DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 29, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 19, 2022, we informed you of imposed enforcement remedies.

On August 18, 2022, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 23, 2022, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 23, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 9, 2022.

NURSE AIDE TRAINING PROHIBITION

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Crystal Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 9, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an"E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 7, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On October 29, 2022, we notified you a remedy was imposed. On November 16, 2022 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 16, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 23, 2022 be discontinued as of November 16, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 9, 2022.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 29, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 19, 2022, we informed you of imposed enforcement remedies.

On August 18, 2022, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 23, 2022, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 23, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 9, 2022.

NURSE AIDE TRAINING PROHIBITION

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Crystal Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 9, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
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- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an"E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 7, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	R-C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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) COMPLETION DATE
{E 000}	Initial Comments Surveyor: 43007 On 9/27/22, 9/28/22, and 9/29/22 an onsite revisit was conducted to determine compliance with CMS Appendix Z Emergency Preparedness Requirements for Long Term Care facilities at CFR §483.73(b)(6), cited during a standard recertification survey exited on 8/18/22. The facility is now IN compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	R-C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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) COMPLETION DATE
{E 000}	Continued From page 1	{E 000}		
{F 000}	Surveyor: 44647 INITIAL COMMENTS Surveyor: 43007 On 9/27/22, 9/28/22, and 9/29/22, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 8/18/22. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The complaints SUBSTANTIATED: H5289175C (MN81306) and H5289177C (MN811430, with deficiencies previously cited at F755 and F803 were reviewed for compliance, F755 was found NOT to be corrected and remains OUT OF COMPLIANCE, and F803 was found to be corrected. The complaints SUBSTANTIATED: H52893782C (MN86762/MN85867), with deficiencies previously cited at F677 and F921 were reviewed for compliance, F677 and F921 were found NOT to be corrected and remain OUT OF COMPLIANCE. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	{F 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	R-C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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) COMPLETION DATE
{F 000}	Continued From page 2 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 657} SS=E	Surveyor: 44647 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	{F 657}		11/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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{F 657}	Continued From page 3 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 42586 Based on interview and document review the facility failed to develop a comprehensive care plan to include assessed and identified needs for 3 of 3 residents (R2, R5, R6) who's comprehensive care plans were reviewed. Findings include: R2's admission Minimum Data Set (MDS) dated 9/21/22, included diagnoses of wedge compression fracture of T11-T12 vertebrae, post traumatic stress disorder (PTSD), chronic pain, spinal stenosis, urinary incontinence, and traumatic brain injury (TBI). If further included moderately impaired cognition and required limited assistance with bed mobility and toileting and was independent with all other activities of daily living (ADL). R2's care plan dated 9/19/22, lacked any indication R4 required assistance with ADL's. R5's admission MDS dated 9/25/22, included diagnoses of syncope and collapse, low back pain, chronic obstructive pulmonary disease (COPD), depression, and malignant neoplasm of the prostate. If further included moderately impaired cognition and required extensive assistance with dressing, independent with eating, and limited assistance with all other ADL's.	{F 657}	1. R2, R5, R6 care plan were updated to reflect correct care levels 2. All residents care plans were updated to reflect correct care levels 3. Nurse Managers educated on how to update care plan and care importance 4. IDT will address care plans as needed in morning meeting every day. Audits will be conducted 3x a week for 3 weeks by DON or designee. 5. All concerns will brought to QAPI	

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{F 657}	Continued From page 4	{F 657}		

R5's progress noted dated 9/19/22, included "Resident eloped from hospital with use of a walker and made it home. Both family members requested that a [WanderGuard] WG be placed on Resident and Writer denied being able to do that with no presenting elopement behaviors but both agreeable to 30 minute safety checks while awake.

R5's progress note dated 9/20/22, included "Resident is [alert and oriented] AO, understands and can be understood. Able to make needs known. slept all night. Continued with Q15 minutes check d/t risk of elopement."

R5's care plan lacked any indication of R5 being an elopement risk.

R6's progress note dated 9/21/22, included "Resident arrived at facility @ 1500 on a stretcher via ambulance and accompanied by two paramedics. Resident is left foot amputee. Resident is alert and oriented X4. Writer welcome resident to room and orient him on the call light. He as a condom catheter and Ostomy bag. Skin is discoloration on the back and have multiple wounds. Resident is assist X2, with wound cares and transfer. Diet is puree and take pills whole with apple sauce."

R6's care plan only contained activities and lacked any indication of how to care for R6.

During an interview on 9/28/22, at 11:20 a.m. licensed practical nurse (LPN)-A stated care plans are initiated by the director of nursing (DON). LPN-A further stated once the care plans

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{F 657}	Continued From page 5 are initiated then any nurse can update them as needed. LPN-A verified R4, R5, and R6's care plans were lacking certain areas specific to those residents needs which included ADL's, diet/nutrition, and risk for elopement and would expect those areas to be included in the comprehensive care plan. Facility policy, Care Planning- Interdisciplinary Team, undated, indicated a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).	{F 657}		
{F 677} SS=D	Surveyor: 43077 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Surveyor: 42586 Based on observation, interview, and document review, the facility failed to ensure routine bathing and hygiene was offered and/or provided for 1 of 4 residents (R59) reviewed for activities of daily living (ADLs). Findings include: R59's quarterly MDS dated 8/30/22, identified diagnoses of anxiety, depression, and cellulitis.	{F 677}	1. R59 routine hygiene and bathing schedule addressed 2. All resident routine hygiene and bathing schedules were addressed 3. Nursing staff will be re-educated on hygiene and bathing by DON or designee 4. All orders placed in PCC for all residents bath schedules and must be signed off by nurse on shift as completed 5. DON or designee will audit bath calendar for completion daily. Audits will be daily for 2 weeks then every other day	11/4/22

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{F 677}	Continued From page 6 R59 was understood and able to understand. R59 had not rejected care. R59 was independent after set up for hygiene, and bathing had not occurred in the seven day look back period. R59's care plan dated 8/25/22, indicated he was independent with hygiene. The care plan lacked a shaving preference. During an observation and interview on 9/28/22, at 3:00 p.m. R59 was sitting in a wheelchair by the nurse's station, his shirt had food and paint stains and was only buttoned with one button in the middle of his chest. R59's fingernails were dirty, he had facial hair, and he appeared disheveled. R59 stated he preferred to be clean shaven and stated, "I look terrible with facial hair." R59 further stated he had never been given a razor and he can't use an electric razor because it burned his face. "It's hard getting anything done around here, everyone has bad attitudes." Surveyor was unable to observe a razor in R59's room or bathroom. Facility policy titled Activities of Daily Living (ADLs) undated, indicated the facility would provide care and services for hygiene and bathing. Facility policy titled Shaving the Resident dated 10/1/21, indicated to remove facial hair and improve the resident's appearance and morale it should be determined how the resident usually shaves (i.e., use of safety edge or electric razor/special products). Staff were directed to assist with a disposable safety razor or electric razor. Surveyor: 42579	{F 677}	for 2 weeks then weekly for 3 weeks. 6. DON or designee will continue to monitor completion and compliance for all residents hygiene and bathing 7. Any issues found will be brought to QAPI	

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{F 679} SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Surveyor: 46885 Based on observation, interview, and document review, the facility failed to comprehensively assess, identify, and provide meaningful activities for (R37) reviewed who was dependent on staff for activities. Findings include: R37's Minimum Data Set (MDS) dated 9/20/22, indicated intact cognition. R37's diagnoses list included: displaced fracture of the greater trochanter of right femur, morbid obesity, major depressive disorder, chronic obstructive pulmonary disease, acute on chronic diastolic congestive heart failure, and suicidal ideation. R37's admission MDS dated 6/20/21, indicated it was somewhat important to do his favorite activities, keep up with the news, go outside when the weather is good, and participate in religious services.	{F 679}	1. R37 activity assessment completed. 2. Activity assessment completed on all residents. 3. Activity assessment will be completed quarterly on all residents. 4. Activities Staff educated on providing person centered activities. 5. Activities staff or designee will complete activities assessments quarterly and compare to attendance records to monitor for attendance of activities. 6. Attendance records will be audited weekly for 4 weeks. 7. Any issues found will be brought to QAPI	11/4/22

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{F 679}	Continued From page 8 R37's care plan dated 9/2/22, indicated an intervention to provide a program of activities that was of interest and accommodated R37's status. Another intervention indicated to explain all procedures and allow R37 to adjust to changes. R37's care plan dated 6/21/22, indicated an intervention to encourage R37 to get out of bed, in addition, an intervention included R37 was totally dependent on staff for locomotion using a hoyer. R37's care plan dated 7/8/22, included interventions to assist R37 with arranging community activities, and providing a program of activities that was of interest and empowered R37 by encouraging and allowing choice, self-expression, and responsibility. The care plan also included an intervention to provide R37 with materials for individual activities as desired and the care plan intervention indicated that R37 liked the following independent activities, however there was no list of independent activities written on the care plan. R37's activity notes for the month of August 2022, indicated R37's activities included use of electronics/phone/TV/computer/movies twenty two times, and the news/current events one time. R37 was unavailable for the news one time and declined a news/current event activity one time. R37 participated in one social/special event one time. R37 had nine check in greeting or short visits. R37's activity notes did not indicate R37 participated in a spiritual or outdoor visit activity. R37's activity notes for the month of September	{F 679}		

