Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 9, 2025

Administrator

The Terrace at Crystal LLC

3245 VERA CRUZ AVENUE NORTH

CRYSTAL, MN 55422

RE: CCN: 245289

Cycle Start Date: June 27, 2025

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 30, 2025, we informed you of imposed enforcement remedies.

On September 3, the Minnesota Department of Health completed a revisit 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

F805--Food in Form to Meet Individual Needs

As a result of the revisit findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 14, 2025, will remain in effect.

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 location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 14, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 2025.

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 30, 2025, 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 14, 2025.

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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 December 27, 2025 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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which

resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	3245 VERA CRUZ AVENUE NORTH , CRYSTAL, Minnesota, 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
E0000	Initial Comments The Terrace at Crystal is a Special Focus Facility (SFF). On 6/29/25 - 7/2/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/26/2025
F0000	INITIAL COMMENTS The Terrace at Crystal is a Special Focus Facility (SFF). On 6/29/25 - 7/2/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H52897974C (MN109554) H52897971C (MN108609) H52897972C (MN113814) H52897967C (MN106359) H52897968C (MN107818) H52897973C (MN108474) AND	F0000		08/26/2025

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 reverse for further 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.

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

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F0000	Continued from page 1 The following complaints were reviewed: H52897969C (MN107183) with a deficiency issued at F686 and F804 H52897970C (MN107861) with a deficiency issued at F804 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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.	F0000		
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550	It is Terrace at Crystal's policy to provide care in an environment promoting resident quality of life, including dignity, respect, and choice. R25's & R203 dining preferences, assistance and needs were reviewed and the care plan was updated. They are both receiving dignified and appropriate dining services. All residents were interviewed about their dining preferences The "Resident Rights and Dignity" policy was reviewed and revised as necessary. All staff received education on person-centered language and dignified dining. Staff ensured all subsequent dining experiences were respectful, using appropriate person-centered language. DON and/or designees will complete audits 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Results, along with resident feedback, will be reviewed at the monthly QAPI meeting to determine further monitoring needs. DON and/or designee is responsible for compliance.	08/26/2025

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F0550 SS = E	Continued from page 2	F0550		

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is NOT MET as evidenced by:

Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R25) who was referred to as a "feeder".

Findings include:

R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R25 was dependent on staff for eating.

R203's entry tracking record indicated R203 admitted to the facility on 6/15/25.

R203's care plan printed 6/29/25, indicated R203 required setup assistance by one staff member to eat.

During meal service on 6/29/25 at 12:14 p.m., dietary aide (DA)-A plated and served food to residents in the dining area. There were approximately eight residents in the dining area, both from the memory care area and non-memory care area. DA-A went to serve R25 when nursing assistant (NA)-E stated she was a "feeder" out loud, and DA-A placed the plate on top of the steam table instead of serving to the resident.

During interview on 6/29/25 at 1:31 p.m., DA-A stated a person who was a "feeder" needed one to one support to eat. DA-A stated "feeder" was not a "humane" term for a

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F0550 SS = E	Continued from page 3 human with emotions and could hear what was said. DA-A stated the term was hurtful, belittling, and may make a resident feel "less human". During interview on 7/1/25 at 1:14 p.m., R203 stated the staff called residents "feeders" "all the time" and it probably made residents feel "bad". During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff should call residents by their name and not their situation. RN-A stated staff cannot call a resident "feeder". During interview on 7/2/25 at 1:58 p.m., the director of nursing stated staff should not refer to residents who needed assistance with eating as "feeders". The DON stated the term would not make a resident feel "good".	F0550		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, before giving psychotropic medications for 2 of 5 residents	F0552	It is Terrace at Crystal's policy to ensure residents have the right to be fully informed of their care and treatment, and to participate in or refuse care after receiving sufficient information to make an informed decision. R24 and R25 medication orders were reviewed, and all consents were signed and obtained. All residents on psychotropic medications, informed consent forms were obtained and fully completed, including documented discussions of risks and benefits with the resident or their legal representative. The policy titled "Antipsychotic Medication Use policy" and "Gradual Dose Reduction" were reviewed and revised as necessary. Licensed nursing staff received education on obtaining informed consent completely and accurately, emphasizing the necessity of documenting discussions regarding risks and benefits. Nurse managers and/or designees will complete psychotropic medication audits for each new admission for 2 months, then monthly for 2 months or until sustained compliance is verified. Audit results will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs.	08/26/2025

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F0552 SS = D	Continued from page 4 (R24, R25) reviewed for unnecessary medication use. Findings include: R24 R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. The MDS recorded R24 as having severe cognitive impairment and consuming both antipsychotic and antidepressant medications. R24's Order Summary Report, signed 5/15/25, identified R24's current physician-ordered medications and treatments along with their respective start date(s). These included orders for duloxetine (antidepressant medication) 20 milligrams (mg) once daily, haloperidol (an antipsychotic medication) with multiple doses ordered daily, and mirtazapine (antidepressant medication) 7.5 mg every bedtime. These medications all had a start date recorded of, "04/29/2025." R24's Medication Administration Record (MAR), dated 6/2025, identified R24's medications along with staff initials to demonstrate their respective administration. The orders for duloxetine, haloperidol, and mirtazapine were listed and each of these medications were recorded as administered for the entire month period. On 7/1/25 at 12:28 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they were R24's financial guardian and were very involved in her (R24) care decisions, too. FM-G stated R24 had been on the antidepressant medication since she was hospitalized a few months prior due to being "very combative" with staff members there. FM-G stated there had been no discussion from the care center about the duloxetine or mirtazapine medications thus far to their recall and then abruptly asked the surveyor aloud, "What are the side effects?!" R24's medical record was reviewed and lacked evidence a signed or verbal consent for use of the medication was obtained prior to them being provided. Further, the record lacked evidence the risks or expected benefits of the medication regimen had been reviewed or discussed with R24 or their responsible family member prior to initiation of the medications. When interviewed on 7/1/25 at 12:41 p.m., licensed practical nurse (LPN)-B explained the "admitting nurse"	F0552	Continued from page 4 DON and/or designee is responsible for compliance.	

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F0552 SS = D	Continued from page 5 was the person who typically obtained consent for psychotropic medications from the resident or family upon admission. LPN-B stated this was done with "a form we have them sign" about the medications, and there should be a separate one for each psychotropic ordered. The forms were then scanned into the electronic medical record (EMR). LPN-B reviewed R24's medical record, including hard chart and EMR, and expressed they were unable to locate any consents for the mirtazapine or duloxetine adding, "We're missing those two." LPN-B stated R24 had family members who were involved with her care and mentioned FM-G by name as the person who helped R24 sign paperwork and make decisions. LPN-B verified they were unable to locate evidence of a signed, informed consent being obtained for the two psychotropic medications adding they'd looked "everywhere that I would know to look [for them]." LPN-B stated mirtazapine and duloxetine both should have had a signed consent due to their potential side effects adding, "Those medications just have to have consent." When interviewed on 7/1/25 at 12:56 p.m., social worker (SW)-A stated nursing was responsible to get medication consents. SW-A added, "Nursing will do that." On 7/1/25 at 3:43 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R24's medical record for the consents. DON stated the admitting nurse should obtain all required consents and document them on paper before getting them scanned into the medical record. DON verified they were unable to locate any signed consents for R24's duloxetine or mirtazapine adding, "I didn't [find them]." DON added, "Something didn't get done." DON stated they would start education with the nurses to ensure consents were obtained moving forward adding obtaining consent was important so the patient "understands the risk and benefits [of the medication]." DON added, "It's part of the state regs [regulations]." R25 R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R25's diagnoses included aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medication.	F0552		

