Electronically Delivered

May 22, 2023

Licensee
Crystal Seasons Living Center
222 South Murphy Street
Lake Crystal, MN 56055

RE: Project Number(s) SL30699015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 4, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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).

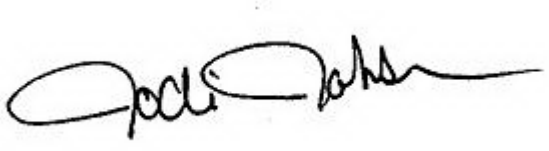
Please address your cover letter for reconsideration requests to:

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

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30699	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SEASONS ASSISTED LIVING	222 SOUTH MURPHY STREET LAKE CRYSTAL, MN 56055

(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: SL30699015 On May 1, 2023, through May 4, 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 36 active residents; 30 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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: Based on observation, interview, and record review the licensee failed to ensure the staff posting included all the required elements, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 1, 2023, at 10:45 a.m., licensed assisted living director /registered nurse (LALD/RN)-A stated two staff always worked the overnight shift from 10:00 p.m. until 6:00 a.m. LALD/RN-A confirmed a select number of residents in the facility required two staff to assist with transfers. On May 2, 2023, at 9:16 a.m. the daily staffing schedule was observed posted in the mailroom near the front entrance of the building. The schedule indicated one staff worked from 10:00 p.m. until 6:00 a.m., and one staff worked from 12:00 a.m. until 7:30 a.m., leaving a two-hour gap from 10:00 p.m. to 12:00 a.m., with only one staff present in the building. On May 3, 2023, at 4:05 p.m. LALD/RN-A confirmed the posted daily staffing schedule was incorrect related to hours worked on the night shift, and that an old form must have been used. The licensee's Staffing Policy dated August 1, 2021, indicated the facility will maintain, at all times, safe staffing levels based upon the acuity level of the current resident population. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 3	0 480		
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 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 May 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 4 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, 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 completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). 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:	0 660		

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0 660	Continued From page 5 The licensee's TB risk assessment dated August 31, 2022, indicated the licensee was a low risk. On May 2, 2023, at 7:55 a.m. ULP-D was observed administering medications to R3. ULP-D's employee record showed ULP-D had a start date of August 7, 2022. ULP-D's employee's record contained a TB Baseline Screening Tool for Health Care Workers form dated August 9, 2022. The form indicated ULP-D had a first-step TST administered on August 9, 2022, and read on August 11, 2022. The form did not include evidence that a second step TST had been completed. On May 4, 2023, at 11:05 a.m. licensed assisted living director/registered nurse (LALD/RN)-A confirmed ULP-D's employee file did not include evidence a second TST had been completed. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for	0 660		

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0 660	Continued From page 6 the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's Tuberculosis & Staff Screening policy dated January 2020, indicated new staff shall have an IGRA blood test or a two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool for HCWs. 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	0 680		

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0 680	Continued From page 7 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan last reviewed October 24, 2022, lacked the following required content: - Emergency prep testing requirements	0 680		

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0 680	Continued From page 8 On May 4, 2023, at 11:05 a.m. licensed assisted living director/registered nurse (LALD/RN)-A confirmed they had not been conducting full-scale exercises, mock disaster drills or table top exercises and knew this was an issue. LALD/RN-A stated they did have an actual event in April 2023, when their sister facility residents had to evacuate that facility and relocate. Documentation related to that event was not provided. The licensee's Emergency Preparedness Training, Exercises and Drills policy dated October 25, 2022, indicated: Annually, [facility management company] staff will participate in a full-scale exercise that is community-based, or when a community-based exercise is not accessible, an individual, facility-based tabletop exercise. Community-based exercises will generally be done in coordination with our Regional Health Care Preparedness coordinator. If a community-based full-scale exercise is not available. the facility will document their attempts to participate in one (document personnel or agencies contacted and reasons for inability to participate) and replace is with a table-top exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility based full-scale exercise for one year following the onset of the actual event. The facility will also conduct an additonal annual exercise that may include, but is not limited to the following:	0 680		

