Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 19, 2024

Licensee
Crystal Edge LLC
9119 Regent Parkway
Brooklyn Park, MN 55443

RE: Project Number(s) SL40135015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 16, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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
Per 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health 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 MDH within 15 business days of the correction order

receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

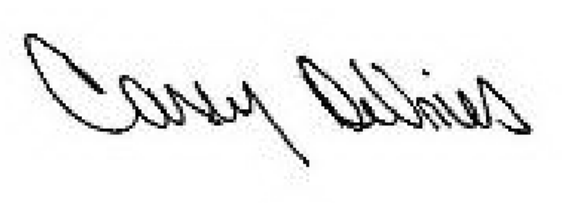
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	40135	A. BUILDING: _____ B. WING _____	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL EDGE LLC	9119 REGENT PARKWAY BROOKLYN PARK, MN 55443

(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: SL40135015-0 On October 14, 2024, through October 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents: four receiving services under the Provisional 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2024, 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 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of one unlicensed personnel ((ULP)-C). 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-C was hired on April 15, 2024, to provide assisted living services to residents. On October 15, 2024, from 8:25 a.m. to 9:03 a.m., during continuous observation, the surveyor observed ULP-C wash hands, and then prepare medications for administration to R2. At 8:33	0 510		

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0 510	Continued From page 3 a.m., when asked to verify medications for R2, ULP-C removed their gloves handled R2's medications with ungloved hands. Without completing hand hygiene ULP-C put on a new pair of clean gloves. At 8:36 a.m., ULP-C administered medications in R2's room. At 8:41 a.m., after completing cares and medication administration with R2, the surveyor observed ULP-C remove gloves. The surveyor then observed ULP-C return to the kitchen of the facility and complete hand hygiene at the sink. After completing hand hygiene, the surveyor observed ULP-C dry their hands on a dish towel instead of using a disposable paper towel. At 8:45 a.m., ULP-C put on clean gloves and began preparing medications for R3. After administering medications, ULP-C removed gloves and washed their hands at sink. At 8:50 a.m., ULP-C put on new gloves on to prepare medications for R5. At 9:03 a.m., ULP-C returned to the nursing station office and removed gloves. The surveyor did not observe ULP-C complete hand hygiene after removing gloves. On October 15, 2024, at 9:39 a.m., ULP-C stated they received training on infection control and hand hygiene at the time of hire. On October 15, 2024, at 10:35 a.m., director of nursing (DON)-A stated that both the DON, and agent registered nurse (ARN)-B were responsible for training staff on infection control practices. DON-A stated that staff are trained to complete hand hygiene before and after completing cares and in between glove changes. Additionally, DON-A stated staff are trained to not handle medications with ungloved hands. The licensee's 8.09 Hand washing policy, dated June 7, 2023, indicated that when conducting a	0 510		

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0 510	Continued From page 4 procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The Centers for Disease Prevention and Control's (CDC), CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated November 29, 2022, under section 5a.2 (a, b, c, d, e, f) read: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. The CDC'S Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, under the section titled "know how to wash hands with soap and water" indicated the following: 1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin. No further information was provided.	0 510		

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0 510	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster preparedness plan with all required content and failed to post the emergency plan	0 680		

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0 680	Continued From page 6 prominently. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 14, 2024, at 11:26 a.m., the surveyor retrieved the licensee's emergency preparedness plan (EPP) from the basement nursing office. Director of nursing (DON)-A stated the licensee's EPP was typically stored in the nursing office behind locked doors. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - Annual review of the Emergency Preparedness Plan; - Quarterly review of missing resident policy; - A written risk assessment utilizing an all-hazards approach; - Categorization of probable risks by likelihood of occurrence; - Written strategies addressing facility and community-based risks; - Missing Resident Plan; - Policies and procedures for sheltering in place; - Policies and procedures for medical documents; - Must develop a policy and procedure to maintain medical documentation the preserves resident information, protects confidentiality, and	0 680		

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0 680	Continued From page 7 secures/maintains the availability of records; - Roles under wavier declared by secretary; - Policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; - Development of Communication Plan; - Policies and procedures including primary and alternate means of communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies, and - Methods for sharing information; The licensee's undated Emergency Management Policy indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780		

