:00 p.m., R1's Diclofenac sodium (non-steroidal inflammatory drug for pain) 1% gel was not documented as administered. The report noted education was provided to the staff member; however, it lacked the name of the staff involved, the name of the person completing the form, and a description of the investigation and actions taken to prevent further incident; - January 24, 2023, at 8:00 p.m., R1's Lidocaine 5% patch was not removed as ordered. The report noted the MD was notified, and staff were instructed to notify the nurse with any change in condition and assess for adverse effects, observed for side effects, and was seen by the MD; however, it lacked a description of the investigation and actions taken to prevent further incident; -February 2, 2023, at 3:00 p.m., R1's Lidocaine 5% patch was not removed as ordered. The report noted the MD was notified, and staff were instructed to notify the nurse with any change in condition; however, it lacked a description of the investigation and actions taken to prevent further incident; and - February 11, 2023, at 8:30 p.m., R1's Lidocaine 5% patch was not removed as ordered. The report noted the MD was notified, resident was assessed for adverse effects, pain, or other issues; however, it lacked a description of the investigation and actions taken to prevent further incident. R6 R6's diagnoses included type 2 diabetes, inflammatory polyarthropathy (pain and inflammation in five or more joints), anxiety, major depressive disorder, asthma, and glaucoma.	01760		

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01760	Continued From page 45 R6's Service Plan Agreement, signed January 30, 2023, indicated R6 received services including diabetic management, bathing assistance, compression stockings, weekly weight monitoring, monthly vital monitoring, blood glucose monitoring, topical medication administration, insulin administration, and medication administration. On March 6, 2023, at 2:42 p.m., the evaluators entered R6's apartment with her permission. R6 was sitting in her recliner and discussed living at the facility and the services the staff provided for her and her husband. R6's record included Medication Incident Report as follows: - On November 12, 2022, at 8:40 p.m., dorzolamide HCl (hydrochloride)/timolol malaete (combination eye drop used to treat increased pressure in the eye) PF 2-0.5% solution with directions to give one drop to both eyes twice daily, was not given as prescribed per documentation in the Medication Administration Record. The report noted the name of the person discovering the incident, physician was notified and R6 was assessed for adverse effects with no apparent issue or adverse effects; however, lacked a description of the investigation and actions taken to prevent further incident. In addition, the report lacked a signature of the staff completing the report. EXPIRED MEDICATION R22 On March 8, 2023, at 9:23 a.m., during medication storage observation of medication cart "3A" with unlicensed personnel (ULP)-P, the evaluator noted R22's timolol maleate (treats high	01760		

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pressure in eyes) 0.5% ophthalmic (eye) solution had a small sticker attached to the bottle with a handwritten date of January 27, 2023, to indicate the date the bottle was opened, and a handwritten date of February 25, 2023, to indicate the date the solution would expire. ULP-P stated R22 was recently admitted and had brought her own medications from her previous facility, and stated the first date was the date on which the bottle was opened at the previous facility and the second date was the date that the solution would expire and would need to be thrown. Although the timolol maleate ophthalmic solution had expired 11 days prior, ULP-P stated she had administered the solution to R22 that morning.

R22 was admitted on February 12, 2023, and had diagnoses including diabetes, muscle weakness, need for assistance with personal cares, unsteadiness on feet, and glaucoma (increased pressure in eyes).

R22's Service Plan Agreement, dated February 15, 2023, indicated R22 received services including bathing, compression stockings, safety checks, and medication administration.

R22's Order Summary Report, dated February 10, 2023, included timolol maleate solution 0.5% instill one drop in left eye two times a day for glaucoma.

R22's Medication Sheet, dated March 2023, noted initials of staff indicating R22 had received the timolol maleate ophthalmic solution into her left eye twice daily from March 4, 2023, through March 9, 2023.

On March 10, 2023, at 9:50 a.m., clinical nurse supervisor (CNS)-A indicated medications with

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accelerated expiration dates should include labeling with the date opened and should be discarded on the expiration date.

The licensee's Storage of Medication and Key Security policy, dated September 27, 2021, indicated medications must be kept in the original container bearing the original prescription label with legible information including the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue, and the name and address of the licensed pharmacy that issued the medications; however, lacked direction to dispose of medications past the expiration date.

TRANSCRIPTION ERROR
R3
R3's diagnoses included essential hypertension (high blood pressure), heart failure, and aortic valve stenosis (narrowed artery that reduces blood flow).

R3's Service Plan Agreement signed on March 6, 2023, noted R3 received services including medication administration, dressing, bathing, toileting, daily weight, oxygen safety checks, and CPAP/BiPAP (continuous positive airway pressure/ Bilevel Positive Airway Pressure) use.

