Electronically Delivered

April 24, 2025

Licensee
The Beacon At Lake Crystal
511 West Blue Earth Street
Lake Crystal, MN 56055

RE: Project Number(s) SL30602016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 27, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

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

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

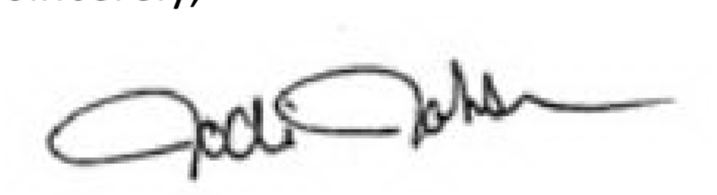
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30602	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BEACON AT LAKE CRYSTAL	511 WEST BLUE EARTH 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 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: SL30602016-0 On March 24, 2025, through March 27, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 17 residents; 17 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the 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 evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as blood test for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 660		

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0 660	Continued From page 4 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's facility TB risk assessment dated January 24, 2025, noted the TB risk level was low. ULP-G was hired to provide direct care and assisted living services on January 11, 2024. ULP-G's employee record contained a TST record, which indicated ULP-G had the first step TST administered on January 16, 2024, and read as negative on January 19, 2024. It also indicated ULP-G had the second step TST administered on February 16, 2024, (four weeks after the first TST was read) and read as negative on February 18, 2024. The form noted if results were negative, the second step would be performed in one to three weeks. ULP-G had another first step TST administered on February 5, 2025, but was a "no show" and did not have it read. ULP-G had another first step TST administered on February 11, 2025, and read as negative on February 14, 2025. ULP-G was a "no show" for second step TST that had been scheduled for February 25, 2025. On March 26, 2025, at 1:45 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated ULP-G needed to get his first and second step TST completed one to three weeks following the first step, and ULP-G had not followed up with his appointments. The licensee's Tuberculosis & Staff Screening	0 660		

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0 660	Continued From page 5 policy dated January 2020, noted new staff shall have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated on the Baseline TB Screening Tool for HCWs Template (page 17), if results were negative, perform the second step in one to three weeks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 6 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently. In addition, the licensee failed to practice and document the testing of its emergency preparedness (EP) plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: EMERGENCY PLAN POSTED On March 24, 2025, at 11:05 a.m. during the facility tour, the surveyor observed there was no signage posted or information regarding the licensee's emergency preparedness plan. Other than emergency exit postings, there was nothing regarding an emergency preparedness plan posted or displayed in the facility's main entrance area.	0 680		

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0 680	Continued From page 7 On March 24, 2025, at 1:28 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated the emergency preparedness book was kept in the fax room, and it was not posted prominently. The licensee's emergency preparedness plan consisted of several documents and policies in a red three-ringed binder dated as reviewed January 30, 2025. The book included a risk assessment, a communication plan, and various policies/procedures. The EP plan did not include evidence the facility had tested it's EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test it's plan and document the results of testing at least twice annually as required. On March 26, 2025, at 10:05 a.m., RN/LALD-C stated the licensee's EP plan lacked the required above component. The licensee's undated, Assisted Living Evacuation Plan noted: 2. Post an emergency disaster plan prominently. The licensee's Emergency Preparedness Training, Exercises, and Drills documented dated October 25, 2022, noted annually, [The Licensee's] 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. If a community-based full-scale exercise is not available, the facility will document their attempts to participate in one and replace it with a table-top exercise. If the facility experiences an actual natural or man-made emergency that requires	0 680		

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0 680	Continued From page 8 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 additional annual exercise that may include: -a second full-scale exercise that is community-based or individual, facility-based; or -a tabletop 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. Such exercises will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 775		

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0 775	Continued From page 9 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on March 27, 2025, from 9:17 a.m. through 10:05 a.m., with director of maintenance (DM)-H, the surveyor observed all the exit doors were equipped with magnetic locks that required a code to unlock. DM-H stated the doors would unlock when the fire alarm was activated and that they were also delayed egress. DM-H pushed the doors to open and in 25 seconds the doors released. The doors did not have a sign that indicates the delayed egress function and were not capable of being deactivated at the fire command center or other approved location as required by State Fire Code in Minnesota Rules, chapter 7511. During same tour the surveyor observed 20-minute fire resistant rated doors on magnetic holds by resident room six and by resident room 17. When the doors were released from the magnet they did not fully close and latch. Fire-resistant rated doors must automatically close and latch as designed to prevent the spread of smoke and fire to adjoining building areas. DM-H stated they understood the requirement and would have the doors adjusted or repaired. DM-H verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 March 27, 2025, from 9:17 a.m. through 10:05 a.m., with director of maintenance (DM)-H, the surveyor observed all the fire extinguisher cabinets located throughout the facility were locked and required a key to open. Fire extinguisher cabinets must be unlocked so the extinguishers are readily	0 790		