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0 680	Continued From page 9 A second full-scale exercise that is community-based or individual, facility-based; or: A table top exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed message, or prepared questions designed to challenge an emergency plan; or; A mock disaster drill No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 10 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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 record review and interview, the licensee failed to provide training to residents who are capable of self-evacuation on the actions to be taken in the event of a fire or similar emergency. 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 May 2, 2023, between approximately 4:15 p.m. and 5:00 p.m. with the Interim Assisted Living Director Designee (IALDD)-B, the Regional Director of Maintenance (RDM)-F, and Director of Maintenance (DM)-E on the fire safety and	0 810		

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0 810	Continued From page 11 evacuation plan and fire safety and evacuation training for the facility. Record review indicated that licensee did not provide training on the proper actions to take in the event of a fire including movement, evacuation, or relocation at least once a year to residents who are capable of assisting in their own evacuation. During interview, IALDD-B, RDM-F, and DM-E stated that training was given upon arrival to the facility but verified that they have not offered this training annually and were not able to provide documentation as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290		

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CRYSTAL SEASONS ASSISTED LIVING	222 SOUTH MURPHY STREET LAKE CRYSTAL, MN 56055

(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
01290	Continued From page 12 Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of two unlicensed personnel (ULP-D, ULP-G). This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-D ULP-D was hired on August 7, 2022. ULP-D's employee record contained a background study dated August 8, 2022, for a previous license, at the same location, operated by the licensee's owner. ULP-D's employee record lacked evidence the licensee affiliated a background study for their current assisted living facility license. ULP-G ULP-G was hired on November 28, 2022. ULP-G's employee record contained a background study dated January 11, 2022, for a previous license, at the same location, operated by the licensee's owner. ULP-G's employee record lacked evidence the licensee affiliated a background study for their current assisted living facility license.	01290		

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01290	Continued From page 13 On May 3, 2023, at 12:57 p.m. assisted living director/registered nurse (LALD/RN)-A confirmed ULP-D and ULP-G each had different HFID (health facility identification) numbers on their background studies for previous licenses held by the facility. LALD/RN-A checked with business office staff which revealed there were several other employees with background studies with incorrect HFID numbers. LALD/RN-A confirmed this was an issue that would need to be corrected quickly. The licensee's Background Study Policy revised December 2016, indicated background studies will be conducted on individuals providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to resident receiving services. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics	01530		

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01530	Continued From page 14 specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four employees (unlicensed personnel (ULP)-D, ULP-G, ULP-H, ULP-I) received the required amount of dementia care training in the required time frame. 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: The licensee provided services under an Assisted Living Facility license.	01530		

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01530	Continued From page 15 ULP-D ULP-D was hired on August 7, 2022, to provide direct care services to the licensee's residents. ULP-D's employee record contained evidence the employee received five hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-G ULP-G was hired on November 28, 2022, to provide direct care services to the licensee's residents. ULP-G's employee record contained evidence the employee received six hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-H ULP-H was hired on June 26, 2022, to provide direct care services to the licensee's residents. ULP-H's employee record contained evidence the employee received seven hours and 30 minutes of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-I ULP-I was hired on April 26, 2022, to provide direct care services to the licensee's residents. ULP-I's employee record contained evidence the	01530		

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01530	Continued From page 16 employee received seven hours and 30 minutes of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On May 3, 2023, at 2:27 p.m. assisted living director/registered nurse (LALD/RN)-A confirmed the above ULP had not completed the required eight hours of dementia training within 160 hours of the employment start date. The licensee's undated, Training Requirement For Assisted Living With Dementia Care policy indicated direct-care employees must have completed at least eight hours of initial training on topics specified within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 17 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three residents' (R2) service plans were consistently implemented as written. 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 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's Assisted Living Agreement Addendum (service plan) dated November 3, 2022, included a service to obtain blood pressures twice daily. On May 2, 2023, at 3:15 p.m. R2 stated staff were supposed to check her blood pressure twice a day, and many days they only checked it once. R2's Service Received log dated April 1, 2023, to April 30, 2023, indicated R2 had her blood pressure taken one time only, 13 out of 30 days; and it was not checked at all on three occasions.	01640		