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{F 679}	Continued From page 9 2022, indicated R37's activities included use of electronics/phone/TV/computer/movies twenty five times, and had four check in greeting or short visits. R37's activity notes indicated R37 did not participate in news/current events and R37's activity notes did not indicate R37 participated in a spiritual or outdoor visit activity. During interview on 9/29/22, at 8:44 a.m., R37 stated nobody has offered to get R37 out of bed to go to activities. R37 stated, "They consider me a pain in the ass because of my size". R37 stated physical therapy was the only staff who got R37 out of bed. R37 stated a family member took R37 outside with physical therapy. R37 stated he received an activity calendar that included an activity of bible study that he was interested in participating. R37 stated he was bored and stated it was difficult to watch television because his roommate also watched television and R37 had to compete with the volume. During interview on 9/29/22, at 10:14 a.m., activity aide-B stated he has to ask someone to get R37 out of bed and stated staff do not tell activity aide-B if they offered to get R37 out of bed. During interview and observation on 9/29/22, at 9:12 a.m., nursing assistant (NA)-B stated that R37 required a hoyer lift and stated the nurse told NA-B not to get R37 up. A hand written note on NA-B's care sheet indicated, "Don't get up". During interview on 9/29/22, at 9:21 a.m. trained medication aide (TMA)-A stated he had not seen R37 up and stated he did not pay attention to	{F 679}		

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{F 679}	Continued From page 10 whether R37 went to activities. During interview on 9/29/22, at 9:25 a.m. NA-C did not know why R37 did not get out of bed. During interview on 9/29/22, at 9:53 a.m. licensed practical nurse (LPN)-B stated R37 rarely got out of bed because he refused and LPN-B stated she instructed NA-B to check in with R37. During interview and observation on 9/29/22, at 10:00 a.m. LPN-B asked R37 if he wanted to get up and R37 asked, "And then what"? LPN-B asked, "Do you want to get up in the chair"? R37 asked again, "And then what" LPN-B asked R37 if he wanted to get up to sit in the chair and R37 declined. During interview on 9/29/22, at 10:02 a.m. R37 stated he did not want to get up to just sit in a chair, and stated if they offered to take him outside it would be different. R37 stated the chair used was a transport chair that R37 would not be able to move himself in. During interview on 9/29/22, at 10:38 a.m. activity director-A stated R37 stayed in his room and stated R37 liked watching television and stated his family visited regularly. Activity director-A stated activity needs are determined through completion of quarterly assessments as well as on admission and annual assessments. Activity director-A stated residents are informed of activities by providing activity calendars and stated her staff would go around. Activity director-A stated R37's goal was to maintain involvement in cognitive stimulation social activity	{F 679}		

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{F 679}	Continued From page 11 as desired. Activity director-A stated they did not offer pet therapy at this time and acknowledged R37's MDS indicated it was somewhat important for R3 to go outside when the weather was nice and stated going forward she would reiterate with her staff to communicate to R37 why he is being asked to get up such as offering to go outside. Activity director-A acknowledged they had no notes regarding R37 going outside or being offered to go outside and stated they dropped the ball there. During interview on 9/29/22, at 11:32 a.m. administrator-A stated they are trying to coach activity director-A since she had recently started and they are working on offering services that stopped due to COVID and stated they will discuss with their team and clarify language they are using. Surveyor: 44651	{F 679}		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on observation, interview, and document	F 684	1.R6 and R9's appointments have been rescheduled. 2. Residents who have	11/4/22

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F 684	Continued From page 12 review, the facility failed to follow up with provider referrals for 2 of 2 to residents (R6 and R9) reviewed for referrals. Findings include: R6's admission Minimum Data Set (MDS) dated 9/27/22, indicated R6 was severely cognitively impaired, required extensive assist of two staff for bed mobility, transfers, and toileting, was always incontinent of bladder, and had a colostomy. R6's diagnoses included kidney failure and diabetes. R6's Discharge Orders and Information dated 9/21/22, indicated R6 was hospitalized with altered mental status and had wounds and wound treatments on his sacrum, left thigh, groin, right thigh, right heel, and had a left above the knee amputation. The document identified R6 had an appointment scheduled with a plastic surgery provider on 9/29/22, at 10:00 a.m. R6's Inter Agency Transfer Form dated 9/21/22, included the statement, "Please keep appointment with plastic surgery on 9/29." R6's orders reviewed 9/29/22, included an order dated 9/21/22 for R6 to visit plastic surgeon at 10:00 a.m. on 9/29/22. On 9/29/22, at 10:32 a.m. R6 was observed lying in bed in the dark in his room. R9's admission MDS dated 9/26/22, indicated R9 was mildly cognitively impaired, and required extensive assistance of one staff for bed mobility, transfers, and toileting. R9 had diagnoses of fracture, peripheral vascular disease, kidney	F 684	appointments will have transportation scheduled prior to appointments. 3. Education given to HUCs on the importance of scheduling appointments and transportation to appointments. 4. Daily audits on transportation 5 days for 1 week, then 3x per week for 1 week, then 1x a week for 2 weeks conducted by DON or designee. 5. Any issues found will be brought to QAPI	

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F 684	Continued From page 13 disease, and lung disease. R9's Admission Record dated 9/29/22, indicated R9's principle admitting diagnosis was displaced left hand fracture. R9's hospital Discharge Orders dated 9/20/22, included instructions for R9 to follow-up with orthopedic provider for outpatient evaluation for dislocated fifth metacarpal fracture. R9's facility orders lacked an order for orthopedic follow up. R9's medical record lacked indication he was seen by orthopedic provider after admission. During interview on 9/29/22, at 11:03 a.m. health unit coordinator (HUC) stated when a resident returned from the hospital or an appointment both the HUC and nursing staff reviewed the orders. She stated she followed up with scheduled appointments and if there wasn't one scheduled, she would schedule it. She stated she did not receive any recent education about how to handle consult recommendations. HUC reviewed the records for R6 and confirmed he had a scheduled appointment for plastic surgery that morning and she did not schedule transportation for it. HUC confirmed R6 did not go to his appointment. She reviewed R9's records and confirmed R9 was supposed to have an appointment with an orthopedic provider one week for admission. She stated she knew he did not go to an appointment because she did not coordinate the appointment or transportation.	F 684		

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F 684	Continued From page 14 During interview on 9/29/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated if there was a new order for a consult the HUC entered it into the computer. LPN-A verified it did not appear R6 went to his scheduled appointment, or that R9 had his follow-up scheduled. He stated he had not received any education regarding a new process recently. During interview on 9/29/22, at 3:48 p.m. administrator stated the HUC scheduled appointments and transportation and both the nurses and the HUCs reviewed hospital paperwork for any consults. He stated he expected staff to follow up and ensure residents went to appointments as scheduled and/or recommended. The facility policy Appointment Scheduling Protocol undated, indicated care coordinators scheduled appointments during intake to address any medical provider needs, set up required transportation based on resident needs, and enter appointments into the scheduling system.	F 684		
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	{F 688}		11/4/22

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{F 688}	Continued From page 15 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 42586 Based on interview and document review, the facility failed to implement an occupational therapy (OT) ordered restorative nursing program to prevent potential decrease in range of motion (ROM) for 1 of 1 resident (R20) reviewed for ROM. Findings include: R20's quarterly Minimum Data Set (MDS) dated 8/31/22, indicated R20 was severely cognitively impaired, non-ambulatory, incontinent of bladder and bowel, and required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. The MDS indicated R20 had zero days of restorative nursing techniques, including active or passive ROM, in the past seven days. R20's Admission Record dated 8/18/22, indicated R20 had diagnoses of altered mental status, traumatic brain injury, partial paralysis due to stroke, seizures, and personality disorder. R20's care plan dated 1/16/22, included a goal of R20 would maintain the current level of function	{F 688}	1. R20s care plane was reviewed and updated to reflect need for maintenance program 2. R20 was placed on a maintenance program 3. All resident's care plans were reviewed for maintenance program and modified as necessary 4. Facility will create a daily maintenance program log and audit the log 3 times a week for 2 weeks then weekly for 2 weeks to ensure ROM is being completed for residents on a maintenance program. 5. Therapy to work with Quality Assurance Aide and DON to review and revamp the maintenance program 6. Any issues will be brought to QAPI	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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) COMPLETION DATE
{F 688}	Continued From page 16 in activities of daily living with an intervention of physical therapy/occupational therapy evaluate and treat as per MD (medical doctor) orders. R20's most recent ROM and Mobility assessment dated 3/5/22, indicated R20 had impairment on one side of both upper and lower extremities. During an interview on 9/28/22, at 12:55 p.m. certified occupational therapist (COTA)-A stated the restorative nursing program was managed by the nursing department and they currently don't have one because the program must be run by a registered nurse (RN) and there wasn't one available. COTA-A further stated the facility had a restorative nursing program about a year ago, but the manager left. COTA-A also verified R20 was not receiving any therapy. During an interview on 9/28/22, at 12:59 p.m. the Director of Therapy (DOT)-A stated nursing oversaw the restorative nursing program, and she was not aware of any program starting since their last survey. DOT-A further stated she has not met with the administrator or director of nursing (DON) to review and revamp the Restorative Nursing Program, educated staff, or completed competencies for the rollout of a new restorative maintenance program. DOT-A also stated there wasn't an RN available to run the program because "It's a huge undertaking for a facility. We had it (restorative nursing program) for a while but then we kept losing our RN's." R20's electronic health record lacked documentation of restorative nursing efforts. The facility policy Restorative Nursing Program	{F 688}		