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THE BEACON AT LAKE CRYSTAL	511 WEST BLUE EARTH 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
0 790	Continued From page 11 available for use during a fire. DM-H verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the 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 staff twice per year per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 12 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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct evacuation drills. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 27, 2025, at 10:17 a.m., director of maintenance (DM)-H provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensees FSEP titled, Monarch Healthcare Management - Fire, dated 12/19, revised 8/1/22 lacked the following required content: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that	0 810		

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0 810	Continued From page 13 showed the location and number of resident sleeping rooms. The FSEP included standard resident evacuation procedures but lacked specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. DM-H stated they conduct fire drills every quarter throughout the year. Record review of licensee's evacuation drill log titled, Fire Drill Report, indicated four evacuation drills were conducted in 2024 with all drills conducted at 2:00 p.m. No other documentation was provided. During an interview on March 27, 2025, at 11:04 a.m., DM-H stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01530		

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01530	Continued From page 14 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 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 two of two employees (unlicensed personnel (ULP)-D, ULP-G) 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 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).	01530		

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01530	Continued From page 15 The findings include: The licensee provided services under an Assisted Living with Dementia Care license. ULP-D ULP-D began providing assisted living services on July 24, 2024. ULP-D's employee record lacked documented evidence the employee received the required eight hours of dementia care training within 160 working hours of the employment start date. ULP-G ULP-G began providing assisted living services on January 11, 2024. ULP-G's employee record lacked documented evidence the employee received the required two hours of dementia care training for each 12 months of employment. On March 26, 2025, at 10:00 a.m. registered nurse/licensed assisted living director (RN/LALD)-C stated ULP-D only had 2.75 hours of dementia care training and indicated he had worked more than 160 hours. In addition, RN/LALD-C stated ULP-G had 1.25 hours of dementia care training, not the two hours required annually. RN/LALD-C stated the licensee had transitioned from one educational platform to another and the required dementia classes were missed on both employees in the transition. The licensee's undated, Training Requirement for Assisted Living with Dementia Care policy noted all assisted living facilities must meet the following training requirements: 3. Direct care employees must have completed	01530		

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01530	Continued From page 16 at least eight hours of initial training within 80 working hours from 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. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01890 SS=E	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 time sensitive medications were dated when opened for one of one resident (R5) with insulin, and one of one resident (R4) with eye drops. 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	01890		

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01890	Continued From page 17 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 26, 2025, at 10:44 a.m., the surveyor observed the licensee's medication cart with unlicensed personnel (ULP)-E. ULP-E stated insulin pens and eye drops should be dated when opened and when they would expire. R5's insulin aspart FlexPen did not include a date indicating when staff opened it, or when it would expire. R4's latanoprost (for increased pressure inside the eye) 0.005% ophthalmic solution did not include a date indicating when staff opened it, or when it would expire. On March 26, 2025, at 10:53 a.m., registered nurse/licensed assisted living director (RN/LALD)-C and clinical nurse supervisor (CNS)-B stated all insulin and eye drops should be dated when opened. The insulin aspart instructions for use revised on February 2023, noted: - Store the FlexPen you are currently using out of the refrigerator at room temperature for up to 28 days. The latanoprost package insert revised August 2011, noted: - Once a bottle is opened for use, it may be stored at room temperature for six weeks.	01890		

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01890	Continued From page 18 The licensee's Storage of Medication policy dated December 2019, noted medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability 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	02040		

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02040	Continued From page 19 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 27, 2025, at 10:17 a.m., director of maintenance (DM)-H provided a document titled, Monarch Healthcare Management - Hazard Risk Vulnerability Assessment, dated 10/25/2022. The document lacked a hazard vulnerability assessment with mitigation factors for the physical environment on and around property. During an interview on March 27, 2025, at 11:04 a.m., DM-H verified that the licensee was not able to provide documentation of a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner.	02140		

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02140	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to 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) 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 held an Assisted Living Facility with Dementia Care (ALFDC) license effective September 1, 2024. During the entrance conference on March 24, 2025, at 10:30 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated she oversaw the staff training in the care of individuals with dementia. RN/LALD-C stated she had completed dementia training modules for supervisors of direct care staff through Care Providers of Minnesota and Pathway Health. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) Dementia care training programs required to ensure compliance with statute 144G.83 are listed, and Care Providers of Minnesota and Pathway Health were not included	02140		