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F0552 SS = D	Continued from page 6 R25's Medication Administration Record dated June 2025, indicated R25 received risperidone (an antipsychotic medication) 1 milligram by mouth at bedtime for severe, recurrent major depressive disorder with psychotic symptoms with a start date of 6/10/25. R25's medical record lacked evidence of an informed consent for risperidone. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated the admitting nurse obtained psychotropic medication consents for new admissions. RN-A stated if there was a change in psychotropic medication there was usually an associated clinic of psychology (ACP) provider involved who spoke with the resident or resident representative about the change in dosage first. If the ACP provider did not involve the responsible party, then nursing would obtain the consent for the psychotropic medication. During interview on 7/2/25 at 11:20 a.m., the director of nursing (DON) stated nursing obtained the consent for risperidone today, since they did not find a risperidone consent form in R25's medical record. During follow-up interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to obtain consents for psychotropic medications. The DON stated it was important to ensure the resident or responsible part were aware of the risks and benefits of the medication before administration. The facility Antipsychotic Medication Use policy dated December 2016, directed the attending physician and other staff to gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy did not specifically address informed consent to educate a resident or responsible party on the side effect/risks and benefits of antipsychotic medication.	F0552		
F0576 SS = D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where	F0576	It is Terrace at Crystal's policy to ensure residents have the right to retain and use personal possessions, including adequate and appropriate storage space, and to have access to and use their personal property, which includes communication devices, in a manner that respects their privacy.	08/26/2025

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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, Minnesota, 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
F0576 SS = D	Continued from page 7 calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure there was reasonable access to private phone use for 1 of 1 residents (R153) reviewed who utilized the facility phone. Findings include:	F0576	Continued from page 7 R153 discharged All residents who utilize personal communication devices were spoken to and educated on their right to privacy during personal conversation and the opportunity to voice their concerns. The policy titled "Resident Use of Telephones policy" was reviewed and revised as necessary. A wireless phone is now available at the nurse station that residents may take to their own room or any private area of their choice for personal conversations. Nursing, activities, and social services staff received education on the resident use of telephones policy. Nursing unit managers and/or social service director will conduct audits 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Results of audits and resident feedback will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs. Social Service Director and/or designee are responsible for compliance.	

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F0576 SS = D	Continued from page 8 R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's profile dated 6/23/25, indicated R153 resided on the third floor. During an observation on 7/1/25 at 1:03 p.m., R153 was observed sitting in a wheelchair in front of a long desk with multiple staff members surrounding it, including trained medication aide (TMA)-B and licensed practical nurse (LPN)-A. The long desk at the nursing station was observed at the middle of two parallel hallways on the third floor with resident's rooms and in front of an elevator. R153 was observed talking on a corded phone and asking someone to "get me out of here". During an interview at 7/1/25 at 1:12 p.m., R153 stated that he did not have his own phone so had asked the facility staff if there was one he could use. R153 stated the "only phone" offered to him was the phone at the nursing station. R153 stated he asked staff to bring the phone to his room, but they said they couldn't, so he had argued with them about it as he didn't want to talk with his wife in front of all the staff members. R153 stated he felt like he did not have enough privacy when he had to make his phone calls at the nurse's station. During an interview on 7/1/25 at 1:14 p.m. with TMA-B and LPN-A, LPN-A stated most residents had their own phone to use but if they did not, they offered them the phone at the nurse's station. TMA-B confirmed that they had neither a cordless phone nor a private area for residents to use the phone if they wanted. During an interview on 7/1/25 at 1:16 p.m., LPN-E, the third-floor nurse manager, stated the only phone that they had to offer residents on the third floor was a phone that could be utilized at the nurse's station and a more private option was not available. During an interview at 7/2/25 at 10:04 a.m., the administrator stated if a resident was able to pay for it, facility staff would install a phone in a resident's room, otherwise residents were able to use the phone at the nursing stations.	F0576		

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F0576 SS = D	Continued from page 9 The facility's Resident Use of Telephones policy dated 3/17, indicated designated telephones were available for residents to make and receive "private" telephone calls. The policy indicated telephones will be in areas that offer privacy and accommodate wheelchair bound residents.	F0576		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent State agency (SA) were posted in a prominent location and readily accessible at all times of the inspection reports within the campus. This had the potential to affect all 51 residents and any visitors who wanted to	F0577	It's Terrace at Crystal's policy to ensure residents, their representatives, and the public have the right to promptly access the results of the most recent survey conducted by the State or Federal government, as well as any plans of correction. The most recent survey report, along with all survey results for the past three years, including complaints, is now posted in a prominent, publicly accessible location within the facility, ensuring they are always readily viewable. The policy titled "Resident Right to Examine Survey Results" was reviewed and revised as necessary. All staff members were educated on the policy and the location of the posted survey results and how to direct residents, representatives, or visitors to this information. The Administrator or their designee will conduct audits 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Results of audits, along with any resident or visitor feedback, will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs. The Administrator and/or designee is responsible for compliance.	08/26/2025

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F0577 SS = C	Continued from page 10 review this information Findings include: The CMS CASPER Report 0003D, dated 6/24/25, identified the completed recertification surveys for the previous three years, with the most recently completed recertification survey having exited on 2/13/25. On 7/1/25 at 11:30 a.m., an informal resident council meeting was held with R8, R13, and R1. The residents were asked, as part of the meeting, if the most recent survey results were readily posted within the facility for them to review at leisure. However, none of the residents voiced they knew the location or these results, nor had the results been discussed with them during the resident council meetings. Immediately following the council meeting, on 7/1/25 around 1:45 p.m., a tour of the nursing home was completed with the administrator. Administrator stated he was responsible along with the director of nursing for keeping the survey binder up to date. The main entrance had a 3-tiered black bookshelf to the right of the front desk which contained 4 three ring binders with 2022, 2023, 2024 and 2025 on the spine of the binders. Above the bookshelf hung a laminated sign "Survey Results." Within the 2025 binder were the results from the survey exited on 4/8/25. The sign above lacked evidence that additional survey results were available upon request. Furthermore, the binder lacked results from standard abbreviated surveys (complaint) surveys which had been investigated since that last recertification survey. The administrator verified these findings during the tour. During the continued tour, on 2nd floor, there was a 3-tiered black bookshelf in the solarium on the backside of the wall, not in visible sight unless a person was in the solarium. Above the shelf was a sign "Survey Results." The bookshelf contained 3 three ring binders. The front of the three binders were marked "2022", "2023" and "2024." Within the binders were the survey results. The most recent results were from the survey with an exit date of 10/7/24 (a follow up visit from the 8/30/24 survey). In addition, the binder lacked any complaint survey results. The sign above lacked evidence that additional survey results were available upon request. The administrator verified these findings during the tour. On 3rd floor, there was a 3-tiered black bookshelf that contained 3 three ring binders with a sign above it which identified "Survey Results." The front of the	F0577		

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F0577 SS = C	Continued from page 11 three binders were marked "2022", "2023" and "2024." Within the binders were the survey results, the most recent results being from the survey with an exit date of 10/7/24 (a follow up visit from the 8/30/24 survey). In addition, the binder lacked any complaint survey results. The sign above lacked evidence that additional survey results were available upon request. The administrator verified these findings during the tour. During the tour and interview, administrator stated the survey binders were needed on each floor as some residents did not leave the floor and should have access to the results. Administrator stated the binders should include the complaint and recertification survey results. During an interview on 7/1/25 at 1:41 p.m., activities director (AD)-A stated that she helped coordinate resident council. AD-A stated they had never talked about survey results during resident council meetings since she had been helping coordinate resident council, which had been about 5 months. A facility policy titled "Resident Right to Examine Survey Results," dated 1/30/17, identified the resident has a right to examine the three most recent annual survey results and any plan of correction. Furthermore, "Information concerning the location of our facility's three most recent survey reports will be posted on the resident bulletin board and at each nurses' station."	F0577		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due	F0580	It is the policy of Terrace at Crystal to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when significant events occur (injury/decline/rooms/etc.) 1. R36, an assessment was completed, and the provider was notified after identification of repeated elevated blood sugar readings. The resident's care plan was updated, and blood glucose monitoring was reviewed. The provider provided updated parameters for notification. 2. All Diabetic residents Blood sugar readings were reviewed and those outside of designated parameters were reviewed for MD notification. New orders were implemented. Care plans were reviewed and updated accordingly. 3. The facility policy titled "Change in a Resident's Condition or Status" was reviewed and updated as necessary.	08/26/2025

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F0580 SS = D	Continued from page 12 to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promptly notify the provider consistently of high blood sugars for 1 of 1 residents (R36) of reviewed for notification of change. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). Section N-Medications indicated	F0580	Continued from page 12 4. All licensed nursing staff received education on the policy, including their roles and responsibilities in identifying and reporting changes in resident condition. 5. Audits will be completed 5x a week to ensure changes in condition are recognized and that the physician is notified in accordance with policy. Audits will be conducted for 8 weeks. 6. Results will be presented during the monthly QAPI meeting for review and determination of continued auditing or corrective actions. 7. The Director of Nursing and/or designee is responsible for compliance.	

