Electronically Delivered

November 3, 2025

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

RE: Project Number(s) SL30699016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Crystal Seasons Assisted Living. Please contact Jodi Johnson at 507-344-2730 on or before November 6, 2025, to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

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 _____	10/15/2025

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: SL30699016-0 On October 13, 2025, through October 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 40 residents; 37 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required	0 100		

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0 100	Continued From page 1 (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.	0 100		

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0 100	Continued From page 2 (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to obtain accurate licensure when they applied for licensure for an assisted living facility, despite sharing one roof with an adjoining clinic in the same building, without having an approved two-hour fire wall. 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: The licensee's health facility identification (HFID) 30699 was located at 222 South Murphy Street, Lake Crystal, Minnesota (MN) 56055, and was attached to 200 East Prince Street, Lake Crystal	0 100		

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0 100	Continued From page 3 MN 56055, by a shared interior wall as leased space and not part of the licensed assisted living facility. On October 15, 2025, at approximately 10:00 a.m., Minnesota Department of Health (MDH) environmental engineer (EE) survey staff toured the facility with director of maintenance (DM)-G. During the tour, EE survey staff observed the following: 1. The clinic is accessed from the assisted living on the main floor only. There are two doors, separated by 11 feet, between the clinic and the assisted living. Neither of the doors were observed to have any fire resistance rating on the doors or the door frames. 2. Clinic staff, visitors, etc. can access the assisted living through these doors. The assisted living is not locked from the clinic. 3. There are two assisted living resident rooms, 215 and 216, that are on the second floor above the clinic. EE staff did not observe anything that indicated fire separation between the first-floor clinic and second floor assisted living resident rooms. On October 15, 2025, at 12:21 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she and DM-G reviewed the original building plans and could not find evidence of a fire separation between the assisted living and the clinic. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		

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0 775	Continued From page 4	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on October 15, 2025, from 9:17 a.m. through 10:38 a.m., with director of maintenance (DM)-G, the surveyor observed the following: FIRE RATED DOORS Door wedges were used to prop open fire rated doors in the receiving room, housekeeping, dietary directors' office, corridor by kitchen, employee lounge, double doors in corridor by resident room 102, linen room, health office, spa room, activity office, directors' office, double door	0 775		

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0 775	Continued From page 5 to activity room. Fire rated doors in the following locations had evidence that an automatic door closer had been removed from the top of the doors in the following locations: Environmental services office, laundry room, resident room 101. DM-G stated that door closers had been removed from all resident room doors. State Fire Code in Minnesota Rules, chapter 7511 requires fire rated doors be maintained to automatically close and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. SMOKE ALARMS The smoke alarm was missing from one of the bedrooms in resident room 215. There was a mounting bracket with a wire harness on the ceiling that DM-G stated was where the alarm was located. Smoke alarms in the following locations were weak sounding or failed to operate when DM-G tested them: living room and one bedroom in resident room 215, bedroom in resident room 208, both bedrooms in resident room 202, both bedrooms and living room in resident room 302, one bedroom in resident room 305, bedroom in resident room 307. DM-G removed the bedroom alarm from the ceiling in resident room 305 and it had a date of April 2008 on the back. DM-G stated that all alarms that looked yellowed and were the same style probably all had the same date on them. State Fire Code in Minnesota Rules, chapter	0 775		

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0 775	Continued From page 6 7511 requires smoke alarms be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. LOCKED EXIT The door from the corridor into stair A and the exterior door on the main floor in stair A both had exit signs above them and were locked with a magnetic lock. The doors had a sign indicating that they were delayed egress and DM-G stated the locks would deactivate if the fire alarms activated. DM-G stated they were not aware of a button or switch located anywhere in the facility that would deactivate the locks. State Fire Code in Minnesota Rules, chapter 7511 requires delayed egress doors have the capability of being deactivated from an approved location. DM-G verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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	01290		

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01290	Continued From page 7 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: 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 one of 45 employees (unlicensed personnel (ULP)-D). 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 was hired on June 24, 2024, to provide direct care services for the licensee's residents. ULP-D's employee record contained a background study (BGS) dated April 28, 2025, 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	01290		

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01290	Continued From page 8 assisted living facility license. On October 14, 2025, at 8:40 a.m. clinical nurse supervisor (CNS)-B stated she had called the supervisor for the human resources (HR) department who stated ULP-D had been hired while she was on maternity leave; this BGS fell through the cracks as someone else completed it and did not affiliate with the current HFID (health facility identification) number. HR supervisor also had indicated to CNS-B that audits on BGS's were completed twice a year to check for this. HR supervisor completed an audit once the surveyor brought ULP-D's BGS affiliation to their attention and all current employees are affiliated with the correct HFID number. The licensee's Personnel Files/Employee Records policy dated November 2019, indicated: 2. The employee file shall contain: h. Verification of the DHS (Department of Human Services) background study response. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530		