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02140	Continued From page 21 in the list of approved training programs for the designated person to oversee staff training by the commissioner. On March 25, 2025, at 12:45 p.m., RN/LALD-C stated she was unaware the Care Providers of Minnesota and Pathway Health training did not meet the requirement according to the approved list provided by the commissioner. The licensee's undated, Training Requirement for Assisted Living with Dementia Care policy indicated persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia including: - Two years of work experience related to Alzheimer's disease or other dementia's or in health care, gerontology, or another related field - Completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required y the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
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.	02320		

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02320	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice by one of two employees (unlicensed personnel (ULP)-D) observed 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: R4's diagnoses included arthritis, low back pain, and mild cognitive impairment. R4's Assisted Living Agreement Addenedum (sic) (identified as the service plan) dated as effective January 31, 2025, included medication administration. R4's prescriber orders dated February 17, 2025, included an order for lidocaine (topical anesthetic) 4% external cream. Apply 4 grams (g) to low back three times daily. R4's medication administration record (MAR) dated March 2025, included lidocaine 4% cream apply 4 g topically to low back three times daily for pain. On March 24, 2025, at 1:33 p.m., the surveyor	02320		

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02320	Continued From page 23 observed ULP-D prepare and administer medications to R4. ULP-D reviewed R4's MAR, sanitized hands, donned clean gloves, and placed about one inch of R4's lidocaine 4% cream to his gloved hand. ULP-D then applied the lidocaine cream to R4's low back. ULP-D did not measure the amount of lidocaine cream applied. Following the application of the cream, ULP-D removed gloves, sanitized hands, and documented the lidocaine 4% cream administration. When interviewed at this time, ULP-D stated he would not apply more than an inch of the cream as this was an estimate of the prescribed 4 grams. On March 24, 2025, at 3:00 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated staff were taught and instructed to use a dosing card measuring device that identifies grams for an accurate measurement of the medication. The licensee's Medication Administration by Unlicensed Personnel policy dated revised August 2021, noted only qualified ULP may provide medication administration and would check the rights for safely giving medication. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

DEPARTMENT OF HEALTH

Type: Full
Date: *03/24/25*
Time: 11:30:00
Report: 1033251127

Food and Beverage Establishment Inspection Report

Location:
The Beacon at Lake Crystal
511 West Blue Earth Street
Lake Crystal, MN56055
Blue Earth County, 07

Establishment Info:
ID #: 0010647
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
The Beacon at Lake Crystal

Phone #: 5077266537
ID #: 46658

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

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

Three compartment sink was measured at 500PPM+.

Comply By: 03/24/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Facility does not have a quaternary ammonium test kit.

Comply By: 04/04/25

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Ice machine drain is routed into the hand washing sink.

Comply By: 03/24/25

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

3-302.12

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

Oil bottle does not have a label.

Comply By: 03/24/25

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Facility is using a house hold refrigerator and waffle maker.

Comply By: 03/24/25

6-200 Physical Facility Design and Construction

6-201.11A

MN Rule 4626.1335A Design, construct, and install floors, floor coverings, walls, wall coverings, and ceilings to be smooth and easily cleanable.

Damaged walls in kitchen, painted sheet rock around the mop sink, missing coving by freezers, and wood coving behind hand sink.

Comply By: 05/26/25

6-300 Physical Facility Numbers and Capacities

6-301.14

MN Rule 4626.1455 Remove the supply of individual disposable towels and hand soap from food preparation sinks, utensil washing sinks, and mop sinks.

Hand soap dispenser is installed at the utensil washing sink.

Comply By: 03/24/25

Surface and Equipment Sanitizers

Quaternary Ammonium: = 500PPM+ at Degrees Fahrenheit
Location: Three Compartment Sink
Violation Issued: Yes

Hot Water: = at 161 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *03/24/25*
Time: 11:30:00
Report: 1033251127
The Beacon at Lake Crystal

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 194 Degrees Fahrenheit - Location: Meatballs-Oven
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Sausage Patty-Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: House Hold Refrigerator
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Two Door Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: One Door Freezer
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033251127 of 03/24/25.

Certified Food Protection Manager Laura L Hutchens

Certification Number: FM79387 Expires: 06/24/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Laura L Hutchens

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033251127

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/24/25
Time In 11:30:00
Time Out

The Beacon at Lake Crystal	Address: 511 West Blue Earth Street	City/State: Lake Crystal, MN	Zip Code: 56055	Telephone: 5077266537
License/Permit #: 0010647	Permit Holder: The Beacon at Lake Crystal	Purpose of Inspection: Full	Est Type:	Risk Category: M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/24/25

Inspector (Signature)