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{F 688}	Continued From page 17 dated 10/1/21, indicated each resident will be screened and or evaluated by the nurse designated to oversee the restorative nursing process for inclusion into the appropriate facility restorative nursing program(s) when it has been identified by the IDT that the resident is in need or may benefit from such program(s). The program will include hygiene, mobility (including active/passive ROM), elimination, dining, and communication, and will be documented on the restorative care forms in the electronic health record. Surveyor: 44651	{F 688}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on observation, interview, and document review, the facility failed to conduct an assessment to determine cause of falls and place interventions based upon the assessment to prevent falls from occurring for 1 of 1 resident (R20) reviewed for falls. Findings include: R20's quarterly Minimum Data Set (MDS) dated	{F 689}	1. R20 care plan was updated with appropriate interventions 2. All residents care plans were updated with appropriate interventions 3. Fall assessments to be completed on all residents all high-risk residents Kardax to be updated appropriately with fall interventions. 4. IDT will discuss cause of falls and interventions to be put in place to prevent falls from occurring during morning IDT meeting. At time of meeting care plan will	11/4/22

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{F 689}	Continued From page 18 8/31/22, indicated R20 was severely cognitively impaired, non-ambulatory, incontinent of bladder and bowel, had no behaviors, and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS indicated R20 had one fall since the prior assessment. R20's Admission Record dated 9/30/22, indicated R20 had diagnoses of altered mental status, traumatic brain injury, partial paralysis due to stroke, seizures, and personality disorder. R20's care plan dated 5/28/21, included R20 was high risk for falls related to confusion, gait/balance problems, incontinence, and paralysis, and included interventions of anticipate needs, keep call light in reach and respond promptly, wear appropriate footwear, physical therapy to evaluate and treat as ordered, and review information on past falls and attempts to determine cause of falls. In addition, the care plan directed staff to record possible root causes, remove any potential causes if possible, and educate resident/family/caregivers/interdisciplinary team as to causes of falls. R20's progress note dated 8/28/22, at 7:45 p.m. indicated R20 was observed on the floor next to the television stand with the television on top of R20 and the cords wrapped around her hands. The progress note lacked evidence of an immediate intervention. R20's progress note dated 8/29/22, at 2:35 p.m. indicated the interdisciplinary team (IDT) discussed R20's incident which included new fall	{F 689}	be audited by DON or designee to note intervention is in place 5. Monitoring and changes to care plans regarding fall interventions will be done Daily in morning IDT meeting by DON or designee. 6. Any issues found will be brought to QAPI	

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{F 689}	Continued From page 19 interventions of 15-minute checks, mount the television to the wall, resident is to have her television remote at all times, and licensed staff were to document why the remote was unavailable during the shift if R20 didn't have the remote. On 9/27/22 reviewed R20's care plan dated 5/28/21, the care plan lacked evidence of the following interventions: 15-minute checks, television mounted to the wall, resident to have her television remote at all times, licensed staff were to document why the remote was unavailable during the shift if R20 didn't have the remote, fall mat next to bed, and bed in lowest position while in bed. On 9/28/22, reviewed the facility Risk Management dated 8/28/22, at 9:22 p.m. lacked evidence of root/cause analysis of the fall. On 9/28/22, at 10:17 a.m. observed R20 lying in bed with a mat on the floor and the bed in low position. The television remote was observed on the bedside table which was across the room by the window. R20 unable to reach the remote. During interview on 9/28/22, at 10:20 a.m. nursing assistant (NA)-A stated R20 was to lay in bed with the floor mat and was checked on "often". NA-A further stated, was unaware of how often R20 needed to be checked on however, the staff check on her "when they can". In addition, NA-A stated, was unaware R20 was to have her remote at all times and was on 15-minute checks. During interview on 9/28/22, at 10:28 a.m. the	{F 689}		

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{F 689}	Continued From page 20 social service assistant (SSA)-A stated each fall prompted an IDT review, interventions for falls, and social services was to update the care plan with the interventions during the IDT review. Further, stated a doctor's order was obtained with each new intervention. Additionally, the process for staff to be aware of fall interventions was to notify the charge nurse and trained medication aides (TMA) and they were to relay the information to the other staff. SSA-A verified R20's care plan was not updated with the current fall interventions. During interview on 9/28/22, at 10:45 a.m. licensed practical nurse manager (LPN)-A stated all new fall interventions should be documented on the care plan to keep all staff aware and prevent R20 from further falls and injuries. LPN-A verified R20's care plan was not updated with fall interventions of fall mat to floor beside bed, bed in lowest position, 15-minute checks, television mounted to the wall, and resident to have television remote at all times. The facility policy Falls and Fall Risk Management dated 5/15/22, indicated staff will identify interventions related to the resident specific risks and causes to try to prevent the resident from falling, and to try to minimize complications from falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If resident continues to fall, staff will re-evaluate whether to continue or change current interventions. Surveyor: 44651	{F 689}		
{F 690}	Bowel/Bladder Incontinence, Catheter, UTI	{F 690}		11/4/22

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{F 690} SS=D	Continued From page 21 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	{F 690}		

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{F 690}	Continued From page 22 Surveyor: 44651 Based on observation, interview, and document review, the facility failed to provide physician's diagnosis and continued need for an indwelling urinary catheter for 1 of 1 residents (R37) reviewed for catheter use. Findings include: R37's admission Minimum Data Set (MDS) dated 6/21/22, identified diagnoses of morbid obesity and hip fracture. R37 required extensive assistance for toileting. The MDS lacked genitourinary diagnoses but indicated R37 had an indwelling catheter. R37's hospital discharge summary dated 6/15/22, indicated he had an indwelling urethral catheter placed on 6/1/22. The discharge summary lacked diagnosis or an indication for use. R37's Bowel and Bladder assessment dated 6/16/22, indicated he was a candidate for scheduled toileting and under the summary section the data was blank and lacked indication he had a catheter or appropriate diagnosis. R37's care plan dated 6/21/22, indicated he had an indwelling Foley catheter but lacked diagnosis or indication for use. R37's provider visit notes dated 6/15/22, 7/5/22, and 7/20/22, and 9/20/22, lacked diagnosis or indication for ongoing use of catheter. A progress note dated 9/1/22, at 6:31 a.m. indicated R37 refused to have his Foley catheter	{F 690}	1. Order received to remove in dwelling catheter for R37. 2. All residents with in dwelling catheters have received proper diagnosis, residents without proper diagnosis have had the indwelling catheters removed. 3. Facility will double check residents orders upon admission for indwelling catheters, when one is found facility will ensure that there is a proper diagnosis to go with the order. This will be completed by the DON or designee. 4. Nursing staff educated on the need for proper diagnosis with in dwelling catheters took place 10/31/2022. 5. Weekly audit on proper diagnosis on in dwelling catheter for 4 weeks. Audits conducted by DON or designee and on going audits will take place on residents in the building with a catheter. 6 .Any issues will be brought to QAPI	

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{F 690}	Continued From page 23 removed. The note indicated he was not comfortable using the urinal. During observation and interview on 9/28/22, at 10:02 a.m. R37 was observed lying in bed with a catheter tube and bang hanging from the foot end of the bed near his left leg. R37 stated he had a catheter because he was able to stand but not walk to the bathroom, and it was easier. During interview on 9/28/22, at 10:07 a.m. licensed practical nurse (LPN)-C confirmed R37 had a urinary catheter but was not sure why. She stated she thought it was because he had a history of urinary tract infections but was not sure. She stated she did not receive any recent education regarding necessity and care of urinary catheters at the facility. During interview on 9/29/22, at 2:23 p.m. LPN-A stated R37 came to the facility with the catheter and could not say why he had it. He stated the provider recommended it be removed, but R37 wanted to keep it. He stated it should be removed. Facility policies for Foley catheters were requested. However, the undated policies titled Foley Catheter Insertion Female Resident, Foley Catheter Removal and Foley Catheter Insertion Male Resident that were provided lacked guidance for assessment of continued use. Surveyor: 42579	{F 690}		
{F 692} SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	{F 692}		11/4/22

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{F 692}	Continued From page 24 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to prevent significant weight loss for 2 of 2 residents (R20, R37) reviewed for significant weight loss. Findings include: R20's quarterly Minimum Data Set (MDS) dated 8/31/22, indicated R20 was severely cognitively impaired, non-ambulatory, incontinent of bladder and bowel, required extensive assist of one staff for eating, and extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and	{F 692}	1. Staff obtained weights for R20, R37 2. Facility obtained weights for all resident in the facility. 3. All nursing staff educated on the clinical importance of obtaining weights secondary to having the potential for all resident to be affected if their weights are not obtained timely. 4. Weights are obtained at a minimum monthly by nursing department to identify weight loss or gain. Weights will be obtained on the residents scheduled bath day unless otherwise ordered to obtain more frequent weights. 5. All facility residents were assessed and based upon their clinical nature a	