On March 7, 2023, at 2:40 p.m., the evaluator entered R3's apartment with his permission. R3 was seated on his bed and discussed living at the facility and the services staff provided for him.

R3's medication administration record (MAR) dated February 2023 and March 2023 indicated that R3 was receiving metoprolol tartrate (immediate-release blood pressure medication)

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01760	Continued From page 48 12.5 mg daily. R3's signed medication order dated January 30, 2023, indicated that R3 should be administered metoprolol succinate (slow-release blood pressure medication) 12.5 mg daily. On March 10, 2023, at 9:35 a.m., CNS-A stated prior to her employment, no medication errors had been reported. She implemented the medication incident report, and the expectation was when an error occurred, the unlicensed personnel complete the initial portion, and it is then printed and put in the locked communication box for the nurse to be investigated and entered into the system. CNS-A stated education is provided to the staff involved on the spot, and they look at how the error occurred and what to do. In addition, CNS-A stated R3's February and March MAR indicated the correct dose but the wrong medication. CNS-A stated the order had been entered on the MAR incorrectly and was a transcription error made by another nurse who had processed the order. CNS-A stated that she will change MAR to reflect the correct medication and fill out a medication error form to document this error. The licensee's Medication Errors policy dated revised August 1, 2021, noted staff were to report any medication errors promptly to the RN, and the RN would immediately investigate any medication errors and implement and document corrective actions to reduce the risk of similar medication errors in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01760		

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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 refrigerated medications were maintained at manufacturer's recommended temperatures by failing to monitor medication refrigerator temperatures. 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 March 8, 2023, at 8:45 a.m., the evaluator and clinical nurse supervisor (CNS)-A observed a locked medication storage room located beside the nursing office, which contained a storage cabinet and a small medication refrigerator that held various medications. CNS-A stated there should be a temperature log for the refrigerator, but she was unsure where it is and would have to check to see where the log was located and who was responsible for monitoring the log. On March 8, 2023, at 8:50 a.m., the evaluator observed the following medications in the	01880		

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01880	Continued From page 50 refrigerator: - cyanocobalamin B-12 (B12 injection); - Prevnar Injection (pneumococcal vaccination); - Boostrix suspension (Tdap vaccination); - Flublock Quad (flu vaccination); - milk of magnesia (laxative); - lactobacillus acidophilus chewable tablets (probiotic); - Restasis 0.05% (eye drops); - Latanoprost 0.005% (eye drops); - thirty-five (35) unopened Novolog (short-acting) insulin pens; - seventy (70) unopened Lantus (long-acting) insulin pens; - eighteen (18) unopened Humalog (short-acting) insulin pens; - fourteen (14) unopened Trulicity (injectable diabetes medication) pens; - eleven (11) unopened insulin aspart (fast-acting) insulin pens; - five (5) unopened Basaglar (long-acting) insulin pens; - four (4) unopened Bydureon BCise (injectable diabetes medication) pens; and - two (2) unopened and one (1) opened Ozempic (injectable diabetes medication) pens. On March 10, 2023, at 8:15 a.m., CNS-A stated they were still trying to get access to the medication refrigerator logs because they had not been able to access the computer system that monitored the temperature. On March 10, 2023, at 10:52 a.m., director of maintenance (DM)-D provided the refrigerator logs and stated they had a computer system that monitored the refrigerator temperatures that would send an email to him and the licensed assisted living director (LALD)-B if the refrigerator temperature dropped below or was above the set	01880		

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01880	Continued From page 51	01880		

range, or if the batteries needed to be replaced. DM-D stated he was unsure of the temperature range set in the computer system, and stated that he had not received any emails about the refrigerator temperature but had received a notification to replace the batteries. LALD-B stated she had not received any emails about the refrigerator temperatures.

On March 10, 2023, at 11:50 a.m., DM-D stated he was able to verify the computer system for monitoring of temperatures was set to alert if temperatures were out of the 36 to 46 degree (º) Fahrenheit (F) range. DM-D stated that the temperature logs he provided showed temperatures below 36º F and he had not been notified.

The medication refrigerator temperature logs provided from January 1, 2023, through March 10, 2023, indicated the following:
-February 1, 2023, through February 28, 2023, contained sixty-one (61) recordings where the temperature dropped below 36º F.
-January 1, 2023, through January 31, 2023, contained one hundred and ninety-two (192) recordings where the temperature dropped below 36º F.