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0 780	Continued From page 8 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with maintenance (M)-D on October 15, 2024, between 9:00 a.m. and 10:30 a.m. the following deficient conditions were	0 780		

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0 780	Continued From page 9 observed: LOWER-LEVEL STAIRS: The surveyor observed that there was not a handrail on these stairs. The surveyor explained to the M-D that a code complaint handrail is required on one side of the stairs. GARAGE: The surveyor observed a cover missing on an electrical receptacle and one was broken on a switch. The surveyor explained to the M-D a cover shall be installed on the receptacle and the broken cover repaired on the electrical switch. SMOKE ALARMS: The surveyor observed that the smoke alarms in the facility were not interconnected. The surveyor explained to the M-D that all the smoke alarms in the home shall be interconnected with the 120-volt smoke alarms outside the resident rooms. SMOKING: The surveyor observed that there was not an approved container provided for cigarette butts on the back deck. The surveyor explained to the M-D that an approved container shall be provided for the employees and residents to discard cigarette	0 780		

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0 780	Continued From page 10 butts. These deficient conditions were visually verified by the M-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 11 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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: A record review and interview were conducted on October 15, 2024, at approximately 10:00 a.m. with maintenance (M)-D on the fire safety and evacuation plan. FIRE SAFETY EVACUTAION PLAN: During record review the M-D stated they do not have a signed contract with a transportation provider or with an alternate location if they needed to move the residents to another facility. Also, the resident rooms were not numbered according to the fire safety and evacuation plan. The surveyor explained to the M-D that a signed	0 810		

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	40135	A. BUILDING: _____ B. WING _____	10/16/2024

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0 810	Continued From page 12 contract for transportation and the alternate location shall be obtained and reviewed annually. Also, the resident rooms shall be numbered to meet the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by	01640		

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01640	Continued From page 13 the resident or resident's designated representative to document agreement on the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on November 13, 2023, to receive assisted living services. R2's diagnosis included schizophrenia, HTN, BHP, paranoid, depression, anxiety, aspiration pneumonia, and dysphagia. R2's record contained an unsigned service plan modification form dated July 31, 2024, which included oxygen therapy and indwelling catheter care. R2's previous signed service plan, dated November 13, 2023, indicated R2 received comprehensive RN assessments, assistance with activities of daily living, medication and therapy administration. On October 15, 2024, at 1:00 p.m., director of nursing (DON)-A stated that R2 did not want to sign the document at the time it was developed. DON-A stated the licensee had no documentation of R2's refusals. The licensee's undated Service Plan policy	01640		

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01640	Continued From page 14 indicated that the service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that unlicensed personnel (ULP)-C and agent registered nurse (ARN)-B followed appropriate medication administration procedures for four of four residents (R2, R3, R4, R5). This practice resulted in a level two violation (a	01760		

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01760	Continued From page 15 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: ULP-C was hired on April 15, 2024, to provide assisted living services to residents. On October 15, 2024, from 8:25 a.m. to 9:03 a.m., during continuous observation, the surveyor observed ULP-C prepare morning medications for three of four residents. On October 15, 2024, at 8:25 a.m., the surveyor observed ULP-C dump medications from a medication set up box into a medication cup for R2. The surveyor asked ULP-C if they had verified medications using the electronic medication administration record (EMAR). ULP-C required explanation from the surveyor of what the EMAR was. At 8:29 a.m., the surveyor directed ULP-C to verify medications against the EMAR. The surveyor observed ULP-C log into a portable tablet to verify medications. ULP-C was not able to explain verification process to the surveyor upon request. On October 15, 2024, at 8:47 a.m., the surveyor observed R3 come to the basement nursing station to receive their morning medications. ULP-C again dumped medications from a medication set up box into a medication cup without verifying medications against the EMAR. During administration, R3 requested to not take their morning multivitamin, and removed the pill	01760		