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{F 692}	Continued From page 25 personal hygiene. The MDS indicated the nutrition care area was triggered and addressed in the care plan, and R20 had no weight gain or loss of 5% or more in the past month. The MDS indicated R20 had diagnoses of traumatic brain injury, partial paralysis due to stroke, and seizures. R20's care plan dated 9/9/22, identified R20 was at nutritional risk due to chewing and swallowing difficulties related to missing teeth and eating too fast, with a goal of stable weight within three pounds. Interventions included "monitor/record/report to MD [medical doctor] significant weight loss of greater than 5 % in one month, greater than 7.5% in three months, and greater than 10% in six months." R20's orders reviewed 9/28/22, included and order for monthly weight every four weeks on Wednesdays starting 5/11/22. R20's Weight Summary (undated) indicated on 08/31/22, R20 weighed 118.0 lbs. On 09/9/2022, R20 weighed 111.5 pounds which is a -5.5 % loss in 10 days. R20's current weight was requested but not provided. R37's admission MDS dated 6/31/22, indicated R37 was cognitively intact required extensive assistance of two staff for bed mobility and toilet use, and was independent with eating. Diagnoses included heart failure, lung disease, high blood pressure, diabetes, and hip fracture. The MDS indicated R37 weight 588 pounds and took a diuretic medication on six of seven days. R37's care plan dated 6/22/22, indicated R37	{F 692}	weight order was obtained for monthly or more frequently (dependent upon the residents clinical outlook). 6. Audits will be conducted weekly by the dietary team and identified Residents in need of their weights to be obtained will be discussed during morning with IDT. 7. Weights will be discussed daily during morning meeting to ensure that the facility is keeping up to date with weight losses and weight gains. 8. Any issues found will be brought to QAPI –	

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{F 692}	Continued From page 26 was at nutritional risk related to high body mass index, with a goal of weight loss of two to four pounds per month. R37's orders reviewed 9/29/22, included an order for furosemide (a water pill) 40 mg once per day for edema starting 6/15/22, and weekly weights related to acute chronic congestive heart failure every Monday starting 8/29/22. R37's Weight Summary (undated) indicated R37 weight 588.4 pounds on 6/15/22, and 547.3 pounds on 9/9/22, which is a 7.0% loss in less than three months. R37's medical records lacked evidence of weekly weights since 9/9/22. During interview on 9/29/22, at 8:52 a.m. nursing assistant (NA)-D stated sometime the nurses gave the NAs a paper with residents who needed weights. She stated they only had one mechanical lift to use between two floors, so they needed to bring it up and down the elevator. She stated most residents were supposed to have a monthly weight and she thought it was due on a certain day but could not recall which day. She stated she had not received any recent education regarding weights. During interview on 9/29/22, at 11:33 a.m. physical therapist (PT)-A stated nursing usually obtained resident weights but sometimes therapy helped with bariatric residents who were on their case load. He stated bariatric residents often had cardiac conditions, so they needed weekly weight monitoring. During interview on 9/29/22, at 11:59 a.m. dietary manager (DM) stated monitoring for weights took	{F 692}		

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{F 692}	Continued From page 27 place on the fifth of the month, and any weight concerns would be brought to the attention of nursing. She stated R20 has triggered for weight loss, and if a resident had significant weight loss staff would take weights more often than monthly. She stated when she rounded on residents, she looked at weights for trends, and R37 needed monitoring for fluid concerns. During interview on 9/29/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated nurses gave the NAs a list of residents who needed weights and they were obtained on the 5th of the month. He stated nursing reviewed them and if there was a variance, they informed the provider. He stated some residents had weekly weights, but most were monthly. He stated R20 had a history of significant weight loss and confirmed R20 had lost more than 5% in 10 days. He stated it was concerning to wait a whole month before taking her weight again. LPN ...stated R37 had an order for weekly weights due to heart failure and medications, and confirmed they were not being done. He stated it was important to monitor for fluid overload. The facility policy Nutritional Status dated 4/1/22, indicated the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates this is not possible and receives a therapeutic diet when there is a nutritional problem.	{F 692}		
{F 695} SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	{F 695}		11/4/22

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{F 695}	Continued From page 28 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on observation, interview, and document review the facility failed to ensure respiratory equipment was properly maintained in accordance with professional standards for 2 of 2 residents (R37 and R3) reviewed for respiratory care. Finding include: R37's admission Minimum Data Set (MDS) dated 6/21/22, indicated he was understood and could understand. R37 required extensive assist of two staff for bed mobility and assist of one staff for hygiene. While in the hospital and as a resident; R37 received oxygen therapy and BiPAP (bi-level positive airway pressure, a device that helps with breathing). R37's diagnosis list included obstructive sleep apnea, dependence on supplemental oxygen and chronic respiratory failure. R37's care plan dated 9/2/22, lacked instruction or frequency for cleaning, changing or maintenance of the BiPAP and oxygen equipment.	{F 695}	1. Respiratory devices were cleaned for R37, R3 2. All residents with respiratory devices were cleaned 3. All nursing staff re-educated on proper respiratory device cleaning. 4. Cleaning/maintenance orders will be entered to be completed weekly and nurse manager or designee will audit completion of noted tasks weekly. 5. Orders placed in PCC for respiratory devices to be cleaned by nursing staff and must be signed off by the nurse on duty. 6. Cleaning maintenance audits will be completed by DON or designee to ensure that the residents' respiratory devices are in fact being cleaned. Audits will take place weekly for 4 weeks. 7. Any issues found will be brought to QAPI	

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	245289	A. BUILDING _____ B. WING _____	R-C 09/29/2022

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{F 695}	Continued From page 29 R37's orders effective 6/15/22, indicated BiPAP use setting 20/10 with 25-30% oxygen and an order for oxygen therapy at three liters to maintain oxygen saturations 88% and above. The orders lacked instruction or frequency for cleaning, changing or maintenance of the BiPAP and oxygen equipment. R37's medical record lacked evidence of daily or weekly cleaning of BiPAP equipment, or evidence of resident refusal. During an interview and observation on 9/28/22 at 10:02 a.m. R37's BiPAP machine brand Philips Respironics was located on his side table and the face mask was cloudy and smudged. R37 stated nursing had not refilled the water in his humidifier bottle and that sometimes the therapy department did that. He stated someone came in once and cleaned his BiPAP machine and tubing about a month prior, but not since. R3's admission MDS dated 9/25/22, indicated he was understood and could understand others. R3 required extensive assist of two staff for bed mobility and assist on one staff for personal hygiene. While in the hospital and as a resident, R3 used CPAP/BiPAP and was instructed to use it as he did prior to hospitalization R3's orders included use CPAP at bedtime at skilled facility starting 9/25/22. R3's care plan dated 9/23/22, lacked instruction or frequency for cleaning, changing or maintenance of the BiPAP and oxygen equipment.	{F 695}		

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{F 695}	Continued From page 30 During observation and interview on 9/28/22, at 9:36 a.m. R3 was lying in bed with his CPAP machine on the table next to his bed. He stated he admitted nine days prior, and nobody had cleaned his CPAP since admission. During interview on 9/29/22, at 8:52 a.m. nursing assistant (NA)-D stated nursing changed out oxygen tubing and added water to the oxygen bubbler, but she did not know who cleaned BiPAP or CPAP machines. She stated nobody had ever told her about that, and she did not receive any education about how and when to do it. During interview on 9/29/22, at 10:59 a.m. licensed practical nurse (LPN)-B stated nursing staff cleaned BiPAP/CPAP tubing and machines weekly, and face masks were cleaned daily, but she had not done it herself and did not know where it was documented. During interview on 9/29/22, at 2:23 p.m. LPN-A stated he cleaned R37's BiPAP machine approximately a month ago and thought staff had been educated on how to clean it and where to document. LPN-A was not sure when R37's BiPAP mask or tubing were last cleaned. An email from LPN-A dated 9/29/22, at 8:12 a.m. indicated there were only two residents in the facility who used CPAP or BiPAP. R3 was not listed. Facility policy titled CPAP/BiPAP Support undated, identified machines were to be wiped clean with warm soapy water and rinsed once a	{F 695}		

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{F 695}	Continued From page 31 week and as needed. Humidifiers were to be cleaned weekly and air dried. To disinfect a vinegar-water solution of one to three should be placed in the clean humidifier, soaked for 30 minutes, and rinsed thoroughly. Filters would be rinsed under water once a week and replaced annually. Disposable filters were replaced monthly. Masks/nasal pillows and tubing should be cleaned daily by placing in warm soapy water and soaking/agitating for 5 minutes with a mild detergent, rinsed and air dried. Head strap should be washed with warm water and mild detergent as needed. Facility policy titled Respiratory Care undated, identified respiratory equipment maintenance should be done in accordance with the manufacturer specifications and consistent with federal, state, and local laws and regulations. Documentation on progress with goals and effectiveness of interventions would be recorded. Northwest Respiratory Handbook dated 2/20, identified the oxygen humidifier bottle must be cleaned between fills of distilled/filtered water or once per week using the following process: soak all parts in warm soapy water for 15 minutes, rinse and shake dry. To disinfect put all parts in a basin with one-part white vinegar to three parts water and soak for 20 minutes. Rinse all parts and air dry. Additionally, the humidifier bottle should be replaced once per month. Additionally, the oxygen cannula should be replaced each week and oxygen extension tubing, and humidifier bottle replaced once every month. Surveyor: 42579	{F 695}		
{F 698}	Dialysis	{F 698}		11/4/22