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01530	Continued From page 9 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial	01530		

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01530	Continued From page 10 training on mental illness and de-escalation topics for one of two employees (unlicensed personnel lead (ULP)-E). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired February 13, 2024, to provide direct care services to the licensee's residents On October 14, 2025, at 9:13 a.m., the surveyor observed ULP-E administering medications to R2. ULP-E's employee file lacked evidence of two hours of initial training on mental illness and de-escalation topics and also one hour or yearly training on the same topics for every 12 months of employment thereafter. On October 15, 2025, at 3:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the above trainings had not been completed by ULP-D. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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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
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 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 observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01640		

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 _____	10/15/2025

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
01640	Continued From page 12 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 October 14, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-I administering medications to R3 in the dining room. ULP-I stated when R3 was finished eating and returned to his room, she would assist him with his TED (thrombo-embolic deterrent - specialized compression garments designed to prevent the formation of blood clots) stockings. R3's provider orders dated September 9, 2025, included: TED stockings - 15-20 mmHg (millimeters of mercury - unit of pressure commonly used in medical settings) XL (extra large). Apply in AM, remove in the PM, for edema. R3's medication administration record (MAR) dated October 2025, included the above order. R3's Assisted Living Agreement Addendum (service plan) dated July 16, 2024, did not include assistance with TED stockings. On October 15, 2025, at 12:23 p.m., clinical nurse supervisor (CNS)-B reviewed R3's service plan and stated it did not include assistance with TED stockings by the ULPs. The licensee's Service Plan Policy August 1, 2021, indicated: The service plan must include all of the following required elements: 1. A description of the services to be	01640		

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 _____	10/15/2025

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
01640	Continued From page 13 provided, the fees for services including any changes to the provider's fee for services, and the frequency of each service. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as	01910		

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 _____	10/15/2025

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
01910	Continued From page 14 applicable, for one of one discharged resident (R4). 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 discharge resident roster provided by the licensee, indicated R4 admitted to the licensee on November 13, 2024, and discharged on September 16, 2025, to another facility. R4's service plan dated June 11, 2025, indicated services included medication administration. R4's Medication Destruction/Return form dated September 16, 2025, included medications that had been sent with R4 upon discharge. The document included the medication name, strength, quantity, and signature of the nurse. The document did not include the prescription number for any of the identified medications including: Tylenol, albuterol-budesonide inhaler, albuterol sulfate for nebulizer, alendronate sodium (for osteoporosis), antacid chewables, antifungal powder, aspirin, atorvastatin calcium (to lower cholesterol), bisacodyl (laxative), calcium carbonate-vitamin D, cetirizine (allergies), famotidine (to reduce stomach acid), folic acid, Lasix (diuretic), metronidazole gel (antibiotic), Miralax (laxative), mometasone	01910		

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 _____	10/15/2025

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

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01910	Continued From page 15 furoate cream (to treat inflammatory conditions), pantoprazole sodium (to decrease stomach acid), prochlorperazine maleate (antipsychotic), sennosides-docusate sodium (laxative), sertraline HCL (antidepressant), spironolactone (diuretic), vista advanced AREDS 2 (multivitamin). On October 15, 2025, at 12:23 p.m., clinical nurse supervisor (CNS)-B stated R4's Medication Destruction/Return form did not include the prescription numbers of all medications sent with the resident upon discharge and should have. The licensee's Disposal of Medication Policy dated November 2019, indicated: Unused Prescription Drugs: - Current unused medications managed by the assisted living provider will be returned to the pharmacy for credit, or given to the client or the client's representative, when the client's medications are no longer managed by the assisted living provider or the medication has been discontinued by the prescribe. - Upon disposition, the assisted living provider must document in the record of disposition of the medication including the medications' name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CRYSTAL SEASONS ASSISTED LIVING	222 SOUTH MURPHY STREET LAKE CRYSTAL, MN 56055

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01940	Continued From page 16 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1, R2).	01940		

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01940	Continued From page 17 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 October 13, 2025, at 10:49 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents including blood glucose testing. R1 R1's Assisted Living Agreement Addendum (service plan) dated July 25, 2025, indicated R1 received services including blood glucose checks twice a day. R1's medication administration record (MAR) dated October 2025, included an order for blood glucose checks every AM and HS (hour of sleep/bedtime). R2 R2's Assisted Living Agreement Addendum (service plan) dated March 3, 2025, indicated R2 received services including blood glucose checks twice a day. R2's provider orders dated August 14, 2025, included: Blood sugar checks - twice daily - check and record blood sugar prior to lunch and	01940		