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F0580 SS = D	Continued from page 13 R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). During an interview on 6/29/25 at 10:45 a.m., R36 stated she had diabetes and had been told she was a "pretty fragile diabetic." R36 stated her blood sugars went up and down and sometimes she required insulin and sometimes she did not. R36's care plan, printed 7/2/25, included R36 had diabetes mellitus with the following interventions: monitor for signs and symptoms of hyperglycemia (high blood sugar); monitor for signs and symptoms of hypoglycemia (low blood sugar); obtain blood sugars per MD order; resident has an order for Dexcom (a continuous glucose monitoring system that is wearable that provides continual real-time blood sugar level reading without the need for frequent fingerstick), sensor to change every 10 days; diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. R36's June 2025 Medication Administration Record (MAR), printed 7/2/25, included the following orders: - Insulin NPH (Neutral Protamine Hagedorn- Human -Isophane) (an intermediate-acting insulin that helps manage blood sugar level in individuals with diabetes) Subcutaneous Suspension 100 unit/milliliter(ml) - Inject 11 units subcutaneously in the evening related to diabetes with a start date of 5/31/25. The record identified it was given all days except 6/14, 6/17, 6/18, and 6/17 which were marked with a "2" indicating "drug refused". The date 6/1 was marked with a "3" indicating "absent from home with meds." - Insulin NPH Subcutaneous Suspension 100 unit/ml - Inject 7 units subcutaneously in the morning related to diabetes with a start date of 6/1/25. The record indicated it was administered all days. - Novolog (rapid acting insulin used to control blood sugar) Injection Solution 100 unit/ml - Inject as per sliding scale: if blood sugar is 151 - 225 = 1 unit; 226 - 300 = 2 units; 301 - 375 = 3 units;	F0580		

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F0580 SS = D	Continued from page 14 376 - 450 = 4 units; 451+ = 5 units, subcutaneously with meals related to diabetes at mealtime only (give even if you skip meal) - Do not give correction dose if blood sugar is less than 150. Check blood glucose at bedtime and do not give correction insulin if blood glucose is less than 200. Start date 5/31/25. - Glucagon Nasal Powder 3 milligram(mg)/dose (dry nasal spray that helps raise blood sugar level in an emergency) 1 spray in nostril as needed for low blood sugar- unsupervised self-administration -In the event of unconscious hypoglycemia or hypoglycemic seizure. May repeat dose if no response after 15 minutes with a start date of 5/18/25. The record identified it was documented every day as "U-SA" which indicated unsupervised self-administration. - Glucose Oral Tablet Chewable (tablet used to quickly raise your blood sugar when it is low) 4 grams (gm), Give 1 tablet by mouth every 6 hours as needed with a start date of 4/16/25. The record indicated it was given on 6/1/25 at 10:32 p.m. and marked as effective and administered on 7/3/25 at 1:34 p.m. and marked as effective. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 2:49 a.m. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 3:31 a.m. - Dexcom CGM G6 - Use to obtain glucose level three times daily before meals and at hs (bedtime) for diabetes with a start date of 6/14/24. - Emergency department to evaluate and treat blood glucose level of 833 and patient is symptomatic. One time only for diabetes with a start date of 6/1/25. Record indicated it was documented with a “9" which indicated "other/progress note" on 6/1/25 at 2:48 a.m. - Encourage patient to drink ice water and extra movement to help lower sugar. One time only for diabetes with a start date of 6/1/25 and was completed on 6/1/25 at 10:36 a.m.	F0580		

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F0580 SS = D	Continued from page 15 R36's orders lacked specific parameters on when to notify the provider regarding blood sugars. R36's Blood Sugar Summary Report, from 5/31/25 to 6/30/25, included the following blood sugar readings in milligrams per deciliter (mg/dL): 6/29/25 at 5:00 p.m. was 443 mg/dL 6/28/25 at 1:39 p.m., was 449 mg/dL 6/28/25 at 9:30 a.m., was 500 mg/dL 6/28/25 at 8:54 a.m., was 500 mg/dL 6/27/25 at 12:25 a.m., was 444 mg/dL 6/27/25 at 12:22 p.m., was 444 mg/dL 6/27/25 at 11:46 a.m., was 444 mg/dL 6/27/25 at 8:42 a.m., was 500 mg/dL 6/27/25 at 8:41 a.m., was 500 mg/dL 6/27/25 at 8:40 a.m., was 500 mg/dL 6/26/25 at 8:30 a.m., was 492 mg/dL 6/24/25 at 9:58 a.m., was 600 mg/dL 6/24/25 at 9:19 a.m., was 600 mg/dL 6/23/25 at 3:30 p.m., was 38 mg/dL 6/22/25 at 9:48 a.m., was 529 mg/dL 6/22/25 at 9:40 a.m., was 529 mg/dL 6/21/25 at 9:14 a.m., was 451 mg/dL 6/20/25 at 9:02 a.m., was 413 mg/dL 6/19/ 25 at 9:05 a.m., was 507 mg/dL 6/18/25 at 9:56 a.m., was 422 mg/dL 6/17/25 at 9:26 a.m., was 473 mg/dL 6/17/25 at 9:01 a.m., was 473 mg/dL 6/16/25 at 8:15 a.m., was 592 mg/dL 6/14/25 at 8:29 a.m., was 600 mg/dL	F0580		

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F0580 SS = D	Continued from page 16 6/12/25 at 8:44 a.m., was 588 mg/dL 6/9/ 25 at 4:38 p.m., was 485 mg/dL 6/9/25 at 2:22 p.m., was 543 mg/dL 6/9/25 at 2:08 p.m., was 543 mg/dL 6/9/25 at 10:11 a.m., was 551mg/dL 6/9/25 at 8:48 a.m., was 55 mg/dL 6/7/25 at 2:56 p.m., was 441 mg/dL 6/7/25 at 11:13 a.m., was 501 mg/dL 6/7/25 at 11:13 a.m., was 441 mg/dL 6/4/25 at 9:46 a.m., was 424 mg/dL 6/4/25 at 9:37 a.m., was 424 mg/dL 6/1/25 at 8:15 a.m., was 546 mg/dL 5/31/25 at 10:19 p.m., was 401 mg/dL R36's progress notes reviewed from 5/31/25 to 6/30/25 and identified the following: -6/1/25 at 7:16 a.m.: resident blood sugar is 546 without any symptoms. -6/1/25 at 11:41 p.m.: Residents blood sugar was 84 upon returning to facility at 9:30 p.m., and at 10p.m. it was 41, 2 glucose tablets along with pudding, apple juice given, and blood sugar went up to 47. Resident ate a cup of oranges and blood sugar went up to 95. -6/24/25: Resident's blood sugar was 600 at 9am so scheduled insulin and sliding scale insulin were given. Rechecked blood sugar at 11am. Message was left for provider. R36's progress notes lacked any additional updates to provider regarding R36's documented high and low blood sugars despite having 20 days of high blood sugars (some days multiple times a day) and 4 days of low blood sugars. Standing Orders for Skilled Nursing Facilities, printed 7/2/25, included the following information on page 3:	F0580		

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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
F0580 SS = D	Continued from page 17 -If type 1 diabetes, notify the provider if any blood glucose results are less than 70 or over 400 and/or change in condition. -Hypoglycemia - blood glucose less than 70: "If patient is symptomatic, conscious, and able to swallow or has a feeding tube: -Administer 6 oz. fruit juice, milk, other high carbohydrate beverage (e.g., Ensure, Boost), or glucose tables or gel orally or via feeding tube. -Repeat BG [blood glucose] after 15 minutes; if <70 [less than 70], repeat above intervention. -If after 2 attempts to treat and BG is still <70, notify provider." During an interview on 7/1/25 at 9:35 a.m., trained medication aid (TMA)-A stated they took blood sugars and reported the findings to the nurse on the floor. TMA-A stated some glucometers would not read the blood sugar if it was too high or low and they would get the nurse if that happened. TMA-A stated they did not notify providers of information as they reported everything to the nurse on the floor. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and had worked with her often. LPN-A stated if a blood sugar was over "300", staff were to notify the provider. LPN-A stated they would document provider notification in a progress note. LPN-A stated R36 was "all over with her blood sugars." During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated they were familiar with R36. LPN-E stated it would vary per resident on when to notify the provider for high or low blood sugars as some residents had parameters on when to notify. LPN-E verified R36 did not have any parameters on when to notify the provider. LPN-E stated the expectation would be that after the provider was notified, it would be documented in a progress note. LPN-E reviewed R36's electronic medical record (EMR) and verified the provider was notified a few times on 6/1/25 regarding R36's high blood sugars and again on 6/24. LPN-E verified there were no other documented notifications in R36's EMR. LPN-E stated she would expect the provider to be notified if the blood sugar was over 451 as that was what insulin orders stopped at. LPN-E reviewed R36's blood sugars and verified she	F0580		