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{F 698} SS=D	Continued From page 32 CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on interview and document review, the facility failed to monitor and assess residents for complications post dialysis treatment for 1 of 1 residents (R52) reviewed for dialysis. Furthermore, the facility failed to ensure ongoing communication and collaboration with the dialysis facility for R52. Findings include: R52's significant change Minimum Data Set (MDS) dated 7/8/22, indicated R52 was cognitively intact, had diagnoses of diabetes and chronic kidney disease and received dialysis. R52's provider order summary reviewed 9/29/22, included an order for dialysis every Monday, Wednesday, and Friday starting 4/11/22. The orders lacked indication of monitoring or assessments required after return from dialysis. R52's care plan dated 9/2/22, lacked indication of monitoring or assessments required after return from dialysis. R52's medical record showed post-dialysis	{F 698}	1. R52 post dialysis assessment completed including weights and vital signs. 2. All residents on dialysis have post dialysis completed including weights and vital signs. 3. Nursing staff educated on the need for pre/post dialysis assessment and communicating with dialysis center to obtain any documentation not received 4. Orders placed in PCC to complete post dialysis assessment upon resident return from dialysis. 5. Audits will be completed daily for 4 weeks. 6. Any issues found will be brought to QAPI	

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{F 698}	Continued From page 33 assessments had not been completed for dialysis dates 9/9/22, 9/19/22, 9/21/22, 9/23/22, and 9/28/22. R52's medical record lacked any post dialysis run reports since 8/17/22. During interview on 9/29/22, at 11:03 a.m. health unit coordinator (HUC) stated R52 had recurring dialysis appointments every Monday, Wednesday, and Friday, and had not refused treatments during the past several months. She stated she used to come back with paperwork, but the dialysis center told HUC the paperwork wasn't always ready when the resident's transportation arrived to take her back to the facility. She thought a nurse could call the dialysis center to get the information, or the resident could bring it back with her after the next visit. HUC stated she asked the dialysis center if they could scan and email or fax the information, but the dialysis center told her their fax often was not working. She stated she had never gone to the center to pick the paperwork up and was not aware of any new process or meeting with dialysis to arrange to receive this information. During interview on 9/29/22, at 10:59 a.m. licensed practical nurse (LPN)-B stated sometimes R52 brought paperwork back, and if not, the HUC was supposed to follow up and have it faxed back to the facility. She stated nursing had to assess anyone on dialysis, including R52, after they returned from dialysis and recorded the assessment in the electronic record. During interview on 9/29/22, at 2:23 p.m. LPN-A	{F 698}		

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{F 698}	Continued From page 34 stated when a resident returned from dialysis, they gave any paperwork to the nurse and the nurse completed a post-dialysis assessment. Upon review of R52's medical record LPN-A confirmed R52 had dialysis three days per week and did not have a documented post-dialysis assessment for all the visits which were required to monitor the resident. He also confirmed there were no post-dialysis run reports in R52's record since the 8/17/22. A facility titled Dialysis, undated, directed staff to ensure an ongoing assessment of the resident's condition was completed before and after dialysis treatment. The policy further directed coordinated plan was required with the dialysis facility.	{F 698}		
{F 700} SS=D	Surveyor: 44647 Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	{F 700}		11/4/22

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{F 700}	Continued From page 35 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on observation, interview, and document review, the facility failed to ensure assist bars were assessed for safety and necessity for 1 of 1 residents (R20) who had bed rails/assist bars affixed to their beds. Findings include: R8's quarterly Minimum Data Set (MDS) dated 8/26/22, indicated R8 was cognitively intact, required extensive assist of two staff for bed mobility, transfers, and personal hygiene, and had diagnoses of kidney failure, high blood pressure, and liver disease. R8's care plan dated 8/10/22, indicated she was at moderate risk for falls, and included an ADL self-care weakness focus. The care plan lacked reference to bed rails. R8's medical record included an order for grab bar assists to promote participation in bed mobility dated 8/11/22. R8's medical record lacked assessment for bed rail safety.	{F 700}	1. Bed rails were removed from identified residents bed based off of bed reassessments 2. All residents that currently have bed rails have been re-assessed for bed rails/grab assist bars to ensure that they are properly placed 3. All nursing staff educated on the medical necessity of bed rails and proper process to assess and obtain bed rails 4. All new residents admitting will be assessed for the use of bed rails, quarterly, and as needed in there is a change in condition. IDT will review assessments and proper use of bed rails. 5. Audits will be performed weekly x 1 month, then monthly x 3 months, then quarterly or annually with the resident's MDS assessment. The DON will be responsible to ensure audits are completed. 6. Results of those audits will be brought to QAPI to determine compliance or the need for further monitoring.	

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{F 700}	Continued From page 36 On 9/29/22, at 10:49 a.m. R8 was observed in bed with one assist bar affixed to the upper part of both sides of her bed. During interview on 9/29/22, at 10:59 a.m. licensed practical nurse (LPN)-B stated side rails could not just be placed on a bed. She stated nursing needed to do an assessment to make sure they were safe for the resident. During interview on 9/29/22, at 11:33 a.m. physical therapist (PT)-A stated nursing usually assessed for side rails and grab bars, or sometimes it was completed by occupational therapy when evaluating bed mobility. He stated the facility was "kind of strict" of side rails to make sure they weren't a restraint. He stated he had not done any evaluation for them himself. During interview on 9/29/22, at 2:23 p.m. LPN-A stated residents needed to be assessed before using bed rails to make sure they are safe. He stated nursing made recommendations and then let therapy know to evaluate. LPN-A confirmed R8 did not have a bed rail assessment completed. The facility policy Bed Rails dated 4/1/22, indicated staff must assess the resident for risk of entrapment, review risks and benefits, and obtain informed consent prior to installation of bed rails, including grab bars and assist bars.	{F 700}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	{F 755}		11/4/22

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{F 755}	Continued From page 37 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure the accurate administration of medications occurred for 1 of 3 (R62) residents reviewed for medication administration.	{F 755}	1. R62 provider was updated by facility and consulting pharmacist for a specific dose for the voltaren gel 2. All residents' medications were reviewed for accuracy and proper administration 3. All orders will be signed off by 2	

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{F 755}	Continued From page 38 Findings include: R62's quarterly MDS dated 7/22/22, indicated she was understood and could understand. R62 had diagnoses of Multiple Sclerosis and depression. R62 had pain occasionally which made it hard to sleep at night and limited day to day activities. R62's September medication administration record (MAR), included an order with a start date of 11/5/21, for Voltaren gel 1% apply to left knee topically two times a day for pain. After review of the MAR the order lacked a dosage. Voltaren gel product information website frequently asked questions (FAQ) page identified the following on 9/28/22: The dosing card should always be used to measure a dose. For each upper body area (hand, wrist, or elbow) squeeze out 2.25 inches (2 grams). For each lower body area (foot, ankle, or knee) squeeze out 4.5 inches (4 grams). During interview on 9/28/22, at 10:51 a.m. licensed practical nurse manager (LPN)-A verified the Voltaren gel had not been updated with a dosage. LPN-A stated medications should include a dosage. A facility policy titled Medication Administration, dated 10/1/21, directed staff to ensure medication administration included the right resident, drug, dose, dosage form, time and route verified with the MAR. Surveyor: 44647	{F 755}	licensed staff to verify accuracy. 4. Nursing staff educated and reviewed medication administration policy on 10-31 -2022. 5. Audits conducted by DON or designee 3 times a week on MAR for 4 weeks 6. Any issues found will be brough to QAPI	

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{F 755}	Continued From page 39	{F 755}		
{F 758} SS=E	Surveyor: 42579 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	{F 758}		11/4/22

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{F 758}	Continued From page 40 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure gradual dose reductions (GDR) were attempted or an adequate medical justification for the use of psychotropic medications for 2 of 3 residents (R7, R63) reviewed for unnecessary medications. Findings include: R7's Admission Record dated 9/29/22, indicated R7 was admitted on 12/8/21 with diagnosis of major depressive disorder, schizophrenia, schizoaffective disorder, bipolar disorder, and anxiety disorder. R7's quarterly Minimum Data Set (MDS) dated 8/5/22, identified R7 was moderately cognitively impaired and demonstrated no physical, verbal, or other behavioral symptoms during the review period. Further, the MDS outlined R7 consumed antipsychotic, antidepressant, and antianxiety	{F 758}	1. GDR was completed or medical reasoning was given for GDR for not needed for R7, R63 2. GDR was completed for all residents or medical reasoning of GDR not needed 3. Nurse management educated on the importance on GDR or obtaining medical reason for GDR not needed 4. Audits will be completed by DON or designee monthly 5. All issue found will be brought to QAPI	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 758}	Continued From page 41 medications on a daily basis during the review period. R7's care plan dated 4/22/22, identified R7 had major depressive disorder with interventions to administer medications as ordered, monitor and document side effects and effectiveness, and pharmacy review monthly or per protocol. The care plan lacked evidence of an intervention to attempt gradual dose reductions for psychotropic medications. Additionally, the care plans lacked any evidence of antianxiety or antipsychotic medication usage. R7's physician orders dated September 2022, identified R7 received Seroquel (an antipsychotic) 250 mg at bedtime with a start date of 12/8/21 and Nortriptyline (an antidepressant) HCL 25 mg at bedtime with a start date of 12/8/21. The pharmacy consultation reports dated from 9/1/22 through 9/29/22, lacked evidence of GDR request for the antipsychotic nor the antidepressant medications for R7. On 9/29/22, review of R7's medical record lacked evidence of GDR attempts or an adequate medical justification for the use of the antipsychotic and the antidepressant medications. R63's admission record dated 9/29/22, R69 admitted on 1/24/18 with diagnosis of major depressive disorder, generalized anxiety disorder, and psychotic disorder with hallucinations.	{F 758}		