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01760	Continued From page 16 from the medication cup and handed the pill to ULP-C. The surveyor observed ULP-C dispose of the medication in a sharps container. On October 15, 2024, at 8:50 a.m., the surveyor observed ULP-C prepare morning medications for R5. The surveyor observed ULP-C dump medications into the medication cup for administration to R5. The surveyor again asked if ULP-C had verified medications against the EMAR. ULP-C then logged into the EMAR on the portable tablet. ULP-C was not able to explain verification process to the surveyor upon request. ULP-C then went to the room of R5 to administer morning medications. R5 was in the bathroom bathing and was unable to take medications at that time. On October 15, 2024, at 9:37 a.m., the surveyor observed ULP-C administered R5's 8:00 a.m., medications. The surveyor asked ULP-C what the process was when administering morning medications late. ULP-C was unable to explain the procedure for late administration of medications. On October 15, 2024, at 10:07 a.m., the surveyor observed ULP-C retrieve the portable tablet to document the morning administration of medications. ULP-C documented having administered medications for four of four residents. The surveyor asked ULP-C why they had documented administering medications for R4 when they had been administered earlier by agent registered nurse (ARN)-B. ULP-C was unable to give an answer as to why they had documented administering a medication they did not administer. The surveyor asked ULP-C why they had documented the morning medication pass so much later than the time they were	01760		

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01760	Continued From page 17 administered, and if the medications would be documented as being administered late for all residents. ULP-C stated that all medications would end up being administered late and demonstrated this to the surveyor by showing the time of administration in the EMAR as being approximately 10:07 a.m., for all residents. On October 15, 2024, at 10:43 a.m., director of nursing (DON)-A stated staff were trained to check the EMAR prior to administration of medication. Additionally, DON-A stated ULP-C would not be allowed to pass medications until they were retrained on medication administration. On October 15, 2024, at 10:48 a.m., ARN-B stated staff were trained to document medications at the time of administration. ARN-B stated this was the reason the licensee had purchased portable tablets, and staff were expected to utilize the tablets for medication administration. Additionally, ARN-B stated they were not aware that ULP-C had documented a medication that had been administered by ARN-B. ARN-B stated staff were trained to only document medications that they had administered. The surveyor asked if it was possible to document a medication administration twice. ARN-B stated if a medication was documented as being administered, it would be impossible to document it a second time and demonstrated for the surveyor. When a medication was documented as being administered, it would appear grey on the EMAR. If the medication was not documented as being administered, it would appear on green the EMAR. ARN-B stated they forgot to document the morning administration of R4's medications. The licensee's undated Documentation of	01760		

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01760	Continued From page 18 Medication Administration policy indicated the following: "The following procedure will be followed for documentation of medication reminders, medication assistance or administration on the Medication Administration Record (MAR) or facility designated form/electronic device: 1. Locate appropriate MAR sheet for the client. Staff will also refer to the medication profile listing the medication name, strength, description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. The profile or the MAR will also tell staff what side effects or problems to watch for and report. 2. Staff administering medications will verify the medications are set up correctly before administration to the client by using the medication profile. If there is any question whether the medications have been set up accurately, the staff will contact the nurse and will receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse. 3. Staff will administer the medication according to the instructions on the MAR. 4. To document the medication reminder or administration, initial the appropriate box (or enter electronically) on the MAR form to verify the medication has been administered at the appropriate time and date. All staff administering medications to a resident must include the staff person's name/initials and title in the signature box on the MAR or applicable authentication. 5. Staff will document each medication reminder, assistance with medications or medication administration immediately after that task has been performed." No further information was provided.	01760		

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01760	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents 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) 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: UNSECURED MEDICATIONS ULP-C was hired on April 15, 2024, to provide assisted living services to residents. On October 15, 2024, at 8:50 a.m., the surveyor	01880		

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01880	Continued From page 20 observed ULP-C prepare medications for administration to R5. ULP-C prepared the following medications: - Acetaminophen 500mg capsule; - Amlodipine 5mg tablet; - Hydrochlorothiazide 12.5mg; - Certavite/antioxidant tablet; - Levetiracetam 750mg tablet; - Metoprolol Succinate ER tablet. On October 15, 2024, at 8:59 a.m., the surveyor observed ULP-C go to the room of R5 to administer morning medications. R5 was out of their room and bathing in bathroom. At 9:03 a.m., ULP-C returned to the basement nursing office with the prepared medications to wait for R5 to be available for administration. At 9:04 a.m., the surveyor observed ULP-C left the medication cup containing R5's morning medications on a table directly adjacent to the nursing office doorway. From 9:04 a.m., to 9:35 a.m., the medications prepared for R5 were left unattended and unsecured on a tabletop next to an open doorway. UNSECURED MEDICATION CABINET On October 15, 2024, at 8:08 a.m., the surveyor went to the licensee's basement nursing office to observe the morning preparation of medications. At this time, the surveyor observed the licensee's medication storage cabinet located near the entrance to the nursing office. The medication cabinet was closed, with the key to the cabinet still in the lock. The key remained in the lock and unsecured until 10:03 a.m., when director of nursing (DON)-A removed the key from the cabinet. On October 15, 2024, at 10:50 a.m., DON-A	01880		