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F0580 SS = D	Continued from page 18 had many blood sugars over 400 in the month of June. During an interview on 7/2/25 at 11:38 a.m., director of nursing (DON) stated the expectation would be the nurses would follow the house standing orders if a doctor did not write specific parameters regarding when to be notified of high and/or low blood sugars. DON stated they expected the provider to be notified if a resident's blood sugar was less than 70 or greater than 400 and expected it to be documented in a progress note. DON stated the provider should have been notified regarding R36 and her blood sugars after review. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated they were familiar with R36. NP-A stated they would expect to be notified if R36's blood sugar was over 450 or below 70. NP-A stated if a resident's blood sugar was over 450, an order would be given to help decrease the blood sugar. NP-A stated when they were notified on 6/1/25 regarding R36's blood sugar being 833, orders for insulin were given to lower her blood sugar along with sending her to the emergency room to be evaluated. NP-A stated the facility communicated with the provider group through "the portal." NP-A reviewed the portal and stated they were notified only a couple of times in June regarding R36's blood sugar being high. A facility policy titled Change in a Resident's Condition or Status, dated 2/2021, indicated "Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status."	F0580		
F0582 SS = A	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F0582		08/26/2025

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F0582 SS = A	Continued from page 19 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-Coverage (NOMNC) was provided timely to 1 of 3 residents (R3) reviewed for beneficiary notices. Findings include: R3's significant change Minimum Data Set (MDS) dated 6/18/25, indicated R3 had intact cognition.	F0582		

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F0582 SS = A	Continued from page 20 R3's SNF Beneficiary Protection Notification Review form dated 4/25/25, indicated R3's last covered day of Medicare Part A service was on 4/25/25, and the termination was provider-initiated when Part A benefit days were not exhausted. R3's NOMNC form dated 4/25/25, indicated R3's last covered day of Medicare Part A service was on 4/25/25, and the resident refused to sign the notice but was "okay with therapy ending today". The form was not signed by the resident but was signed by licensed social worker (LSW)-A and dated 4/25/25. R3's Census record dated 6/29/25, indicated a switch from her primary payer source of Medicare A to Minnesota Medicaid on 4/26/25, and then R3 remained in the facility. During an interview on 7/1/25 at 1:34 p.m., R3 stated she did not recall anyone reviewing the form mentioned above with her but was okay with her therapy services ending. During an interview on 7/1/25 at 1:48 a.m., LSW-A confirmed she oversaw reviewing NOMNCs with residents and, after reviewing R3's medical record, could not find evidence that the notice had been given to R3 at least two days before the end of Medicare Part A coverage as required. During an interview on 7/2/25 at 10:04 a.m., the administrator confirmed LSW-A oversaw beneficiary notices and deferred questions regarding this to LSW-A. The facility's NOMNC policy dated 11/1/27 indicated the NOMNC must be delivered at least two calendar days before Medicare-covered services end.	F0582		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F0585	It is Terrace at Crystal's policy to ensure that all resident grievances are acknowledged, investigated, and resolved promptly and thoroughly, and that appropriate actions are taken to address the concerns raised, especially when they involve clinical needs such as specialized diets. R31 grievances regarding their diabetic diet were	08/26/2025

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F0585 SS = D	Continued from page 21 reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	Continued from page 21 immediately reviewed. R31's weight gain and dietary preferences were reassessed. A new individualized diabetic meal plan has been created and implemented. The residents' concerns were addressed directly and documented in the grievance. All residents with physician-ordered diabetic diets were reviewed to identify any similar concerns or unresolved grievances. The facility's "Grievances/Complaints Policy" was reviewed and revised as necessary. Nursing, dietary, and social workers received education and training on, identifying verbal and written grievances, timely investigation and documentation. Audits will be conducted by the social worker and/or designee weekly for 4 weeks. 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Audit results will be reviewed during QAPI meetings to determine additional actions or system changes. The social worker is responsible for ongoing compliance and monitoring.	

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F0585 SS = D	Continued from page 22 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to appropriately follow up on continued and repeated voiced grievances of provided food for a diabetic diet for 1 of 2 residents (R31) reviewed for grievances who gained 35% of their weight since being admitted to the care facility. Findings include: R31's annual Minimal Data Set (MDS), dated 4/26/25, R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes.	F0585		

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F0585 SS = D	Continued from page 23 R31's weights, listed in the electronic medical record (EMR), indicated R31 weighed 165 pounds at admission to the care center and their most recent weight was listed as 231 pounds, a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet. R31's EMR lacked any progress notes from dietary or nutritional services and lacked any mention of R31's food concerns despite repeated vocal complaints. The facility's grievance log for the past six months was reviewed and also lacked any mention of R31's voiced complaints about the food she was receiving. During an interview on 6/29/25 at 10:35 a.m., R31 stated she had to buy her own fridge and food to ensure she had foods to eat that would work within her diabetic diet, stating she should be on a diabetic diet but feels the facility does not follow it. R31 stated she had told multiple people about her food concerns but had not worked with the dietician at the care facility. During an interview on 7/1/25 at 10:48 a.m., licensed practical nurse (LPN)-B stated the food at the facility had been an issue for "over a year" stating they don't offer R31"diabetic options" such as sugar free items or syrup. LPN-B confirmed R31 had voiced her complaints plenty of times and R31 would often say, "they know I'm on a diabetic diet and give me all these carbs". LPN-B further stated many times R31 would make the decision not to eat the food that was served to her. LPN-B stated dietary was aware of the complaints. During an interview on 7/1/25 at 11:58 a.m., the certified dietary (district) manager (CDM) stated if a resident had an order for a diabetic diet, then the system would automatically push starch items to half portions or substitute out that item for a different item. The CDM stated they had started education with diabetic residents to help them understand that they might still see carbs on their plate even if they were on a diabetic diet and to help the residents "understand where we [the facility] are coming from regarding diabetic diets." The CDM stated R31 was on a consistent carbohydrate diet, not a renal diet, which would include more carbs than a renal diet. The CDM further stated R31 was a vocal person so the assumption was that everyone had heard her concerns, however, "sometimes word doesn't travel as well as we would like - we are working to have better communication between the floor staff and us".	F0585		

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F0585 SS = D	Continued from page 24 During an interview on 7/1/25 at 12:49 p.m., LPN-A stated R31 complained about the facility food all the time and voiced complaints about not getting food consistent with a diabetic diet. LPN-A stated she let the nurse manager know about R31's complaints but had not noticed any changes. During an interview on 7/2/25 at 8:57 a.m., the third-floor nurse manager, LPN-E, stated she had heard complaints from R31 about how terrible the food was but did not recall any complaints specific to her diabetic diet. During an interview on 7/2/25 at 10:15 a.m., licensed social worker (LSW)-A, who was the grievance officer at the facility, stated she would have expected to hear about repeated concerns relating to food or receiving proper diets, confirming she did not have any formal grievances for R31. A facility policy titled Grievances/Complaints - Staff Responsibility, revised 10/2017, indicated should a staff member overhear or be the recipient of a complaint voiced by a resident concerning care in the facility, including food, the staff member is encouraged to help, or guide, the resident to file a written complaint with the facility.	F0585		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of	F0605	It is the policy of Terrace at Crystal to ensure that residents are not administered unnecessary medications and that all medications, including antipsychotics, are monitored for effectiveness and potential side effects. R7, a clinical review was completed to assess for symptoms and side effects associated with the prescribed antipsychotic medication. Orthostatic blood pressure assessment was conducted, and no acute symptoms were identified at the time of evaluation. The physician was notified, and the resident's care plan and medication monitoring parameters were updated to include orthostatic vital signs per protocol. Residents receiving antipsychotic medications have been reviewed to ensure proper documentation and monitoring for side effects, including orthostatic hypotension were/are in place. Care plans and MARs were reviewed for compliance with psychotropic medication monitoring guidelines and updated as warranted and/or necessary. The facility's policy titled "Psychotropic Medication Use" was reviewed and revised as necessary	08/26/2025

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F0605 SS = D	Continued from page 25 resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §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. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F0605	Continued from page 25 All licensed nursing staff received education on the revised policy, including, how to conduct and document orthostatic blood pressure measurements, recognizing and responding to symptoms of orthostatic hypotension as well as communicating findings to the provider and updating care plans accordingly. Staff were re-educated on side effect monitoring requirements for psychotropic medication use. Audits of 20% of residents on antipsychotic medications will be conducted weekly for 2 months, and then monthly for 2 additional months to ensure ongoing compliance with side effect monitoring requirements. Results will be reviewed during QAPI meetings for further review and determination of further auditing and monitoring need. The Director of Nursing and/or designee is responsible compliance with this plan.	