The manufacturer's instructions for Novolog last reviewed November 2021, indicated to store unopened pens in a refrigerator between 36 and 46º F.

The manufacturer's instructions for Lantus, last reviewed 2022, indicated to store unopened pens in a refrigerator between 36 and 46º F.

The manufacturer's instructions for Humalog, last reviewed October 2022, indicated to store

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01880	Continued From page 52 unopened pens in a refrigerator between 36 and 46º F. The manufacturer's instructions for Bydureon BCise last reviewed November 2021, indicated to store unopened pens in a refrigerator in between 36-46ºF. The manufacturer's instructions for Ozempic, last reviewed January 2023, indicated to store unopened pens in a refrigerator between 36 and 46º F. The licensee's Storage of Medication and Key Security policy dated September 27, 2021, indicated medications requiring "refrigeration" or "temperatures between 2º C (Celsius) (36ºF) and 8ºC (46ºF)" are kept in a refrigerator with a thermometer to allow temperature monitoring daily; twice daily if vaccines are being stored. If the temperature goes out of the noted temperature range, the nurse will review each medication and notify the manufacturer to review if the medication needed to be discarded. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label for three of six residents (R5, R13, R20) and failed to ensure time sensitive medications were dated when opened for 7 of 8 residents (R5, R13, R20, R19, R21, R9, R12). 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: MEDICATION MAINTAINED BEARING PRESCRIPTION LABEL & TIME SENSITIVE MEDICATIONS DATED WHEN OPENED R5 R5's diagnoses included type 2 diabetes. R5's Service Plan Agreement signed January 30, 2023, indicated R5 received services including diabetic management, behavior management, grooming, catheter cares, housekeeping, laundry, bathing and dressing, and insulin administration. R5's physician orders, dated July 26, 2022, included Insulin Aspart (fast acting, same as Novolog) 100 units/milliliter, give 14 units at supper. Hold insulin if blood sugar under 100. Also included, "Date when first opened," and	01890		

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01890	Continued From page 54 "Once opened: Discard after 28 days." On March 7, 2023, at 4:05 p.m., the evaluator observed while unlicensed personnel (ULP)-L prepared to administer R5's insulin. ULP-L unlocked medication cart labeled "2A" and opened the top drawer which contained several insulin pens, eye drops, and inhalers. ULP-L picked up an insulin pen and stated the insulin pen belonged to R5, and proceeded to prime the insulin pen by dialing to two units and pushing the plunger. The Aspart FlexPen lacked a prescription label or any identifying information to indicate it belonged to R5. ULP-L stated she knew it was R5's because each resident had their own "spot" in the cart; however, there was no identifying information to indicate the insulin pen belonged to R5. In addition, the Aspart FlexPen lacked a date indicating when it was opened and when it would expire. ULP-L stated, "No date on here," and indicated there was no way to know how long the insulin pen had been in use. ULP-L proceeded to dial the insulin pen to 14 units and walked to R5's room to administer the insulin. R13 R13's diagnoses included type 2 diabetes with long term use of insulin. R13's Service Plan Agreement, dated March 1, 2023, indicated R13 received services including daily weight monitoring, bathing, dressing, grooming, medication administration, and blood glucose monitoring. R13's prescriber orders, dated November 16, 2022, included Novolog (fast acting) insulin 5 units at each meal. In addition, R13's prescriber orders dated February 20, 2023, included Lantus (long acting) insulin 30 units twice daily.	01890		

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01890	Continued From page 55 On March 7, 2023, at 4:15 p.m., the evaluator completed medication storage observation of medication cart "2A" with ULP-L. R13's two Lantus insulin pens lacked a prescription label or any identifying information to indicate it belonged to R13, and a Novolog insulin pen included a label with R13's name; however, lacked a date indicating when it was opened and when it would expire. ULP-L stated she "just knew" that the Lantus insulin pens belonged to R13 and indicated there was a sticker on the Novolog insulin pen intended to write the open date; however, was blank. R20 R20's diagnoses included type 2 diabetes with diabetic neuropathy (nerve damage). R20's Service Plan Agreement, dated March 1, 2023, indicated R20 received services including medication set up, diabetic management, blood glucose monitoring, and insulin administration. R20's prescriber orders, dated October 25, 2022, included Aspart/Novolog FlexPen 5 units subcutaneously (under the skin) once daily before the evening meal, and included, "(DISCARD WITHIN 28 DAYS AFTER FIRST USE)." Also, Glargine (same as Lantus) 60 units twice daily, and included, "(DISCARD WITHIN 28 DAYS AFTER FIRST USE)." R20's prescriber orders dated January 16, 2023, included decrease Lantus insulin to 50 units twice daily. On March 8, 2023, at 9:18 a.m., the evaluator completed medication storage observation of medication cart "3A" with ULP-P. R20's Lantus insulin pen and two Novolog insulin pens included a black handwritten room number; however,	01890		

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01890	Continued From page 56	01890		

lacked a prescription label or any identifying information to indicate it belonged to R20 and lacked a date indicating when it was opened and when it would expire. ULP-P stated it would be difficult to know when the pens were opened and when they needed to be discarded.