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01880	Continued From page 21 stated staff were trained to not pull a medication until they are ready to administer, and if the resident is not ready, medications should be secured in the resident specific locked compartments. Additionally, DON-A stated the medication cabinet should be always secured. The licensee's undated Medications Management Services policy indicated the RN will develop and update as needed specific procedures for controlling and storing medications including controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of four residents (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) and was issued at an	01890		

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01890	Continued From page 22 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On October 16, 2024, at 10:26 a.m., the surveyor conducted a review of the licensee's locked medication cabinet. The surveyor found the following expired medications belonging to R4: - Trazodone 50mg tablets, with an expiration date of July 5, 2023; - Melatonin 5mg tablets, with an expiration date of July 2024. On October 16, 2024, at 10:40 a.m., director of nursing (DON)-A stated that agent registered nurse (ARN)-B was responsible for monitoring the medication cabinet and the expired medications should have been removed. DON-A stated these medications were prescribed as PRN (as needed) medications and R4 does not use them anymore. The licensee's undated medication disposition of disposal policy indicated the facility would develop policies to be followed in disposing of medications that were no longer used or after the resident had been discharged or died. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 23 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) with oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 14, 2024, in the bedroom of R2, the surveyor observed one oxygen tank standing on end, directly adjacent to but not touching the wall behind a recliner, one oxygen tank in a portable roller, and one oxygen concentrator in R2's room. On October 16, 2024, at 12:46 p.m., director of nursing (DON)-A stated that R2 had been receiving oxygen therapy since August 1, 2024, and they were waiting on a storage rack to arrive. The licensee's undated Safe Oxygen Use and Storage policy indicated the facility staff would ensure that the resident had an appropriate	02310		

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02310	Continued From page 24 storage cart or stand for the oxygen cylinder or oxygen concentrator and would educate the resident/resident's representative about safe use and storage of oxygen. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *10/14/24*
Time: 12:40:00
Report: 1013241122

Food and Beverage Establishment Inspection Report

Location:
Crystal Edge LLC
9119 Regent Parkway
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0043698
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

TCS FOODS ARE STORED AND COOKED ON-SITE. RAW MEAT AND RAW SHELL EGGS ARE COOKED ON SITE. NO FOOD PROBE THERMOMETER WAS AVAILABLE. COMPLY WITH ABOVE RULE. DISCUSSED THERMOMETER USE WITH STAFF.

Comply By: 10/21/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HOT WATER SANITIZING DISH MACHINE IS USED IN THE KITCHEN TO WASH WARE. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. DISCUSSED TEST STRIPS AND DISH MACHINE TESTING WITH STAFF.

Comply By: 10/30/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE FACILITY HAS A RESIDENTIAL KITCHEN. TCS FOOD THAT WAS COOKED THEN COOLED ON-SITE BY STAFF DAYS PRIOR WAS STORED IN THE GARAGE REFRIGERATOR. COMPLY WITH RULE. DISCUSSED SAME DAY SERVICE WITH STAFF AND FOOD WAS DISCARDED.

Corrected on Site

Type: Full
Date: *10/14/24*
Time: 12:40:00
Report: 1013241122
Crystal Edge LLC

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Rice
Temperature: 40 Degrees Fahrenheit - Location: Garage refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Garage refrigerator
Violation Issued: No

Process/Item: Cream cheese
Temperature: 41 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator Z. Morth.

The establishment has a residential kitchen. The kitchen has wood cabinets, LVT floor, tile walls, laminate counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013241122 of 10/14/24.

Certified Food Protection Manager: Haja Uche

Certification Number: 125351 Expires: 10/04/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Haja Uche
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998

Type: Full
Date: *10/14/24*
Time: 12:40:00
Report: 1013241122
Crystal Edge LLC

Food and Beverage Establishment Inspection Report

jerry.malloy@state.mn.us