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{F 758}	Continued From page 42 R63's quarterly MDS dated 7/26/22, identified R63 was severely cognitively impaired and demonstrated no physical, verbal, or other behavioral symptoms during the review period. Further, the MDS outlined R63 consumed antipsychotic and antidepressant medications on a daily basis during the review period. R63's care plan dated 11/10/22, identified R63 received an antidepressant with interventions to administer antidepressant medications as ordered by physician. The care plan lacked evidence of antipsychotic medication usage. R63's physician orders dated September 2022, identified R63 received Seroquel 200 mg at bedtime with a start date of 3/25/21, Remeron (an antidepressant) 7.5 mg daily with a start date of 3/25/21, Seroquel 75 mg daily with a start date of 4/22/21, and Depakote 375 mg twice a day with a start date of 10/26/21. The pharmacy consultation reports dated 9/1/22 to 9/29/22, lacked any evidence of GDR requests for the antipsychotic nor the antidepressant medications for R63. On 9/29/22, review of R63's medical record lacked evidence of GDR attempts or an adequate medical justification for the use of the antipsychotic and the antidepressant medications. During an interview on 9/28/22, at 10:57 a.m. the licensed practical nurse manager (LPN)-A verified R7 and R63 medical records lacked GDR's or documentation of the medical justification to not reduce the medication. LPN-A	{F 758}		

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{F 758}	Continued From page 43 stated the GDR's should have been completed. The undated, GDR policy, indicated Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, a gradual dose reduction must be attempted in two (2) separate quarters, with at least one (1) month between the attempts, unless clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated	{F 758}		
{F 759} SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Surveyor: 42579 Surveyor: 43007 Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 36% with 4 errors out of 11 opportunities involving 1 of 1 resident (R37) who were observed during medication administration and the facility failed to ensure new admissions received medications in a timely manner for 2 of 2 residents (R2, R3) reviewed for medication errors.	{F 759}	1. All nursing staff re-educated on medication administration policy, medication error policy and general overview of medication services 2. All residents have the potential to be affected by this type of situation 3. All nursing staff will be educated upon the hire and yearly thereafter on medication administration policy, medication error policy and proper procedure for updating appropriate parties for any medication concerns. 4. Audits conducted by DON or designee 3 times a week for 4 weeks 5. All issues found will be brought to QAPI	11/4/22

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{F 759}	Continued From page 44 Findings include: During an observation on 9/29/22, at 8:27 a.m. trained medication aide (TMA)-A prepared R37's morning medications. TMA-A included Amlodipine Besylate 10 MG, Furosemide 40 MG, Methadone HCL 5 MG, Spironolactone 25 MG, Gabapentin 600 MG, Metoprolol Tartrate 50 MG, and Venlafaxine HCL ER 150 MG into a plastic medication cup. TMA-A placed Polyethylene Glycol 17 GM into an eight-ounce plastic cup and mixed it with eight ounces of water. TMA-A took the plastic cup with medications and the water cup with medication into R37's room and administered the medications to R37. R37 took all medications and drank all the water with medication. TMA-A went back to the medication cart to sign off medications. State Agency (SA) surveyor reviewed medications with TMA-A and made TMA-A aware of scheduled medications not given to R37: Senna-Docusate 8.6-50 MG two tablets, Prednisone 10 MG, Venlafaxline HCL ER 75 MG, and Tiotropium Bromide Monohydrate Aerosol Solution two puffs. TMA-A attempted to locate the Tiotropium inhaler, after not being able to locate the inhaler TMA-A asked R37 if the inhaler was in the room. R37 explained the inhaler had not been offered to him in over a week. TMA-A did not find the inhaler. R37's medication administration record (MAR) for September 2022, identified the following orders: -start date 6/16/22, Amlodipine Besylate (high blood pressure medication) 10 MG give 10 MG by mouth one time a day for high blood pressure. -start date 6/16/22, Furosemide (diuretic - "water pill") tablet 40 MG give one tablet by mouth one time a day for edema.	{F 759}		

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{F 759}	Continued From page 45 -start date 8/20/22, Methadone HCL (pain medication) 5 MG tablet give 5 MG by mouth one time a day for pain. -start date 6/16/22, Polyethylene Glycol (constipation medication) 3350 packet 17 GM give 17 gram by mouth one time a day for constipation. -start date 6/16/22, Prednisone (steroid) tablet 10 MG give 10 MG by mouth one time a day for chronic obstructive lung disease. -start date 6/16/22, Senna-Docusate Sodium (laxative-constipation medication) 8.6-50 MG give two tablets by mouth in the morning for constipation. -start date 6/16/22, Spironolactone (diuretic - "water pill") tablet 25 MG give 25 MG by mouth one time a day for high blood pressure. -start date 6/16/22, Tiotropium Bromide Monohydrate (lung disease medication) Aerosol Solution 2.5 MG/ACT two puffs inhale orally one time a day for COPD. -start date 6/16/22, Venlafaxine HCL extended release (ER) (depression medication) 24 hour 75 MG tablet give 225 MG by mouth one time a day for mood. -start date 8/19/22, Gabapentin (seizure medication) capsule 300 MG give 600 MG by mouth two times a day for anticonvulsant. -start date 6/15/22, Metoprolol Tartrate (high blood pressure medication) tablet 50 MG give one tablet by mouth two times a day for hypertension. -start date Upon interview on 9/29/22, at 8:51 a.m. TMA-A verified the Senna-Docusate 8.6-50 MG two tablets, Prednisone 10 MG tablet, Venlafaxline HCL ER 75 MG capsule, and the Tiotropium	{F 759}		

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{F 759}	Continued From page 46 Bromide inhaler were not administered to R37 until reviewed with the surveyor. TMA-A stated the MAR wasn't read completely and the five rights of medication administration should have been used. Upon interview on 9/29/22, at 9:02 a.m. licensed practical nurse manager (LPN)-A stated TMA-A should always use the five rights of medication administration prior to administering the medications to the resident. Further, stated if a medication wasn't located the staff should call the pharmacy to re-order the medication and call the physician to inform of the missed medication. R2's medication administration record (MAR) for September 2022, indicated the following medication orders: -Start date 9/16/22, at 8:00 a.m. Lidocaine patch 4% apply to the T-12 topically one time a day for pain. Apply to intact skin to most painful area, not given until 9/17/22, at 8:00 a.m. -Start date 9/17/22, at 6:00 a.m. Pantaprazole Sodium tablet delayed release give 40 MG by mouth one time a day for esophagitis, not given until 9/18/22, at 6:00 a.m. -Start date 9/17/22 at 8:00 p.m. Belbuca Film 150 MG (Buprenorphine HCL) place and dissolve one film buccally two times a day for pain, not given until 9/21/22, at 8:00 a.m. -Start date 9/16/22, at 9:00 a.m. Cyclobenzapine HCL 10 MG give one tablet by mouth three times a day for compression of T-12 vertebrae, not given until 9/16/22, at 9:00 p.m. -Start date 9/16/22, at 2:00 p.m. Gabapentin capsule 300 MG give two capsules three times a day for compression of T-12 vertebrae, not given until 9/16/22, at 9:00 p.m.	{F 759}		

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{F 759}	Continued From page 47 -Start date 9/16/22 11:00 p.m. Ibuprofen 600 MG give one tablet by mouth three times a day for analgesic, not given until 9/17/22, in the a.m. -Start date 9/16/22, at 10:00 a.m. Acetaminophen 500 MG give two tablets by mouth every six hours for compression of T-12 vertebrae, not given until 9/16/22, at 4:00 p.m. Review of R2's electronic medical record (EMR) on 9/29/22, lacked evidence of any medications being administered to R2 on 9/15/22, which was R2's admission date. On 9/29/22, reviewed R2's Allina Health discharge summary which indicated R2 was discharged on the morning of 9/15/22 with medication orders to continue at the admitting facility. R2's progress note dated 9/15/22, at 12:12 p.m. indicated R2 arrived and admitted to the facility at 11:00 a.m. R2's progress note dated 9/15/22, at 4:00 p.m. indicated R2's medications were not at the facility and R2 didn't have his pain medications available. Further, indicated R2 requested to return to the hospital due to pain rating of 9 out of 10. R2 stated, "I can't function like this, in all this pain". Additionally, staff called non-emergency 911 and sent R2 to the emergency room for pain management. The progress note lacked evidence of the staff notifying the physician of R2's pain and medications unavailability. R2's progress note dated 9/17/22, at 8:04 a.m. indicated R2's medications had not arrived from the pharmacy yet due to R2's insurance and	{F 759}		