TIME SENSITIVE MEDICATIONS DATED WHEN OPENED

R19
R19's diagnoses included anxiety, type 2 diabetes, high blood pressure, and skin cancer.

R19's Service Plan Agreement, dated March 1, 2023, indicated R19 received services including bathing set-up, monthly vital monitoring, and medication administration.

R19's prescriber orders, dated August 29, 2022, included latanoprost (treat high pressure inside eye) 0.005% ophthalmic (eye) drops one drop to affected eye(s) at bedtime.

On March 7, 2023, at 4:15 p.m., the evaluator completed medication storage observation of medication cart "2A" with ULP-L. R19's latanoprost bottle included a pharmacy label with dispense date of November 29, 2022; however, lacked a date indicating when it was opened and when it would expire. ULP-L stated the eye drops should have been labeled with the opened dated when first used.

R21
R21's diagnoses included high blood pressure, epilepsy, and glaucoma (pressure within the eyeball).

R21's Service Plan Agreement, dated March 1,

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01890	Continued From page 57	01890		

2023, indicated R21 received services including bathing, compression stockings, dressing, grooming, medication administration, and eye drop administration.

R21's prescriber orders, dated June 20, 2022, included latanoprost 0.005% instill one drop to both eyes every night at bedtime, "Date on first day opened," and "Discard after 42 days once opened."

On March 8, 2023, at 9:18 a.m., the evaluator completed medication storage observation of medication cart "3A" with ULP-P. R21's latanoprost bottle included a pharmacy label with dispense date of December 23, 2022; however, lacked a date indicating when it was opened and when it would expire. ULP-P stated there was no way to know how long the eye drops had been in use.

R9
R9's diagnoses included Parkinson's Disease, type 2 diabetes, spinal stenosis, sleep apnea, osteoarthritis of the hip, polyneuropathy, major depressive disorder, generalized osteoarthrosis, and essential tremor.

R9's Service Plan Agreement, dated January 30, 2023, indicated R9 received services including diabetic management, blood pressure monitoring, monthly vital signs, housekeeping, bed making, trash removal, laundry, medication administration, blood glucose monitoring, and routine safety checks twice per day.

R9's prescriber orders, dated November 21, 2022, included Novolog FlexPen inject 4 units subcutaneously three times daily with meals, and Lantus Solostar inject 30 units subcutaneously

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01890	Continued From page 58 every night at bedtime, "Date insulin when first opened," and "Once opened: Discard after 28 days." On March 8, 2023, at 9:18 a.m., the evaluator completed medication storage observation of medication cart "3A" with ULP-P. R9's two Novolog FlexPens included pharmacy labels, with dispense dates of October 21, 2022, and December 20, 2022; however, lacked a date indicating when each pen was opened and when they would expire. Also observed, R9's Lantus Solostar insulin pen included a pharmacy label with dispense date of December 25, 2022; however, lacked a date indicating when the pen was opened and when it would expire. ULP-P stated it would be difficult to know when the pens were opened and when they needed to be discarded. On March 10, 2023, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated medications should include a pharmacy label and medications with accelerated expiration dates should include labeling with the date opened and should be discarded on the expiration date. The manufacturer's instructions for Insulin Aspart/Novolog, dated February 1, 2023, indicated the pen should be discarded 28 days after first use. The manufacturer's instructions for Lantus, dated August 2022, indicated the pens should be thrown away after 28 days, even if insulin was left. The manufacturer's instructions for latanoprost eye drops, dated 2022, indicated the unopened eye drops should be kept in the refrigerator until	01890		