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F0605 SS = D	Continued from page 26 §483.45(e) Psychotropic Drugs. 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 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: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 5 residents (R7) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include: A National Library of Medicine (NIH) Management of	F0605		

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F0605 SS = D	Continued from page 27 Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... orthostatic hypotension should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R7's quarterly Minimum Data Set (MDS), dated 4/26/25, indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications. R7's electronic medical record (EMR) contained an order for orthostatic blood pressure once a month due to "psych" medication use. The order instructed the nursing staff to obtain a lying, sitting, and standing blood pressure five minutes apart. R7's EMR further contained on order, dated 3/8/24, for Olanzapine (an atypical antipsychotic medication) 10 milligrams (mg) by mouth at bedtime. R7's most recent fall risk screening, dated 5/6/26, indicated R7 was at high risk for falls. R7's EMR, including the medication and treatment administration records, vitals section, and progress notes, lacked evidence staff had obtained orthostatic blood pressure readings for the past 2 months that were reviewed. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated there were currently no residents on R31's floor who had orders for orthostatic blood pressures that she was aware of. TMA-B stated orders for any vital signs would pop up on their medication administration records. During an interview on 7/1/25 at 1:46 p.m., consultant pharmacist (CP)-A stated all antipsychotic medications pose a risk of causing orthostasis and residents who consumed antipsychotic medications should be monitored for orthostatic hypotension. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated if a resident needed to have orthostatic blood pressure readings it would show	F0605		

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F0605 SS = D	Continued from page 28 up, and be documented, in the residents' medication administration record. LPN-A confirmed currently no residents had any orthostatic blood pressure readings. During an interview on 7/2/25 at 8:57 a.m., third floor nurse manager and (LPN)-E stated the expectation was for orthostatic blood pressure readings to be obtained monthly if a resident was receiving an antipsychotic medication. LPN-E confirmed R7 had an order for orthostatic blood pressures to be obtained monthly, however was unable to find evidence they had been completed, confirming the information was not in R7's medication or treatment administration record or vital sign documentation, stating "he has an order so it should be on the MAR [medication administration record]". A facility policy titled Antipsychotic Medication Use, revised 12/2016, indicated nursing staff would monitored for side effects and adverse consequences of antipsychotic medication including cardiovascular effects such as orthostatic hypotension.	F0605		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F0636	It is the policy of Terrace at Crystal to complete a comprehensive and accurate Minimum Data Set (MDS) assessment for each resident, ensuring that all areas of resident performance, functional status, and preferences are thoroughly evaluated. This assessment is used to develop an individualized, person-centered care plan and ensure regulatory compliance. R24 MDS was reviewed for completeness and accuracy. Identified discrepancies in activity preferences and resident performance areas were corrected. Resident representatives were interviewed again to confirm their preferences and functional abilities. A facility-wide audit of all MDSs completed in the last 30 days will be conducted to verify accuracy and thoroughness. The policy titled “MDS Completion and Submission Timeframes policy” was reviewed and revised as necessary Education on MDS accuracy and performance, functional status, and preferences was provided for the activity director who is responsible for contributing to the MDS. Audits of MDS assessments will be conducted by the MDS coordinator and/or designee 1x per week for 2 months,	08/26/2025

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F0636 SS = D	Continued from page 29 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set	F0636	Continued from page 29 then monthly for 2 months or until sustained compliance is verified. Audit results will be reviewed during QAPI meetings to determine additional actions or system changes. The remote MDS Coordinator and their facility contact person are responsible for ensuring compliance with accurate and complete MDS assessments.	

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F0636 SS = D	Continued from page 30 (MDS) was completed in a thorough manner to ensure all areas of resident performance and activities preference were evaluated for 1 of 4 residents (R24) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose of providing guidance with how to complete the Resident Assessment Instrument (RAI), and it outlined an admission MDS was considered a comprehensive assessment. The manual listed a section labeled, "SECTION F: Preferences For Customary Routine and Activities," along with directions to complete the section. The directions outlined, "The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities." The manual directed to interact with the resident or, if needed, complete the staff examination if the resident is unable to respond. On 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated they were unsure if R24 would participate even, however, expressed they had never been asked or consulted on R24's activity preferences, either. R24's admission MDS, dated 5/5/25, identified R24 admitted to the care center on 4/28/25 from the acute care hospital and had multiple medical conditions including heart failure, dementia, and a history of stroke/transient ischemic attack (TIA). The MDS section labeled, "Section F - Preferences for Customary Routine and Activities," provided spacing to record answers with gathered data including an Interview for Daily Preferences (F0400) and Interview for Activity Preferences (F0500). However, the entire section of the MDS (F0300 to F0800) was either left blank or marked, "Not Assessed." R24's medical record was reviewed and lacked evidence R24 had been evaluated for their routine and/or activity preferences during the assessment reference date (ARD) period (See F679).	F0636		

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F0636 SS = D	Continued from page 31 On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas "dashed" with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was "not acceptable." RN-O reviewed R24's medical record and verified the section of the MDS had been dashed and explained staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and "gives us [staff] an opportunity to see if the resident is progressing or declining." A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, "Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI]."	F0636		
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the quarterly Minimum Data Set (MDS) was completed in a thorough manner to ensure areas of cognition and potential depressive symptoms were fully evaluated for 2 of 4 residents (R22, R23) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined a	F0638	It is the policy of The Terrace at Crystal to complete accurate and timely quarterly Minimum Data Set (MDS) assessments for each resident, ensuring that all areas of cognition and mood are thoroughly evaluated. These assessments are essential to developing and maintaining individualized, person-centered care plans that address the mental and emotional well-being of each resident and ensure regulatory compliance. R22 and R23, the most recent quarterly MDS assessments, were reviewed for completeness and accuracy. BIMS and PHQ-9 mood assessments were re-administered. A facility-wide audit of all quarterly MDSs completed in the past 30 days will be conducted to ensure accurate evaluation of cognitive and mood indicators. The policy titled “MDS Completion and Submission Timeframes policy” was reviewed and revised as necessary. Education was provided to the social work team regarding quarterly MDS assessments. Audits of all completed quarterly MDS assessments will be conducted 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified.	08/26/2025

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F0638 SS = D	Continued from page 32 quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident' status between comprehensive assessments " ... to ensure critical indicators of gradual change in a resident's status are monitored." The manual included a section labeled, "SECTION C: COGNITIVE PATTERNS," which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, "These items are crucial factors in many care-planning decisions;" with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, "SECTION D: MOOD," which outlined the section would be used to help address mood distress and social isolation adding, "Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity," and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R22 R22's most recent quarterly MDS, dated 4/11/25, identified R22 had multiple medical conditions including high blood pressure, renal insufficiency or failure, and dementia. The MDS listed, "Section C - Cognitive Patterns," with areas to record R22's Brief Interview for Mental Status (BIMS) and/or the Staff Assessment for Mental Status. However, nearly all of these responses were marked, "Not Assessed." In total, section(s) C0100 to C1000 were marked, "Not Assessed," or left blank. The MDS listed, "Section D - Mood," with areas to record R22's Resident Mood Interview (PHQ-9) and/or a Staff Assessment of (the) Resident Mood, and potential social isolation symptoms. However, again, nearly all of these responses were marked, "Not Assessed." In total, section(s) D0100 to D0700 were marked, "Not Assessed," or left blank. R22's medical record was reviewed and lacked evidence either of these sections or corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the assessment reference date (ARD) to help determine what, if any, complications or issues R22 was demonstrating with these respective areas. R23 R23's most recent quarterly MDS, dated 5/22/25, identified R23 had multiple medical conditions including a history of stroke and aphasia (language disorder; difficulty with words). The MDS listed,	F0638	Continued from page 32 Audit results will be reviewed during QAPI meetings to determine additional actions or system changes. The remote MDS Coordinator and/or designee are responsible for ensuring continued compliance with accurate and thorough completion of quarterly MDS assessments.	