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{F 759}	Continued From page 48 payment information had not been supplied to the pharmacy by the facility. The progress note lacked evidence of the staff notifying the physician of the medications unavailability. R2's progress note dated 9/17/22, at 11:11 p.m. indicated R2 inquired about pain medication and was informed pain medication required a prior authorization before the medication can be sent to the facility. Further, indicated R2 inquired about going to the emergency room to have a doctor prescribe a pain medication his insurance would pay for. The progress note lacked evidence of the staff notifying the physician of R2's pain and medications unavailability. R2's progress note dated 9/20/22, at 1:11 p.m. indicated R2's physician was notified regarding pain medication unavailability, five days after admission. Upon interview on 9/29/22, at 9:02 a.m. licensed practical nurse manager (LPN)-A stated if a medication wasn't located the staff should call the pharmacy to re-order the medication and call the physician to inform of the missed medication. Further, stated a new admission should have their medication list and facesheet with insurance information sent to the pharmacy. Additionally, if medications don't arrive timely the staff should call the doctor to inform of the potential missed medications. Facility policy titled Medication Administration dated 10/1/21, included medication administration needed to include the right resident, drug, dose, dosage form, time and route and verify all against the MAR. Medications were	{F 759}		

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{F 759}	Continued From page 49 generally considered timely if given one hour before or after the designated time. Additionally, medication errors must be reported immediately to the nursing supervisor as well as physician and resident or resident representative. A medication error report would be completed and submitted for review to the quality assessment and assurance committee and the medical director.	{F 759}		
F 835 SS=F	Surveyor: 44647 Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and	F 835	1. Facility obtained a full time DON 2. Administrator reviewed policies and advised as necessary 3. Administrator education DON on the importance of correcting deficiencies 4. IDT sat and reviewed deficiencies and put together a plan of correction 5. Administrator will meet with DON daily to ensure that audits are being done	11/4/22

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F 835	Continued From page 50 psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility. Refer to F657, F677, F677, F689, F690, F692, F695, F698, F700, F755, F758. F759, F880, F881, F919, and F921. Findings include: Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained. Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated, "No plans of correction have been done ...the past DON didn't complete anything ...no education ...nothing ...so we know you will have to recite them all and we are now going to get to work on it all." No policy or procedure on administrative oversight was provided by the end of the survey.	F 835	and plan of correction is being followed. 6. IDT team will meet daily to ensure that all audits are being completed according to the schedules set for respective audits. 7. Administrator will meet with Regional Director of Operations weekly to update on status and progress of POC and other pertinent information regarding the facility.	
{F 880} SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	{F 880}		11/4/22

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{F 880}	Continued From page 51 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	{F 880}		

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{F 880}	Continued From page 52 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on interview and document review, the facility failed to develop and implement an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and potential spread of infection to the extent possible. The facility failed to review and update the IPCP annually and establish facility-wide systems. This had the potential to affect all 65 residents residing in the facility as well as all staff and visitors. Findings include: During interview on 9/29/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated the	{F 880}	1. Facility has hired a full time Infection Preventionist 2. Staff will be educated on Infection Prevention Program on 10/25/2022 3. Governing body will be educated on the importance of having a facility infection preventionist at all times (training on 10/21/2022) 4. Facility will have multiple staff trained to be an infection preventionist to ensure that there is no lapse in coverage. 5. Infection Preventionist will review Infection Prevention Program at QAPI DPOC Element 1. Root Cause analysis done (see attached)	

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{F 880}	Continued From page 53 facility did not have anyone acting as infection preventionist and did not know if the facility had an infection control program, or where one might find that information. He stated he did not know where or how infections were being tracked at the facility. During interview on 9/29/22, at 12:24 p.m. administrator stated the facility did not have an infection preventionist or an IPCP. He stated this could lead to a lack of staff education regarding infection control practices and increased potential for the spread of infections due to lack of identification and tracking. The facility IPCP was requested but not provided. Surveyor: 44647 Surveyor: 43007	{F 880}	2. Policies reviewed and revised the following policies are attached: Facility Policies and Procedures for Annual Review Infection Prevention and Control Program Infection Preventionist Monitoring Compliance with Infection Control Policies and Practices for Infection Control 3. Education was done with the governing body on the importance of the infection preventionist and sign in sheet is attached. Infection preventionist training has taken place and proof of training is attached. 4. Infection preventionist has begun tracking and trending infections in the building. Infection Preventionist is reviewing and completing the infection log daily and as needed.	
{F 881} SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Surveyor: 44651 Based on interview and document review, the	{F 881}	1. All nursing staff were educated on the tracking and trending control program.	11/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	R-C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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) COMPLETION DATE
{F 881}	Continued From page 54 facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor appropriateness of antibiotic use to prevent antibiotic resistance. This had the potential to affect all 65 residents residing in the facility. Additionally, the facility failed to ensure an ongoing review of antibiotic use for 1 of 1 residents (R62) reviewed who was prescribed oral antibiotics. Findings include: R62's quarterly Minimum Data Set (MDS) dated 7/22/22, identified a diagnosis of neurogenic bladder and an indwelling catheter. R62 had no urinary tract infections (UTIs) in the past 30 days and did not have other infections identified. R62 received an antibiotic seven out of seven days in the look back period. R62's provider visit notes dated 9/13/22, and 9/21/22, lacked mention for indication and duration of extended antibiotic use. R62's Order Summary Report printed 9/28/22, identified the antibiotic sulfamethoxazole-trimethoprim tablet 400-80 milligrams (mg) give one tablet per day for infection with a start date of 4/27/22. The order lacked an end date and lacked type of infection. R62's medication administration record from 4/27/22 through 9/28/22, indicated she had received sulfamethoxazole-trimethoprim consistently since the start date of 4/27/22.	{F 881}	Infection Preventionist or designee will review and revise policies for infection surveillance as needed. Infection Preventionist or designee will develop and implement and infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines. Infection Preventionist or designee will ensure the change nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. 2. All residents have the potential to be affected by this situation. 3. Facility will provide training for the Infection Preventionist, DON, nursing/leadership/leadership/management and facility administration. The training will cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. Training will be completed by 11/04/2022. 4. Infection Preventionist will have the CDC Nursing Home Infection preventionist training by 11/04/2022. 5. Infection Preventionist or designee will review infection prevention tracking and trending logs and data analysis daily. Infection Preventionist or designee will review the results of audits and monitor with QAPI 6. Infection Preventionist will be overseen by the administrator and work audited by the QAPI team monthly. Does not include plans to monitor its	

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{F 881}	Continued From page 55 R62's care plan printed 9/29/22, lacked a focus area for infection or extended antibiotic use. During an interview on 9/29/22, at 12:24 p.m. the administrator stated the facility did not have an infection preventionist and was unable to speak to the antibiotic stewardship program. He stated he thought there might have been some documentation but was unable to locate it. During interview on 9/29/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated all antibiotics should have a start date and end date, and he was not sure why R62 did not. He stated since the previous infection preventionist left the facility did not have anyone to review those things, and he did not know anything about a tracking log or process for monitoring antibiotic use. The facility antibiotic stewardship program policy and tracking logs were requested but was not provided. Surveyor: 43007	{F 881}	performance to make sure that solutions are sustained. need measurable audits	
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology,	F 882		11/4/22

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F 882	Continued From page 56 epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to develop and implement an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and potential spread of infection to the extent possible. The facility failed to review and update the IPCP annually and establish facility-wide systems. This had the potential to affect all 65 residents residing in the facility as well as all staff and visitors. Findings include: During interview on 9/29/22, at 2:23 p.m. licensed practical nurse (LPN)-A stated the facility did not have anyone acting as infection	F 882	1. All nursing staff were educated on the tracking and trending control program. Infection Preventionist or designee will review and revise policies for infection surveillance as needed. Infection Preventionist or designee will develop and implement and infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines. Infection Preventionist or designee will ensure the change nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. 2. All residents have the potential to be affected by this situation.	

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F 882	Continued From page 57 preventionist and did not know if the facility had an infection control program, or where one might find that information. He stated he did not know where or how infections were being tracked at the facility. During interview on 9/29/22, at 12:24 p.m. administrator stated the facility did not have an infection preventionist or an IPCP. He stated this could lead to a lack of staff education regarding infection control practices and increased potential for the spread of infections due to lack of identification and tracking. The facility IPCP was requested but not provided.	F 882	3. Facility will provide training for the Infection Preventionist, DON, nursing/leadership/leadership/management and facility administration. The training will cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. Training will be completed by 11/04/2022. 4. Infection Preventionist will have the CDC Nursing Home Infection preventionist training by 11/04/2022. 5. Infection Preventionist or designee will review infection prevention tracking and trending logs and data analysis daily. Infection Preventionist or designee will review the results of audits and monitor with QAPI 6. Infection Preventionist will be overseen by the administrator and work audited by the QAPI team monthly. Does not include plans to monitor its performance to make sure that solutions are sustained. need measurable audits	
{F 919} SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Surveyor: 44651	{F 919}	1. The call light was provided to the	11/4/22