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01890	Continued From page 59 opened for use and then stored at room temperature for six weeks after opening. R12 R12's diagnoses included type 2 diabetes, heart disease, and obesity. R12's Service Plan Agreement dated March 1, 2023, indicated R12 received services to include diabetic management and injection of Ozempic medication (treat high blood sugar) by nurse. R12's physician orders signed November 28, 2022, included an order for Ozempic 0.25 milligrams (mg) subcutaneous injection weekly on Wednesdays. On March 8, 2023, at 8:45 a.m., the evaluator observed the medication storage room which included the medication refrigerator, with CNS-A. The medication refrigerator included an opened Ozempic pen for R12 that had not been labeled with an open date. On March 8, 2023, at 8:50 a.m., CNS-A stated that all injectable medications should be labeled with an open date when it was first used. Manufacturer's instructions for Ozempic dated October 2022, indicated the open pen could be stored for 56 days at room temperature between 59 to 86 degrees Fahrenheit (F) or in a refrigerator between 36 to 46 degrees F. The Licensee's Storage of Medication and Key Security policy, dated September 27, 2021, noted the RN would identify where the medications would be stored in the resident's individualized medication management plan, and indicated, until the medication was set up for immediate or later	01890		

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01890	Continued From page 60 administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not	02170		

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02170	Continued From page 61 limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for five of five residents (R1, R4, R6, R3, and R5). 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: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022. R1	02170		

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02170	Continued From page 62 R1's diagnoses included type II diabetes, heart failure, and history of traumatic brain injury. R1's Service Plan Agreement signed on January 30, 2023, noted R1 received services including orientation for moderate confusion, grooming, toileting, and medication administration. R1's Dimensions: My Way form, identified as the activity evaluation, dated February 1, 2023, noted R1's past and current interests. However, it lacked an evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identifications of activities for behavioral interventions. The form instructed staff to fill in everything on the form, and if it did not pertain to enter "N/A [non applicable]", and if an answer was unknown, to write unknown. The form had sections for personality, emotional/social needs, and patterns, what brings calm or comfort, habits, routines, and preferences, eating habits, favorite foods and beverages, assistive devices, former skills and abilities, things that may be upsetting, and things to do to relax were all left blank. The form had a section titled "My Activity Plan", which noted daily for items to be planned and offered daily as walks, coloring, and movies. It also noted weekly for items to be planned and offered weekly as gardening, pet therapy, and sing-along. The sections titled activity related goals, monthly, and other goals, individual plan for regular outdoor activity, adaptations for activities if not noted above, and individualized	02170		

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02170	Continued From page 63 plan for behavioral interventions were left blank. On March 10, 2023, at approximately 12:30 p.m., activities (A)-N stated she had completed R1's evaluation, and said some areas were left blank, as she had a difficult time getting R1 to answer the questions. A-N stated she did not contact R1's family for input. R4 R4's diagnoses included type 2 diabetes, high blood pressure, epilepsy (seizures), and depression. R4's Service Plan Agreement, signed on January 30, 2023, indicated R4 received services including assistance with bathing, compression stockings, weekly vitals, and medication administration. R4's Resident Activity Assessment, undated, identified R4's past and current interests and current abilities and skills; however, lacked an evaluation of the following: - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identifications of activities for behavioral interventions. R4's record lacked an individualized activity plan based on the activity evaluation that reflected R4's activity preferences and needs. R6 R6's diagnoses included type 2 diabetes, inflammatory polyarthropathy (pain and inflammation in five or more joints), anxiety, major depressive disorder, asthma, and glaucoma.	02170		

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THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

(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
02170	Continued From page 64 R6's Service Plan Agreement, signed January 30, 2023, indicated R6 received services including diabetic management, bathing assistance, compression stockings, weekly weight monitoring, monthly vital monitoring, blood glucose monitoring, topical medication administration, insulin administration, and medication administration. R6's Resident Activity Assessment, undated, identified R6's past and current interests and current abilities and skills; however, lacked an evaluation of the following: - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identifications of activities for behavioral interventions. R6's record lacked an individualized activity plan based on the activity evaluation that reflected R6's activity preferences and needs. R3 R3's diagnoses included essential hypertension (high blood pressure), heart failure, and aortic valve stenosis (narrowed artery that reduces blood flow). R3's Service Plan Agreement signed on March 6, 2023, noted R3 received services including medication administration, dressing, bathing, toileting, daily weight, oxygen safety checks, and CPAP/BiPAP (continuous positive airway pressure/ Bilevel Positive Airway Pressure) use. R3's Resident Activity Assessment, undated, identified R3's past and current interests and current abilities and skills; however, lacked an evaluation of the following:	02170		

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	33613	A. BUILDING: _____ B. WING _____	03/10/2023