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

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01940	Continued From page 18 supper. On October 14, 2025, at 11:38 a.m., the surveyor observed unlicensed personnel (ULP)-E perform a blood glucose test for R2. When interviewed following the observation, ULP-E stated there was no direction to staff in the MAR on when to contact the nurse if R2's blood glucose value was too high or too low. R1 and R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse (RN) when a problem arose with treatments or therapy services. On October 15, 2025, at 12:23 p.m., CNS-B reviewed R1 and R2's treatment plan and stated it did not include direction to staff for blood glucose parameters and when to notify a nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	02320		

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02320	Continued From page 19 by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-E) administered insulin as per manufacturer instructions during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included type II diabetes mellitus without complication. R5's Assisted Living Agreement Addendum (service plan) dated September 9, 2025, indicated R5 received assistance with medication administration. R5's provider order dated October 2, 2025, indicated: Increase Novolog to 9 units. Inject SQ (subcutaneously-under the skin) with meals along with correction scale. Novolog Correction Scale: 151-200 = 1 unit 201-250 = 2 units 251-300 = 3 units 301-350 = 4 units 351-400 = 5 units	02320		

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02320	Continued From page 20 On October 14, 2025, at 11:19 a.m., the surveyor observed ULP-E checking R5's blood glucose value which was 156. ULP-E stated she would be giving R5 one extra unit along with the scheduled 9 units for a total of 10 units. ULP-E removed the cap from R5's Novolog insulin pen, applied a needle, dialed the pen to 10 units, then administered the insulin into R5's abdomen after cleansing the skin with an alcohol prep pad. ULP-E failed to cleanse the port of R5's Novolog insulin pen with an alcohol prep pad prior to applying the needle and failed to prime the pen with 2 units of insulin prior to dialing up the dosage. On October 14, 2025, at 11:35 a.m. following the above observation, ULP-E stated she had not been trained to cleanse the port of the insulin pen with alcohol prior to applying the needle. ULP-E further stated being aware of the need to prime the insulin pen with 2 units prior to dialing up the dose, although forgot to do that. On October 14, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated she would expect staff to use an alcohol wipe to cleanse the port of an insulin pen prior to applying the needle and believes that is how staff are trained. CNS-B further stated staff are trained to prime the insulin pen with two units of insulin prior to dialing up the dosage. The Novolog (insulin aspart) injection FlexTouch Pen Instructions for Use revised February 2023, indicated: Preparing you NovoLog FlexPen A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. Attaching the needle. Remove the protective	02320		

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02320	Continued From page 21 tab from a disposable needle. Screw the needle tightly onto you FlexPen. Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injection air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with you finger a few times to make any air bubble collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Crystal Seasons Assisted Living
222 SOUTH MURPHY STREET
Lake Crystal, MN 56055
Blue Earth County
Parcel:

Phone:

License Info

License: HFID 30699

Risk:
License:
Expires on:
CFPM: Laura Hutchens
CFPM #: FM79387; Exp: 6/24/2027

Inspection Info

Report Number: F1034251152
Inspection Type: Full - Single
Date: 10/15/2025 Time: 11:00:46 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection conducted in conjunction with HRD.

Establishment uses an employee illness log.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F1034251152 from 10/15/2025

Laura Hutchens

McKenna Mathews

McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

Crystal Seasons Assisted Living
Lake Crystal
County/Group: Blue Earth County

Inspection Info

Report Number: F1034251152
Inspection Type: Full
Date: 10/15/2025
Time: 11:00:46 AM

Food Temperature: Product/Item/Unit: Carrots**; Temperature Process:** Hot-Holding
Location: Steam Table at 183 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Mashed Potatoes**; Temperature Process:** Hot-Holding
Location: Steam Table at 180 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Pork**; Temperature Process:** Hot-Holding
Location: Steam Table at 203 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sloppy Joes**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Pasta Salad**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38.5 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Coffee**; Temperature Process:** Cold-Holding
Location: Coffee Machine at 37.2 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

Crystal Seasons Assisted Living
Lake Crystal
County/Group: Blue Earth County

Inspection Info

Report Number: F1034251152
Inspection Type: Full
Date: 10/15/2025
Time: 11:00:46 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 166.7 Degrees F.
Comment:
Violation Issued?: No