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{F 919}	Continued From page 58 Based on observation, interview, and document review the facility failed to ensure residents' call lights were accessible and functioning for 1 of 1 residents (R41) reviewed for call lights. Findings include: R41's annual Minimum Data Set (MDS) dated 9/19/22, indicated R41 was severely cognitively impaired, and frequently incontinent of bladder and occasionally incontinent of bowel. R41 required extensive assistance of one staff for bed mobility, transfers, ambulating, toileting, personal hygiene, and dressing. The MDS indicated she had diagnoses of high blood pressure, kidney disease, dementia, and schizophrenia. During observation and interview on 9/28/22, at 12:55 p.m. R41 was lying in bed in her room. There was no call light plugged into the receptacle on her side of the room, however there was a soft touch pad call light plugged in to the one next to it intended for the other patient bed. The pad was lying on the floor in the corner between the wall at the head of the bed and the floor, approximately three feet away from R41. R41 stated "it's not working, you can't fix it". Surveyor tested the call light for function and noted there was no indicator on the scrolling call light system or the light above the resident's door. On 9/28/22, at 1:05 p.m. licensed practical nurse (LPN)-A accompanied surveyor to test R41's call light. LPN-A looked at the wall and attempted to locate the call light for R41's side of the room. He confirmed it was not there and stated R41 was using the one for the other side of the room.	{F 919}	resident that was identified 2. All residents have the potential to be affected by this type of situation 3. Staff educated on placing resident's call light within reach and timely response time 4. To ensure that the call lights are being answered in a timely manner the facility will change its current system to have group sheets for aides and nurses to have assigned rooms ensuring that the call lights are answered in a timely manner. 5. Groups will be audited individually for compliance to call light response time once a day. 6. All call lights will be checked weekly by maintenance to ensure that the call lights are operational. 7. Call light audits including timely response times will be conducted by DON or designee. Daily audits for 1 week on alternating shifts, then 3x per week for 2 weeks on alternating shifts, then 1x per week for 1 week on alternating shifts 8. All issues will be brought to QAPI	

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{F 919}	Continued From page 59 Upon testing the light LPN-A confirmed it was not working, and then stated she should be using the thin red string attached to the wall instead of the white cord. LPN-A gave the long red string to R41 and left the room. During interview on 9/29/22, at 9:02 a.m. director of environmental services (DES) stated he was just made aware of the call light situation with R41's room. He stated there was no call light cord attached to the box and staff were giving R41 the one attached to the wall that wasn't even functional. He stated all old red string cords should have been removed from the rooms a long time ago since they were for bathrooms only. He confirmed none of the two boxes in R41's room had a functioning call light cord attached to it. The facility policy Resident Call Light System, dated 10/1/21, indicated staff should position the call light conveniently for the resident to use, tell the resident where the call light is, and show him/her how to use the call light.	{F 919}		
{F 921} SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Surveyor: 43077 Surveyor: 44651 Based on observation, interview and document review the facility failed to maintain a sanitary	{F 921}	1. The Environmental Director or designee will make a visual observation and notate the cosmetic and infrastructure needs for repair and will initiate repairs for the identified residents.	11/4/22

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{F 921}	Continued From page 60 and homelike environment for 5 of 5 (R19, R24, R46, R13, R63, and R20) residents reviewed for environmental cleanliness. On 9/29/22, between 8:15 a.m. and 8:50 a.m. The door on the closets for R13, R24, and R46 were missing. All residents stored personal items within their closets. On 9/29/22, at 8:38 a.m. surveyor observed dried dark-brown matter on the wall above R19's bed. On 9/29/22, at 8:41 a.m. surveyor observed an approximately 12-inch x 1-inch Velcro strip adhered to R63's door frame soiled with an approximately one-inch-long mark of dried dark reddish-brown matter. On 9/29/22, at 8:45 a.m. surveyor observed numerous (20+) small smudged brownish spots on the wall next to R20's bed, including on the call light cord where it connected to the wall. During interview on 9/29/22, at 8:52 a.m. nursing assistant (NA)-D stated if staff noticed something needed repair, they contacted maintenance. She stated she did not know how to work the phone to call them, so she would leave them a note to try to talk with them in person. During interview on 9/29/22, at 9:02 a.m. director of environmental services (DES) stated staff were educated to enter any repair requests into the computer system, but sometime if nurses noticed things needing repair, they told him. He stated if it wasn't something that could be dealt with right away, he put it on a list, so he did not forget. DES stated they removed all the broken hinges	{F 921}	2. All residents have the potential to be affected by this type of situation. 3. Cosmetic and room repairs will be added to the list of capital projects for repairs will be addressed by the maintenance director or designee. 4. Environmental Director will make a visual inspection of the building's infrastructure and will add necessary repairs to the TELS system or departmental documentation. Inspections will be added to the schedule for bi-annually or as needed. 5. Facility will create a room cleaning schedule for environmental services. 6. Cleaned rooms will be audited daily by the housekeeping supervisor and Administrator. 7. Audits will be completed daily for 2 weeks then 2 times a week for 2 weeks. 8. Any issues will be brought to QAPI	

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{F 921}	Continued From page 61 from the closet doors, but the doors were still missing, and he assumed the list of which needed replacement was thrown away. He stated some of the building repairs would be completed as soon as finances permitted, but he did not have any evidence of a list of such repairs, nor communication with leadership regarding prioritization or potential timeline. DES stated he knew about the soiled Velcro and commented, "the Velcro I still have to get to". He stated he knew of two walls which needed to be cleaned due to smeared feces, (R19, R20) and he was going to find housekeeping that day to make sure they were taken care of. The facility policy, "Safe/Clean/Comfortable/Homelike Environment" (undated), instructed, "The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely."	{F 921}		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 17,2022. At the time of this survey, The Terrace at Crystal was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/08/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Terrace at Crystal is a 3-story building with a full basement that was constructed in 1971 and was determined to be of Type II (111) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a	K 000		

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K 000	Continued From page 2 census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the commerical kitchen suppression	K 324	K324 1. Documentation will be kept of inspection of the Kitchen Ansul Hood	9/8/22

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2022**

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THE TERRACE AT CRYSTAL LLC	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

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K 324	Continued From page 3 system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/17/2022 between the hours of 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the facility does not have copies of the semi-annual fire suppression reports for the kitchen hood. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 324	System for at least 3 years. 2. The Director of Environmental Services will review documentation and obtain all missing documentation of the buildings fire systems or obtain new inspection with documentation. 3. The Director of Environmental Services will obtain all missing documentation of the buildings fire systems or obtain new inspection with documentation and keep documentation for at least 3 years. 4. The quality assurance committee will do annual building audits to documentation is kept. 5. Completion date of 09/06/22	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm Signaling Code, section 14.4.5. This deficient	K 345	K345 1. The fire alarm servicing vendor will be contacted, and documentation will be obtained, or a new inspection will be scheduled. 2. The Director of Environmental	9/8/22

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K 345	Continued From page 4 finding could have a widespread impact on the residents within the facility. Findings include: On 08/17/2022 between the hours of 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the facility did not have a copy of the last annual fire alarm inspection report. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 345	Services will review documentation and obtain all missing documentation of the buildings fire systems or obtain new inspection with documentation. 3. The Director of Environmental Services will obtain all missing documentation of the buildings fire systems or obtain new inspection with documentation and keep documentation for at least 3 years. 4. The quality assurance committee will do annual building audits to documentation is kept. 5. Completion date of 09/06/22	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		9/8/22

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K 353	Continued From page 5 Based on observation, document review, and staff interview, the facility failed to maintain the Sprinkler System per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5 and 5.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/17/2022, between the hours of 9:00 AM and 1:00 PM, it was revealed by observation that there were a number of ceiling tiles missing throughout the facility. Rooms (dirty laundry by 216, storage room and maintenance shop in the lower level, hallway on 2nd floor) were a number of them noted. 2. On 08/17/2022, between the hours of 9:00 AM and 1:00 PM, it was revealed by a review of the available documentation that there was no record of the annual fire sprinkler system testing being completed for 2021. An interview with the Facility Maintenance Director verified these deficiencies finding at the time of discovery.	K 353	K353 1. All damaged and missing ceiling tiles have been replaced. Staff was reeducated to not remove ceiling tiles unless replacing them. Proper documentation will be kept for annual inspections. Contractor will do annual inspections once per year and not be allowed to do two inspections in one year in leu of one the following or previous year. 2. The Director of Environmental Services will reverify all ceiling tiles remain in place and keep proper annual documentation. 3. The Director of Environmental Services will do weekly rounds to ensure all ceiling tiles are in place and intact and monthly checks of the logbooks to ensure inspections and documentation are up to date. 4. The quality assurance committee will do annual building audits to ensure all ceiling tiles remain in place and intact and documentation is correct. 5. Completion date of 09/15/22	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712		9/8/22

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K 712	Continued From page 6 with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1. This deficient finding widespread impact on the residents within the facility. Findings include: On August 17, 2022 between the hours of 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the facility did not have documentation of fire drills for 3rd and 4th quarters of 2021. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 712	K712 1. Fire drills will continue to be conducted each quarter with one shift per month. 2. Director of Environmental Services will ensure fire drills continue and a record is kept for at least 3 years. 3. Director of Environmental Services will look at the fire drill date of the previous months before completing a fire drill to ensure weeks are not being repetitive. 4. Director of Environmental Services will review the logbook monthly to ensure fire drills are being conducted correctly. 5. Completion date of 08/30/22	
K 917 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 917	K917	9/8/22

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K 917	Continued From page 7 facility failed to maintain electrical junction boxes per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2 and NFPA 70 (2011 edition) National Electirical Code, section 314.28 (c). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On August 17, 2022 between 9:00 AM and 1:00 PM, it was revealed by observation that there was an open electrical box located in the ceiling in front of the elevator car on the 2nd floor. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 917	1. The open electrical box has been covered with a blank electrical plate. 2. All outlets will be double checked to insure they have an intact and proper plate. 3. The Director of Environmental Services will ensure no electrical plates are removed without being replaced. 4. Director of Environmental Services will inspect all outlet covers annual to ensure they remain in place. 5. Completion date of 09/09/22	