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02170	Continued From page 65 - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identifications of activities for behavioral interventions. R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs. R5 R5's diagnoses included type II diabetes, chronic kidney disease, hypertension (high blood pressure), and depression. R5's Service Plan Agreement signed on January 30, 2023, noted R5 received services including diabetic management, catheter care, insulin administration, and bathing. R5's Resident Activity Assessment, undated, identified R5's past and current interests and current abilities and skills; however, lacked an evaluation of the following: - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identifications of activities for behavioral interventions. R5's record lacked an individualized activity plan based on the activity evaluation that reflected R5's activity preferences and needs. On March 8, 2023, at 12:00 p.m., activities director (AD)-O stated the assisted living resident's did not have a completed individualized activity plan, only the memory care residents did.	02170		

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	33613	A. BUILDING: _____ B. WING _____	03/10/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 66 AD-O also stated that she was newer to the position and wanted to implement a tool she has previously used to complete the activity assessments and plans for all of the resident's but had not obtained approval yet from her management to do so. The licensee's Events Program policy dated March 2016 noted events would be scheduled on a regular basis to enrich the residents' lives including, but not limited to, social events, religious events, exercise, creative opportunities, intellectual opportunities, cultural events, volunteer opportunities, work opportunities, and intergenerational programs/events. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (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 the care and services were provided according to acceptable health care and medical, or nursing standards for two of three residents (R2, R5) with hospital beds with bedrails.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	03/10/2023

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02310	Continued From page 67 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 On March 7, 2023, at 10:20 a.m., the evaluator and clinical nurse supervisor (CNS)-A entered R2's room with her permission. R2's hospital bed had bilateral brown metal bedrails in the raised position. Both bedrails were tight when wiggled. The evaluator observed CNS-A measure the bedrails. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 3 3/4 inches. The measurements between the bottom of the rail and the top of the mattress for zone 2, was zero inches. The measurements between the mattress and the bedrail for zone 3, measured 1/2 inch. The measurements under the rail, at the ends of the rail for zone 4, measured zero inches. R2 stated she used the bedrails to help her to reposition herself while in bed. R2's diagnoses included weakness, chronic pain syndrome, joint disorder, unspecified glaucoma, age-related osteoporosis without pathological fracture, pain, and edema. R2's Service Plan Agreement dated February 21, 2023, indicated R2 received services including assistance with transportation, bathing, dressing, grooming, monthly vital signs, medication	02310		

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02310	Continued From page 68 administration, bed mobility, escort assistance, toileting, housekeeping and laundry, and transfer assist. R2's Basic Assessment / ULP (unlicensed personnel) Services form dated February 21, 2023, and March 6, 2023, noted: - the resident used a bedrail; - the type of bed rail being used was identified as a hospital bed; - Zone measurements for zone 1, zone 2, and zone 3 all indicated less than 4.74 (inches; - the measurements met the Food and Drug Administration (FDA) guidelines; - the device met the manufacturer requirements; - the predisposing factors identified as weakness, pain, non-weight bearing, and impaired range of motion (ROM); - identified risks of using bed rail noted entrapment; - resident risk factors indicated not applicable; - benefits of using the bed rail noted independence, proper positioning, and safe mobility; - there were no areas large enough that could cause resident entrapment; - the desired reason for use of the bed rail as bedrail assists the resident to turn from side-to-side in bed and self-positioning, assists with stabilization of transfers in and out of bed, provides a feeling of comfort and security, and allows maximum participation with bed mobility and transfer; - the device does not prevent the resident from voluntarily getting out of bed; - the device was appropriate for resident use; - the resident was appropriate to use the device; and - safety interventions with use of bed rail indicated use with staff assistance and supervision.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 69 R2's Bed Rails - Intended Purpose, Potential Risks and Client (resident) Agreement form signed by R2 on February 21, 2023, noted intended purpose of the bedrails and potential risks of the bed rails, and indicated R2 had been given a Guide to Bed Safety. It also indicated the facility's maintenance staff would be responsible for applying the bed rails and measurement of all areas / zones of risk to ensure the greatest safety possible with the bed rails. The box was checked that R2 still chose to use the bed rail. R2's record lacked a comprehensive assessment to include evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device, which included accurate measurements of the entrapment zones. R5 On March 7, 2023, at 9:08 a.m., the evaluators and CNS-A entered R5's room with his permission. R5's hospital bed had a brown metal hospital bed rail in the raised position on the left side of the bed. The bed rail was loosely attached and could easily be moved away from the mattress and forward and backwards towards the head and foot of the bed. The evaluators observed CNS-A measure the bed rails. The six openings between the bars for zone 1 varied in size, with the largest opening measuring 4 1/2 inches. The measurements between the bottom of the rail and the top of the mattress for zone 2, was zero inches. The measurements between the mattress and the bed rail for zone 3, measured zero inches. The measurements under the rail, at the ends of the rail for zone 4, measured zero inches. R5 stated he utilized the bed rail to independently transfer in and out of bed and stated the bed rail had been loose for at	02310		