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01640	Continued From page 18 On May 4, 2023, at 11:05 a.m. assisted living director/registered nurse (LALD/RN)-A stated R2's twice daily blood pressure checks were no longer a physician ordered service, because a medication they had been monitoring the blood pressure for was discontinued; however, R2 had requested staff to continue to monitor her blood pressure twice daily. LALD/RN-A confirmed R2's blood pressure was not consistently being taken twice a day per the service plan. The licensee's Service Plan Policy revised August 1, 2021, indicated the assisted living must implement and provide all services required by the current service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication procedures were followed during medication administration for 1 of 1 resident (R5) who received insulin. 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: R5's diagnoses included diabetes mellitus with chronic kidney disease. R5's signed physician orders dated April 11, 2023, included an order for Novolog Flexpen 100 unit/ml (units per milliliter) subcutaneous (under the skin) solution pen-injector. Inject 6 units with breakfast, lunch and supper. R5's Service Plan dated November 28, 2022, indicated the resident received insulin injections four times daily by trained staff. On May 2, 2023, at 11:30 a.m., unlicensed personnel (ULP)-D was observed administering insulin to R5 prior to lunch. ULP-D instructed R5 to have a seat in a chair in the resident's apartment prior to administration. ULP-D then prepared the insulin pen appropriately and utilized	01760		

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01760	Continued From page 20	01760		

an alcohol wipe to cleanse the skin on R5's upper arm prior to the injection. ULP-D cleansed the front of R5's upper arm midway between the left shoulder and elbow. ULP-D then administered the insulin into the muscle of R5's left upper arm where she had applied the alcohol. R5 was observed to flinch when the injection was given. When interview immediately following R5's insulin injection, ULP-D stated she had been trained to administer insulin that way.

On May 3, 2023, at 4:05 p.m. assisted living director/registered nurse (LALD/RN)-A stated ULP were trained to administer insulin into the adipose tissue in the abdomen and the back of the upper arms. ULP were also instructed to pinch the skin prior to injecting and then release the skin once the needle has gone into the skin (prior to injecting the medication). LALD/RN-A confirmed insulin was not to be injected into a muscle.

ULP-D's Medication Administration - Injections - Subcutaneous (SQ, Sub-Q) competency form dated January 10, 2023, included: 21. Pinch the skin and inject the needle into the subcutaneous skin, waiting 8 -10 seconds before removing from the injection site.

The licensee's Insulin Policy revised August 1, 2021, indicated insulin medications must be administered according to the prescriber's orders.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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01890	Continued From page 21	01890		
01890 SS=D	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the original prescription label for one of one resident (R5) who received insulin. 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: R5's diagnoses included diabetes mellitus with chronic kidney disease. R5's Service Plan dated November 28, 2022, indicated the resident received insulin injections four times daily by trained staff. R5's signed physician orders dated April 11, 2023, included an order for Novolog Flexpen 100 unit/ml (units per milliliter) subcutaneous (under	01890		

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01890	Continued From page 22 the skin) solution pen-injector. Inject 6 units with breakfast, lunch, and supper. On May 2, 2023, at 11:30 a.m. unlicensed personnel (ULP)-D was observed preparing R5's Novolog insulin pen for administration. The surveyor noted there was no prescription label on the pen, although it did contain R5's name. ULP-D confirmed there was not a prescription label on the pen or in the medication cart. ULP-D stated she went by the electronic medication administration record (eMAR) for the dosing instructions. ULP-D then proceeded to administer the insulin to R5. On May 3, 2023, at 4:05 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated when insulin pens are delivered from the pharmacy, they come in a bag which has the prescription label attached. LALD/RN-A confirmed the bag with the prescription label should be kept in the medication cart with the insulin pen. The licensees's Insulin Policy revised August 1, 2021, indicated: 2. F. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or	01970		