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F0638 SS = D	Continued from page 33 "Section C - Cognitive Patterns," with areas to record R23's BIMS and/or the Staff Assessment for Mental Status. However, nearly all of these responses were marked, "Not Assessed." In total, section(s) C0100 to C1310 were marked, "Not Assessed," or left blank. The MDS listed, "Section D - Mood," with areas to record R23's Resident Mood Interview (PHQ-9) and/or a Staff Assessment of (the) Resident Mood, and potential social isolation symptoms. However, again, nearly all of these responses were marked, "Not Assessed." In total, section(s) D0100 to D0700 were marked, "Not Assessed," or left blank. R23's medical record was reviewed and lacked evidence either of these sections or corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the ARD to help determine what, if any, complications or issues R23 was demonstrating with these respective areas. On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas "dashed" with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was "not acceptable." RN-O reviewed R22's medical record and verified the sections of the MDS were dashed and reiterated staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O reviewed R23's medical record and verified the sections of the MDS were dashed and, again, reiterated "the dashing situation" had been explained to the staff at the campus. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and "gives us [staff] an opportunity to see if the resident is progressing or declining." A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, "Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI]."	F0638		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641	It is the policy of The Terrace at Crystal to ensure that each resident receives an accurate Minimum Data Set (MDS) assessment reflective of their current status at the time of completion. MDS assessments must be completed by staff qualified to assess relevant care areas and knowledgeable about the resident's condition,	08/26/2025

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F0641 SS = D	Continued from page 34 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 residents (R50) reviewed for hospitalization. Findings include: R50's Discharge-return not anticipated Minimum Data Set (MDS) dated 4/13/25 identified discharge from facility was planned and R50 discharged to "Short-Term General Hospital (acute hospital, IPPS)." During record review, R50's nursing progress noted dated 4/13/25 identified "Resident discharged from the	F0641	Continued from page 34 needs, strengths, and areas of decline. Accurate MDS documentation ensures regulatory compliance, appropriate care planning, and continuity of care. R50 discharged A facility-wide audit of all MDS discharge assessments completed in the past 30 days will be conducted The policy titled “MDS Accuracy and Discharge Documentation” was reviewed and revised as necessary. Nursing leadership, social services, MDS, activities and dietary received education focused on coding accuracy, with emphasis on commonly miscoded areas such as Sections G, GG, I, A, and Z. MDS Coordinator will audit 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Audit results will be documented and reviewed during monthly QAPI meetings to evaluate trends, accuracy, and opportunities for additional training. The remote MDS Coordinator and an in-facility designee are jointly responsible for oversight and ongoing monitoring of MDS coding accuracy and compliance.	

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F0641 SS = D	Continued from page 35 facility to home with all her medication and instruction with her family members at 3:30 p.m." During interview with licensed practical nurse (LPN)-A on 6/30/25 at 5:01 p.m., LPN-A stated she recalled R50 and stated, "She went home it was planned". During interview with R50 on 6/30/25 at 6:00 p.m., R50 stated, "Yes I was there and discharged home." During interview with registered nurse and MDS facility liaison (RN)-MDS on 7/1/25 at 10:36 a.m., RN-MDS reviewed R50's electronic medical record (EMR) and stated R50 discharged home on 4/13/25. Further review of R50's Discharge-return not anticipated MDS dated 4/13/25, RN-MDS stated the MDS was coded incorrectly, "it is not accurate". RN-MDS stated expectation for MDS to be coded accurately was "it concerns payment sources". During interview with MDS clinician (MDS) on 7/1/25 at 12:13 p.m., MDS reviewed R50's 4/13/25 Discharge-return not anticipated MDS and confirmed, "we have [R50] dc'd [discharged] to hospital". MDS stated that "it looks like it was coded incorrectly" and "incorrectly coding will affect quality measures for the facility and impacts payment and reimbursement". Facility policy titled Certifying Accuracy of the Resident Assessment, revised 2019 state "The information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment".	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F0656	It is the policy of The Terrace at Crystal to develop and maintain comprehensive, individualized care plans that fully address each resident's needs, including diet preferences and allergies. Care plans are developed by the interdisciplinary team (IDT) and updated regularly to reflect resident preferences, medical needs, and changes in condition. For Resident #37, the care plan was reviewed to ensure it accurately reflected the resident's dietary preferences and allergies. The care plan was updated to include all relevant diet restrictions, allergies, and preferences.	08/26/2025

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F0656 SS = D	Continued from page 36 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 2 residents (R37) reviewed for diet preferences/allergies. Findings include: R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care. Pertinent diagnoses include type 2	F0656	Continued from page 36 All residents with documented dietary restrictions or allergies have the potential to be affected by this practice. A facility-wide audit of care plans for residents with diet restrictions and allergies completed within the past 90 days will be conducted. The policy titled “Care Plan, Comprehensive Person-Centered” was reviewed. It clearly defines procedures for accurately assessing, documenting, and incorporating dietary preferences and allergies into care plans. Education will be provided to nursing staff, dietary personnel, and interdisciplinary team members on thorough care plan development, emphasizing dietary preferences, allergy identification, and timely updates. Weekly care plan audits will be conducted to verify accurate documentation and incorporation of dietary needs and allergies for 4 weeks and monthly for 2 months. Audit results will be reviewed at monthly QAPI meetings to assess compliance and determine the need for further education. DON and dietary manager are responsible for oversight and compliance.	

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F0656 SS = D	Continued from page 37 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood, and the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated the facility was aware of his food allergy. R37 stated he did not eat it, but it happened again just a few days ago and he had followed up with staff. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: - Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences.	F0656		

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F0656 SS = D	Continued from page 38 R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions." R37's allergy list, printed 7/2/25, lacked indication of allergy to shellfish, seafood or fish. R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants used the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R37 and worked with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet	F0656		

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F0656 SS = D	Continued from page 39 orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic too. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated residents' food allergies and their food preferences should be listed on their care plan. DON verified R37's food allergies and food preferences were not listed and should be on the care plan. A facility policy titled Care Plan, Comprehensive Person-Centered, reviewed 6/23, "assessment of residents are ongoing, and care plan are revised as information about the residents and the residents' conditions change."	F0656		
F0657 SS = D	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	F0657	It is the policy of The Terrace at Crystal to ensure that each resident receives timely, person-centered care plan reviews and revisions, with full participation of the resident and/or their representative, and the interdisciplinary team (IDT). For Resident #41, the timing of the care conference was reviewed to support ongoing interdisciplinary collaboration and resident involvement. Care Conference was held. The care plan will be reviewed, updated as necessary, and documentation will be completed to reflect the conference. All residents are at risk for being affected by this deficient practice. A facility-wide audit will be completed to identify any residents overdue for a care conference. All identified residents will be scheduled and hold care conferences within appropriate timeframes. The care plans will be reviewed and updated to reflect current resident status, preferences, and goals of care. The policy titled “Care Plan, Comprehensive Person-Centered” was reviewed to ensure compliance with F-657. Refresher training will be provided to unit managers,	08/26/2025

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F0657 SS = D	Continued from page 40 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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide routine care conferences to allow for resident participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 2 residents (R41) reviewed for care conferences. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's electronic medical record (EMR) indicated R41 had one care conference since being admitted to the care facility. A progress note, dated 10/24/24, indicated R41 "had her care conference today at 1:00pm. Pt [patient], SW [social worker], and Nurse Manager were in attendance." During an interview on 6/29/25 at 3:07 p.m., R41 stated she had "been to maybe one" care conference since being admitted to the facility and had concerns about her care. During an interview on 7/1/25 at 8:17 a.m., licensed social worker (LSW)-A stated the resident care conferences and care plan review should be held "roughly" every three months and generally coordinate with the MDS cycle. LSW-A stated she had not held a care conference for R41 as R41 had "not been agreeable", however stated the interdisciplinary team should still meet quarterly to discuss the residents' care, even if the resident did not want to participate. LSW-A stated timely and routine care conferences were important to ensure there were no resident changes the team may have missed. During an interview on 7/2/25 at 12:06 p.m., the director of nursing stated it was expected that care conferences were held quarterly, even if the resident did not want to participate.	F0657	Continued from page 40 social services, therapy, dietary, and other IDT members on the policy and the importance of timely care conferences, proper documentation, and resident-centered care planning. Weekly audits will be conducted for newly completed care plans and care conference schedules. A sample of at least 5 residents per month will be reviewed for care conference timeliness and documentation. Results will be discussed during monthly QAPI meetings to evaluate compliance and identify opportunities for improvement. Social Worker and DON and/or designee are responsible for oversight and compliance.	