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02310	Continued From page 70 least a month. R5's diagnoses included spinal stenosis, type II diabetes, chronic kidney disease, obesity, osteoarthritis, and moderate major depression. R5's Service Plan Agreement signed January 30, 2023, by the resident, indicated R5 received services including diabetic management, behavior management, grooming, catheter cares, housekeeping, laundry, bathing and dressing, and insulin administration. R5's Basic Assessment / ULP Services form dated January 26, 2023, noted: - the resident used a bed rail; - the type of bed rail being used was identified as a hospital bed; - zone measurements for zone 1, zone 2, and zone 3 all indicated less than 4.75 inches; - the measurements met the FDA guidelines; - the predisposing factors identified as low endurance or strength; - identified risks of using the bed rail noted strangulation; - risk factors indicated weakness; - benefits of using the bed rail noted promoting independence, and assisting with mobility; - there were not areas large enough that could cause resident entrapment; - the desired reason for use of the bed rail as bed rail assists in improving strength; - the device does not prevent the resident from voluntarily getting out of bed; - the device was appropriate for resident use; - the resident was appropriate to use the device; and - safety interventions with use of bed rail indicated resident was able to safely use the bed rail.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 71 R5's Bed Rails - Intended Purpose, Potential Risks and Client (resident) Agreement form signed by R5 on March 6, 2023, noted intended purpose of the bedrails and potential risks of the bed rails, and indicated R5 had been given a Guide to Bed Safety. It also indicated the facility's maintenance staff would be responsible for applying the bed rails and measurement of all areas / zones of risk to ensure the greatest safety possible with the bed rails. The box was checked that R5 still chose to use the bed rail. R5's record lacked a comprehensive assessment to include evidence of physical inspection of the bed rail and mattress for areas of entrapment and stability of the device which included accurate measurements of the entrapment zones. On March 7, 2023, at 10:55 a.m., CNS-A stated the comprehensive assessment should include the measurements of the entrapment zones per the FDA guidelines. The licensee's Assessment and Use of Side Rails (bed rails) revised February 1, 2023, noted upon admission and ongoing, the nurse would assess the need and safety of side rails, and staff would alert the nurse if a resident had any type of side rail or similar equipment. It noted the nurse would provide education for the resident and resident representative regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation. In addition, it noted the nurse would determine whether the side rail / equipment met the following facility required standards for hospital beds to include: - manufacturer information must be available and the device must be installed and maintained per manufacturer guidelines, and the device must meet the FDA measurement requirements;	02310		

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02310	Continued From page 72 - if the nurse determines the side rails are not an appropriate device for the resident, the device would be removed, and the resident / representative would be provided with alternatives for addressing resident needs; - devices that are deemed to be appropriate would be assessed on an ongoing basis to ensure appropriateness of the device along with input from the maintenance team to ensure the device was in good repair and free of defects, concerns for recall, or safety concerns; and - if the device was deemed to be inappropriate and the resident refused to remove the device, the facility may decide to terminate the resident agreement due to inability to provide a safe environment that would meet the resident's needs. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 8, 2023, the immediacy of correction order 2310 was removed as confirmed by evaluation supervisor review, however non-compliance remained at a scope and level of G.	02310		

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02310	Continued From page 73 In addition, based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of three residents (R5). The evaluator along with CNS-A observed R5's bed which was an Invacare bariatric full-electric bed frame with a bariatric mattress on top of the frame. On top of the bariatric bed and mattress laid another queen size mattress. The evaluator lifted the queen size mattress and observed the queen mattress was being supported on the right side by two plastic shelving units and a wooden speaker box. The bed's queen size mattress was against the far-right wall of R5's bedroom and was level with the window. On March 7, 2023, at 9:08 a.m., CNS-A stated she had not seen R5's bed before today but felt it was very unsafe and it should have been reported to her by an unlicensed staff. On March 7, 2023, at 9:30 a.m., R5 stated that he had moved the queen-sized mattress on top of his hospital bed because he had complained that the hospital bed was too small and no one did anything, so he fixed it. The Invacare Model BAR600IVC user guide, dated October 19, 2016, indicated bed accessories designed by other manufacturers had not been tested by Invacare and use of non-Invacare bed accessories may result in injury or death. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

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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: (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	03000		

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03000	Continued From page 75 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 interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 6, 2023, at approximately 9:55 a.m., a request was made to licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A to review all vulnerable adult reports the licensee had made to MAARC in the last six months. R1's diagnoses included type II diabetes, heart failure, and history of traumatic brain injury.	03000		