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01970	Continued From page 23 electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 3, 2023, at 11:04 a.m., R3 was observed seated in a wheelchair in her apartment watching television. R3 had on white compression stockings on her lower legs bilaterally. R3 stated staff assisted her with putting on and taking off the stockings. R3's diagnoses included multiple sclerosis and paraparesis (partial paralysis of the lower limbs). R3's progress note dated March 3, 2023, at 11:54	01970		

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01970	Continued From page 24 a.m., indicated: "New order received to pharmacy for ace wraps. On in AM and off in PM." R3's Assisted Living Agreement Addendum (service plan) dated April 10, 2023, included a service to apply ACE wraps bilaterally on lower legs in the AM. R3's medical record lacked evidence of a prescriber order for the compression stockings. On May 3, 2023, at 12:59 p.m. unlicensed personnel (ULP)-I stated they used to wrap R3's legs with ACE wraps and was unaware R3 had compression stockings. On May 3, 2023, at 1:04 p.m. ULP-G confirmed R3 had compression stockings that staff assisted with putting on and taking off. ULP-G was unsure how long R3 had been utilizing the stockings. On May 3, 2023, at 4:05 p.m. licensed assisted living director/registered nurse (LALD/RN)-A confirmed R3 had a physician order for ACE wraps. LALD/RN-A stated upon investigation, it was noted R3's family member had brought the compression stockings into the building and directed staff to utilize them instead of the ACE wraps; staff had not contacted nursing. LALD/RN-A confirmed there was not a physician order for the compression stockings. The licensee's Implementing Medication and Treatment Orders policy revised August 2021, indicated: 1. Upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24	01970		

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01970	Continued From page 25 hours. 2. If a Licensed Nurse is not on duty when an order is received, the ULP will: a. Notify licensed nurse within one hour of receipt of order. If licensed nurse is not available, staff will leave voice message on voice mail describing order and the resident involved. b. If it is at the end of a shift and you have not received direction from the licensed nurse, make certain the next shift knows that a message has been left, what the message is regarding and that you are awaiting direction from the licensed nurse. c. Orders can only be implemented when in direct contact with the licensed nurse. ULP will NOT implement orders or changes to orders unless in direct contact and instruction with the licensed nurse. The original signed order or faxed order will be place in a designated place for the nurse to review at the next scheduled licensed nurse visit. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, Se 2105
Mankato, MN

Type: Full
Date: *05/02/23*
Time: 12:32:11
Report: 1028231075

Food and Beverage Establishment Inspection Report

Location:
Crystal Seasons
222 Murphy Street
Lake Crystal, MN56055
Blue Earth County, 07

Establishment Info:
ID #: 0020656
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Crystal Seasons, ALF, LLC

Phone #: 5077262266
ID #: 46622

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.

2-300 Personal Cleanliness

2-301.12A ** Priority 1 **

MN Rule 4626.0070A Food employees must clean their hands and exposed portions of their arms for 20 seconds, using soap in a handwashing sink that is properly equipped.

Ensure that food employees are washing their hands for at least 20 seconds. An employee was observed washing for less than 10 seconds.

Comply By: 05/02/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

The top of the dish machine must be cleaned to remove build-up of food and carbonate debris.

Comply By: 05/02/23

Surface and Equipment Sanitizers

Hot Water: = at 192 Degrees Fahrenheit
Location: Dish Machine - RInse
Violation Issued: No

Lactic Acid/DDBSA: = 272ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Lactic Acid/DDBSA: = 272ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Type: Full
Date: *05/02/23*
Time: 12:32:11
Report: 1028231075
Crystal Seasons

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

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

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

Process/Item: Walk-In Freezer
Temperature: -5 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

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 1028231075 of 05/02/23.

Certified Food Protection Manager: Laura Hutchens

Certification Number: FM79387 Expires: 06/23/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Laura Hutchens
Food Service Director

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us