Electronically Delivered

April 22, 2022

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

RE: Project Number(s) SL30602015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 22, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
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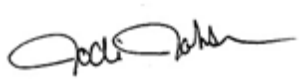
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

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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 _____	03/22/2022

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30602015 On March 21, 2022, through March 22, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 18 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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: On March 21, 2022, at 2:09 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On March 21, 2022, at 2:16 p.m. LALD-A acknowledged they were not listed as Director of Record with BELTSS and stated they were not aware they needed to be registered as Director of Record for licensee.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 according to the Minnesota Food Code. This had the potential to affect all 18 residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 480		

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0 480	Continued From page 3 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 22, 2022, for the specific Minnesota Food Code deficiencies.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 4 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 residents). The findings include: On March 21, 2022, at 12:17 p.m. during the facility tour, 911 emergency number was not observed to be posted in common areas and near telephones provided by the assisted living facility. At that time, LPN-B confirmed the 911 emergency sign was usually posted, but it had been taken down. LPN-B indicated she would put back up. On March 22, 2022, at 9:15 a.m. licensed assisted living director (LALD)-A confirmed the 911 signage was reposted, and it's location. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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	0 810		

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0 810	Continued From page 5 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 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 a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

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0 810	Continued From page 6 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 March 22, 2022, at approximately 10:05 a.m. with licensed practical nurse (LPN)-B, regional maintenance (RM)-G, and maintenance director (MD)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, LPN-B stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, LPN-B stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, LPN-B stated that the licensee provides training to employees on fire safety annually thereafter. A policy was provided that stated that the licensee provides employee training annually on fire safety and evacuation.	0 810		

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0 810	Continued From page 7 Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, LPN-B stated that the licensee had not conducted any evacuation drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety or personal property of a resident. This had the potential to affect all 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), 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	0 970		

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0 970	Continued From page 8 of the residents). The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the facility's liability for health, safety or personal property of a resident. -Page 12, section 12 of the contract included "Provider is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment unit or on providers's premises. Resident will not be liable to the provider, or any other person claiming through or under provider by right of subrogation or otherwise, for damage to the apartment unit or to provider's premises from causes or risks normally covered by standard fire and extended coverage insurance, or which are actually covered by any other insurance. The parties to this contract shall procure from their insurers a waiver of all rights of subrogation which one insurer under said policies might have as against another, said waiver to be	0 970		

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0 970	Continued From page 9 in writing for the express benefit of the other." On March 21, 2022, at 3:30 p.m. licensed assisted living director (LALD)-A verified the licensee's contract included the above content, and stated the same contract was utilized for all residents residing in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 10 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D) with records	01500		

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01500	Continued From page 11 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a start date of June 8, 2018, and began providing assisted living services on August 1, 2021. ULP-D's employee training records lacked evidence ULP-D had successfully completed annual training as required since June 21, 2019, in the following area: -training on reporting of maltreatment of vulnerable adults under section 626.557. On March 22, 2022, at 3:00 p.m. human resource (HR)-F confirmed ULP-D lacked the required annual training. HR-F indicated staff were supposed to complete the training as assigned stating, "we hold them accountable, but don't hold their hand." The licensee's Required Annual Staff Training policy dated November 2019, indicated all staff performing direct care services would complete at least eight (8) hours of annual training for each 12 months of employment, and must include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557.	01500		

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 _____	03/22/2022

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

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01500	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 13 by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1 and R2) with records reviewed. 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: R1 R1's Service Plan Agreement Addendum dated August 16, 2021, indicated R1 received assistance with showering, dressing, medication administration, laundry, and housekeeping. R1's Service Plan lacked the following: - the schedule and methods of monitoring staff providing services R2 R2's Service Plan Agreement Addendum dated November 26, 2021, indicated R2 received assistance with showering, dressing, ostomy cares, medication administration, laundry, and housekeeping. R2's Service Plan lacked the following: - the schedule and methods of monitoring staff providing services On March 22, 2022, at 10:51 a.m. licensed assisted living director (LALD)-A verified the	01650		

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01650	Continued From page 14 content was lacking on the service plan and stated the same service plan format was utilized for all residents residing within the facility. The licensee's Service Plan policy dated November 2019, noted the service plan would include schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of six residents (R4) with records reviewed.	01760		

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01760	Continued From page 15 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 Service Plan Agreement Addendum dated August 6, 2021, identified services included medication administration. R4's prescriber's orders dated March 2, 2022, included Systane drops (lubricating eye drop medication) and directed to instill one drop in each eye, four times daily for dry eyes. On March 22, 2022, at 11:38 a.m. the surveyor observed unlicensed personnel (ULP)-C obtain R4's Systane eye drops from the medication cart for administration. ULP-C entered R4's room, applied gloves and administered one drop to the left eye, and proceeded to the right eye when R4 verbally refused eye drop administration to the right eye. ULP-C removed gloves, sanitized hands and proceeded back to the medication cart where ULP-C documented eye drop administration on R4's electronic medication administration record (eMAR). When interviewed at this time, ULP-C verified she documented medication as administered stating she was not sure what to do when a resident refused a medication. ULP-C further indicated R4 frequently refused the eye drop to the right eye. On March 22, 2022, at 11:54 a.m. licensed	01760		