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F0657 SS = D	Continued from page 41 A facility policy titled Care Plans, Comprehensive Person-Centered, revised 6/2023, indicated the interdisciplinary team would review and update the care plan at least quarterly, in conjunction with the required MDS assessment.	F0657		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language,	F0676	It is the policy of The Terrace at Crystal to ensure that residents who are unable to carry out activities of daily living (ADLs) independently receive the necessary services to maintain good hygiene, grooming, and overall well-being, including fingernail care. Residents who require assistance must have clearly outlined care interventions in their care plan, and staff must provide timely and consistent support in accordance with the resident’s assessed needs. R23, fingernail care needs were reviewed as part of routine hygiene services and provided fingernail care. The resident’s care plan was reviewed and updated to include detailed instructions and scheduled intervals for nail care A facility-wide audit of residents dependent on staff for ADLs will be conducted, focusing on nail care needs and hygiene interventions. Any resident identified as needing nail care received services promptly, and their care plans were updated to reflect ongoing support needs. The facility policy titled “Care of Fingernails/Toenails Policy” was reviewed to reinforce requirements for routine fingernail care as a component of ADL services. Education will be provided to all nursing staff on performing fingernail care, recognizing signs of unmet hygiene needs, documenting care provided, and ensuring care plans accurately reflect resident support requirements. Audits of ADLS will be completed through weekly audits 1x per week for 2 months, then monthly for 2 months to verify accurate documentation and incorporation of dietary needs and allergies. Results will be reviewed during monthly QAPI meetings to assess compliance trends and determine if additional corrective actions or training are necessary. The Director of Nursing (DON) and/or designee is responsible for oversight and compliance with this plan.	08/26/2025

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F0676 SS = D	Continued from page 42 (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene cares for 1 of 1 resident (R23) reviewed who needed assistance with fingernail care. Findings include: R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). The MDS indicated R23 needed substantial/maximal assistance with person hygiene which included combing hair, shaving, washing/drying face and hands, etc.. R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). R23's care plan printed 6/30/25, directed staff to check nail length and trim and clean on bath day and as necessary and to report any changes to the nurse. The care plan indicated R23 required extensive assist of one staff for personal hygiene. R23's Treatment Administration Record (TAR) dated June 2025, directed staff to complete a weekly skin review and/or bath, and nursing staff to open a skin review assessment and complete. The order directed staff to chart all refusals in the evening every Wednesday. The order had a start date of 7/12/23 and discontinued date of 6/27/25. R23's Weekly Bath Audit dated 6/25/25, indicated R23 received a bed bath, did not have any new skin alterations, and was not resistive to or refused bathing. The audit did not reference nail care. R23's Point of Care (POC; an app which allows care staff to document ADLs) documentation, indicated R23 refused bathing on 6/25/25.	F0676		

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F0676 SS = D	Continued from page 43 R23's recent progress notes indicated R23 was seen by podiatry for foot care on 6/17/25. R23's progress notes did not indicate fingernail care or refusals of fingernail care. During observation and interview on 6/29/25 at 9:11 a.m., R23's nails were multiple millimeters (mm) in length with dark debris underneath them. R23 stated staff assisted him with nail care, and he would like his nails cut. During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his wheelchair and dressed. R23's nails were in the same condition as the previous observation. R23 reiterated he wanted his nails cut and cleaned. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated R23 refused to have his nails cut at times and told the nurse when he refused. NA-K stated they would cut his nails after lunch. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A stated residents nails were trimmed on bath days and refusals should be documented. LPN-A verified the condition of R23's nails and stated his nails needed to be trimmed. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected nail care to be completed with weekly showers and as needed to prevent infection and maintain resident dignity. The facility policy Care of Fingernails/Toenails dated February 2018, indicated nail care included daily cleaning and regular trimming, and proper nail care aided in the prevention of skin problems around the nail bed and from accidental scratching and injury to residents' skin. The policy directed staff to document the reason why and intervention taken if a resident refused nail care.	F0676		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F0679	It is the policy of The Terrace at Crystal to ensure that each resident receives a program of activities that is designed to meet their individual physical, mental, and psychosocial well-being, in accordance with	08/26/2025

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F0679 SS = D	Continued from page 44 §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: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 1 of 2 residents (R24) reviewed for activities. Findings include: R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. However, the section to record R24's activity preferences and routines was left blank or marked, "Not Assessed [See F636]." On 6/29/25 at 10:46 a.m., R24 was observed lying in bed while in her room on the locked unit. R24's television was turned on and positioned along the opposite wall of her bed. R24 was interviewed and expressed aloud, "I don't know," when asked how long they'd lived at the center. R24 was dressed in a hospital-type gown and her hair appeared with a light, greasy-looking shine. R24 was asked about what, if any, activities the floor staff involve her with and she abruptly responded, "Would you leave me alone?!" Following, on 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G explained they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated R24 had been outside "maybe once" since admitting from their recall and expressed the staff may be offering them to her and she's declining them but was unsure. FM-G stated R24 had a television in her room which she needed help to operate and expressed they were unsure if staff knew that or not adding, "I don't know they realize that." FM-G stated R24 enjoyed mystery and "murder shows" on the television. Further, FM-G reiterated they were unsure	F0679	Continued from page 44 their comprehensive assessment and personal preferences. Activity programming must be person-centered, culturally relevant, and adjusted to the resident's abilities and interests. R24 activity needs were reviewed to support quality of life through meaningful engagement. The Activity Director met with the resident to assess their interests, preferences, and functional capabilities. The updated care plan was reviewed with IDT. A facility-wide audit will be conducted of all residents' activity assessments and care plans completed within the last 90 days. Any resident whose interests or functional ability were not clearly reflected in their activities care plan will be reassessed. Care plans will be updated accordingly, and activity interventions were implemented to ensure resident-centered engagement. The policy titled "Activity Programs policy" was reviewed and revised as necessary Activities staff, IDT members, and social services will be educated on conducting comprehensive activity assessments, documenting resident interests and abilities, and developing and implementing individualized care plans that promote quality of life. Audits will be completed 1x per week for 2 months, then monthly for 2 months to verify accurate documentation and incorporation of activity interests and preferences Results will be reviewed during monthly QAPI meetings to assess compliance trends and determine if additional corrective actions or training are necessary. The Activity Director and DON are responsible for oversight and compliance with this plan.	