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03000	Continued From page 76 R1's Service Plan Agreement signed on January 30, 2023, noted R1 received services including orientation for moderate confusion, grooming, toileting, and medication administration. A MAARC report was noted on September 10, 2022, at 9:16 p.m., R1 was standing near her closet when she fell to the floor hitting her head. Unlicensed personnel (ULP)-M was in the room at the time and had just set the medication on the dresser, and when she turned around, resident fell. ULP-M was unable to stop the fall. ULP-M called the nurse, who instructed to call 911. When the paramedics arrived, R1 said she had fallen and hit her head, and she also stated she was pushed. The MAARC reports was noted as submitted September 12, 2022, at 2:28 p.m. On March 10, 2023, at approximately 9:20 a.m., CNS-A stated although she was not employed at the time of this report, their policy is to report immediately, no later than within the first 24 hours. The ULP would notify the nurse on-call, who would notify the CNS to report the incident if needed. The licensee's Vulnerable Adult Reporting and Investigation policy dated reviewed December 2, 2020, noted as soon as the resident was safe, the staff witnessing the maltreatment or CNS would notify the common entry point. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/06/23*
Time: 11:00:08
Report: 7930231050

Food and Beverage Establishment Inspection Report

Location:
The Sanctuary At St Cloud
2410 20th Avenue Se
St Cloud, MN56304
Sherburne County, 71

Establishment Info:
ID #: 0038846
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202526325
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.

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

THE QUATERNARY AMMONIA DISPENSER AT THE THREE COMPARTMENT SINK WAS NOT FUNCTIONING AT TIME OF INSPECTION (MIXTURE DISPENSED WAS 0PPM). HILLYARD MAINTENANCE WAS CALLED. ERIC IS USING THE BACK-UP SUPPLY OF SANITIZER UNTIL DISPENSING SYSTEM IS REPAIRED.

Comply By: 03/07/23

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.

PROVIDE A WATERPROOF THERMOMETER OR THERMO-LABELS LIKE STATED ABOVE FOR THE MEMORY CARE SERVING KITCHEN DISHWASHER.

Comply By: 03/13/23

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

DRY STORAGE ROOM: GRANOLA IN A BAG AND FLOUR, SUGAR AND PANKO STORAGE BINS DID NOT HAVE A LABEL ON THEM AT TIME OF INSPECTION. LABEL BINS/BAGS WITH CONTENTS NAME.

Comply By: 03/07/23

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

STORAGE CONTAINERS WERE WET NESTED ON THE DRY STORAGE RACK NEAR THE BACK PREP AREA. ENSURE ALL CONTAINERS ARE AIR DRIED BEFORE STACKING THEM.

Comply By: 03/07/23

4-900 Protecting Clean Items

4-904.13

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

LIKE STATED ABOVE. AT TIME OF INSPECTION PRESET TABLEWARE WERE LYING ON TOP OF NAPKINS ON THE TABLES. WRAP OR COVER.

Comply By: 03/07/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

LIKE STATED ABOVE. ALL OF THE SIGNS (EXCEPT THE SIGN NEAR THE OFFICE) STATE "HANDWASHING SINK ONLY" ON THEM. ALL SIGNS MUST NOTIFY EMPLOYEES TO WASH THEIR HANDS. ERIC STATED HE WOULD PRINT NEW SIGNS.

Comply By: 03/07/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 0 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET ON BACK PREP LINE
Violation Issued: Yes

Quaternary Ammonia: = 0 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE NEAR DISH ROOM
Violation Issued: Yes

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET--REMIXED FROM BACK-UP SUPPLY
Violation Issued: No

Hot Water: = at 163.9 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE--KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Steam Table
Temperature: 165 Degrees Fahrenheit - Location: TURKEY PATTY
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 34 Degrees Fahrenheit - Location: HAM--COOK LINE PREP COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: STRAWBERRY YOGURT--UPRIGHT COOLER NEAR DINING ROOM DOOR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: LEAF LETTUCE--TWO DOOR COOLER IN BACK PREP AREA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK--UPRIGHT COOLER IN MEMORY CARE SERVING KITCHEN
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: SPAGHETTI NOODLES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: SESAME CHICKEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 153 Degrees Fahrenheit - Location: VEGETABLE RICE SOUP
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	4

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 7930231050 of 03/06/23.

Certified Food Protection Manager: ERIC W. ERVASTI

Certification Number: 74642 Expires: 09/06/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us