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01760	Continued From page 16 assisted living director (LALD)-A stated ULP-C should not have documented the medication as given since the prescriber order was not followed. LALD-A indicated she would instruct ULP-C to make an amendment and add a note to R4's eMAR. A policy on documentation of medication administration was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	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 all medications were securely locked and only authorized personnel had access for R1, one of one resident reviewed. 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	01880		

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01880	Continued From page 17 situation has occurred only occasionally). The findings include: On March 21, 2022, at 1:30 p.m. R1 opened the unlocked medication box sitting on the back of the toilet in the resident's room. The medication box contained eight prescription containers of powders and creams with the resident's name and prescription number. The lock was sitting in a nearby soap dish. On March 22, 2022, at 2:10 p.m. licensed practical nurse (LPN)-B confirmed the medication box should be locked. The licensee's Storage of Medications Policy dated December 2019, noted medications shall be stored to prevent diversion of medications by tenants or others. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01890		

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01890	Continued From page 18 review, the licensee failed to ensure time sensitive medications were dated when opened for two of two residents (R1, R5) with insulin and one of one resident (R4) with eye drops with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 22, 2022, at 11:05 a.m. ULP-C administered insulin to two residents. The insulin pens were not labeled with an opened or expired date. In addition, one insulin pen was illegible. ULP-C confirmed the pens were not labeled. R1's Medication Administration record read, Novolog flex pen solution (soln) five (5) units three times per day and Victoza inject 1.8 milligrams (mg) subcutaneously once daily. R5's Medication Administration record read, Insulin Aspart flex pen per sliding scale,inject subcutaneous three times per day and Lantus Solostar 100 units/milliliter (ml) inject 24 units subcutaneously at bedtime. On March 22, 2022, at 11:30 a.m. LPN-B confirmed three insulin pens lacked an open or expired date. LPN-B stated labeling process of pens was usually completed during a medication	01890		

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01890	Continued From page 19 audit every two weeks. R4 On March 22, 2022, at approximately 11:38 a.m. the locked medication cart was reviewed with unlicensed personnel (ULP)-C. R4's Systane 0.4%-0.3% (lubricating eye drops) lacked a date the eye drops had been opened or a date the eye drops would expire. On March 22, 2022, at approximately 11:38 a.m. ULP-C confirmed the eye drops lacked the opened date and stated, "it's supposed to." On March 22, 2022, at 11:54 a.m. licensed assisted living director (LALD)-A stated eye drops were to be dated when opened. The licensee's Labeling of Medication policy dated December 2019, noted insulin pens should be labeled with the date opened. There was no specific instruction on dating eye drops. No further information 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	02040		

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02040	Continued From page 20 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 hazard vulnerability assessment or safety risk assessment of the physical environment 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 22, 2022, at approximately 11:45 a.m. with licensed assisted living director (LALD)-A, licensed practical nurse (LPN)-B, and human resources (HR)-F on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A provided additional documentation that the licensee had performed a	02040		

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02040	Continued From page 21 hazard assessment in conjunction with the Emergency Preparedness Planning and Resource Manual. Further review indicated that the hazard vulnerability assessment performed was did not meet the requirements for the assessment of the physical environment on or around the property and did not have any mitigation factors listed. 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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	02140		

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02140	Continued From page 22 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 21, 2022, at approximately 11:20 a.m. licensed assisted living director (LALD)-A, stated she oversaw training staff in the care of individuals with dementia. On March 21, 2022, at approximately 3:30 p.m. LALD-A stated she had not completed any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care. LALD-A stated she was unaware of the requirement until recently and would be registering for a class soon. The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

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03090	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 the residents). The Findings include: On March 21, 2022, at approximately 12:15 p.m. during the tour of the facility, the electronic monitoring notice was not posted at the facility entrance as required. On March 21, 2022, at approximately 12:30 p.m. licensed practical nurse (LPN)-B acknowledged the licensee had failed to post the required electronic monitoring notice, indicating a sign had previously been displayed in the front window, but it had been taken down last week. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *03/22/22*
Time: 13:17:16
Report: 1028221051

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.

4-300 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.

Provide an instant read food thermometer.

Comply By: 03/24/22

5-200A Plumbing: approved materials/design

5-202.12A ** Priority 2 **

MN Rule 4626.1050A Provide a handwashing sink equipped with running water at a temperature to permit handwashing for at least 15 seconds through a mixing valve or combination faucet.

Currently only a small amount of warm water is dispensed from the handwashing sink in the kitchen area. The volume of warm water coming from the handwashing sink must be increased.

Comply By: 04/08/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

A state licensed Certified Food Protection Manager must be employed by this establishment as soon as possible.

Comply By: 03/24/22

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

The interior of the ice machine must be cleaned to remove scale build-up.

Comply By: 03/24/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

The top of the interior of the microwave must be cleaned to remove food residue accumulation.

Comply By: 03/24/22

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Meatballs
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Beef
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -17 Degrees Fahrenheit - Location: Beverage Air - Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

Type: Full
Date: *03/22/22*
Time: 13:17:16
Report: 1028221051
The Beacon at Lake Crystal

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221051 of 03/22/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Sherry Hoernemann
Cook

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