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F0679 SS = D	Continued from page 45 if R24 would participate in activities even, however, stated nobody from the care center had ever talked with them about her likes or dislikes for activities since she admitted. R24's medical record was reviewed and lacked evidence R24 had been comprehensively assessed for what, if any, individual or group-based activities she would like to attend; nor did the record have evidence of any other activities (i.e., 1:1) being provided. R24's care plan, printed 7/1/25, identified all R24's current or potential concerns the facility had identified and implemented interventions to address. The care plan was reviewed and lacked any recorded focus statements, goals, or interventions for leisure and/or activities despite R24 admitting to the care center months prior. Further, the entire electronic medical record (EMR) lacked any completed tasks or progress note(s) in the system to demonstrate R24 had been provided any activities since she admitted to the care center. On 6/30/25 at 1:33 p.m., R24 was again observed lying in bed while in her room. R24's television was turned on and a day-time drama television show was on. R24 was asked about the show or if she enjoyed it, however, R24 just mumbled a response which was not discernable. R24 was asked if she was able to use the remote or needed help and just stared at the surveyor with no audible response. When interviewed on 6/30/25 at 1:36 p.m., nursing assistant (NA)-A stated they had worked with R24 prior, and expressed R24 needed help with nearly all her cares. NA-A stated R24 would rarely get up from bed and expressed it "all depends" on her mood and what she'd allow each day. NA-A stated R24 would get up to the wheelchair maybe "three to four times [week]" and then added, "She really likes to be in her room." NA-A stated they were aware of some activities happening "at the back there" on the unit, however, had only seen her at a few they could recall. NA-A stated R24 liked her "criminal shows" and would try to keep those on the television for her. NA-A stated they knew R24 enjoyed 'criminal shows' as "I work with her a lot of times," adding nobody from the care center activities' staff had ever told them which channels or shows to play for R24 adding, "I just found out on my own." NA-A verified R24 would, at times, not speak to staff and would remain silent adding R24 needed to "be in a good mood" to converse. When questioned how other staff, including pool staff, would know which shows or channels R24 enjoyed NA-A responded aloud, "That's hard." NA-A stated the staff used a "care guide" which had all residents listed on it and reviewed this with the	F0679		

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F0679 SS = D	Continued from page 46 surveyor. R24's name was listed, however, the guide lacked any information on which channels, shows, or activities R24 enjoyed or wanted. NA-A verified the guide lacked this information and expressed aloud, "It's not there." NA-A stated having it listed on the care guide would help others adding, "Everybody works different with these people." When interviewed on 6/30/25 at 1:45 p.m., trained medication aide (TMA)-A stated they had worked with R24 prior and described her as needing "a lot of help" with cares. TMA-A explained R24 could be "real mean" sometimes and "not too often" would get up from bed. TMA-A stated physical therapy (PT) was working with her and even for them, R24 would still "not too often" get up from bed. TMA-A stated they had never seen R24 attend any activities prior and was unsure what, if any, in-room activities the staff were doing for her adding, "I haven't seen it." TMA-A stated R24 could "tell you what she wants" if she needed the television adjusted but then expressed R24 would not usually speak to people she didn't like or didn't know adding the aides often rotate amongst the units "all the time." TMA-A stated the activities personnel would know more about R24. On 6/30/25 at 1:51 p.m., the activities assistant (AA)-A was interviewed, and explained they worked on the memory care unit. AA-A stated a previous activities supervisor used to do the comprehensive assessments for residents, however, lately it had been them doing it. AA-A stated activities' likes and dislikes were tracked using a paper flow sheet on each floor and then entered into the system under the "assessments" tab. AA-A stated the activities director (AD) did the care plans adding, "We don't do that." AA-A stated the AD would likely have more information on the assessment and care planning of activities. AA-A explained they were aware of R24 and expressed aloud, "She don't come out their room." AA-A stated they do a "coffee and chat" quick with her everyday but R24 often didn't verbally respond to her. AA-A stated they "check on her" a few times every day they felt. AA-A explained they used to track activities within the EMR, however, a previous management staff told them to stop doing so as "State [MDH] can't see it," which is where the paper flow sheets came from. AA-A stated this had been the process since "like two administrators ago" from their recall. AA-A stated R24 was "not a normal person to talk to" but felt she enjoyed "the old, old shows" and "like gray and white shows" from her recall. Later, on 6/30/25 at 2:01 p.m., the AD and AA-A were interviewed and the paper flow sheets, as completed by	F0679		

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F0679 SS = D	Continued from page 47 AA-A, were provided for review. These identified a paper with rows and columns which had multiple resident room numbers on the side and spacing to record across the paper for each day of the week. These identified: May 26 to May 31; R24's name and room number were identified. The flow sheet recorded a 1:1 was held four times, however, it didn't record any date(s) or length of time or what activities (i.e., nail care, reading news) were completed during it. June 2 to June 6; R24's name and room number were identified. The flow sheet recorded a 1:1 was held six times, once each day from Monday to Saturday, respectively. However, again, the sheet didn't record any length of time or what activities were completed during it. June 9 to June 14; R24's name and room number were identified. The flow sheet recorded a 1:1 was held five times, once each day from Monday to Wednesday, and on Friday and Saturday. The flow sheet recorded a single entry on Thursday which read, "Unv." However, again, the sheet didn't record any length of time or what activities were completed during the 1:1 sessions or an explanation for what 'unv' meant. July 12 (i.e., "7/12"); R24's name and room number were identified. R24 was not listed on the flow sheet and no activities were recorded for her. AA-A explained the 1:1's recorded on the flow sheet for R24 were the 'coffee and chat' sessions they had explained. AA-A acknowledged the charting on the flow sheet showed only once but reiterated they stopped in the room a "couple times a day" to check on her. AD explained the AA staff help complete the comprehensive assessments for each resident upon admission which were then entered into the EMR adding that should be done "as soon as they come in." From those assessments, then the care plan gets developed in the EMR. AD reviewed R24's medical record and verified it lacked any completed assessments for activities and the care plan lacked information or interventions for activities adding, "It's not in there." AD stated they felt it was completed and possibly just not entered adding, "I know we did it." AD stated the lack of assessment and care plan made it appear "like they [staff] didn't talk to her at all." AA-A stated they had search for a paper copy of the completed assessment, however, were unable to locate it adding aloud, "Maybe we missed one." However, both AD and AA-A verified residents' should be assessed and care planned for their activities preferences adding such was important, "So we know what	F0679		

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F0679 SS = D	Continued from page 48 they like and like to do." AA-A stated they would go and assess R24 now since this was identified. A facility provided Activity Programs policy, dated 3/2025, identified activities would be offered based on the comprehensive assessment and preferences of each resident. The policy outlined activities were scheduled seven (7) days a week and residents would be given opportunity to contribute to the planning, conducting and critiquing of them. The policy directed, "All activities are documented in the resident's medical record."	F0679		
F0684 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: Based on observation, interview, and document review, the facility failed to ensure proper wheelchair positioning for eating was maintained to promote comfort for 1 of 1 resident (R22); and failed to ensure medical devices for edema management were consistently applied to reduce peripheral swelling for 1 of 2 residents (R258) reviewed for edema care. Findings include: R22 R22's quarterly Minimum Data Set (MDS), dated 4/11/25, identified R22 had dementia but demonstrated no delusional thinking, however, the section to record R22's cognition was dashed as, "Not Assessed [see F638]." On 6/29/25 at 8:48 a.m., R22 was observed seated in the Broda-style wheelchair while in the dining room on the locked unit. R22 was positioned next to the table with his meal served on the table. R22's wheelchair back was in a reclined position at approximately 50 degrees and R22 was observed leaning forward approximately 12 to 14 inches from the wheelchair back to eat his meal. The	F0684	It is the policy of The Terrace at Crystal to ensure that residents receive the necessary care and services to maintain or improve their highest practicable physical, mental, and psychosocial well-being, in accordance with their comprehensive assessments and individual care plans. This includes proper positioning during meals to promote comfort and safety, and consistent application of prescribed medical devices to manage clinical conditions such as edema. R22 wheelchair positioning during meals was reviewed to ensure safe and comfortable dining. The resident’s seating and dining position was evaluated by nursing and therapy staff. R258 use of prescribed medical devices for peripheral edema management was reviewed to support consistent and effective care. The resident’s care plan was updated. Residents requiring specialized seating or therapeutic devices care plans were reviewed and updated as needed to ensure appropriate positioning and consistent use of medical devices. The facility prepared a policy titled “Resident Wheelchair Positioning Policy and Therapeutic Devices Use Policy”. Education will be provided to nursing staff, therapy, and restorative aids on proper wheelchair positioning for mealtimes and the clinical importance of consistent medical device application for edema control and the importance of edema management and the documentation of device use Ongoing monitoring will be conducted through weekly audits 1x per week for 2 months, then monthly for 2 months to verify quality of care	08/26/2025

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F0684 SS = D	Continued from page 49 seat of the wheelchair was approximately 12 to 14 inches from the ground and the table height was elevated, placing the meal plate at R22's chest level while he consumed the meal. Later, at 8:55 a.m., R22 continued to eat the meal from his plate in the same position, with several areas of spilled food on the table and R22's lap visible. There was no obvious attempt to correct R22's position during the observed meal service. R22's Physician Order, dated 12/12/24, outlined R22 was on hospice care and directed to continue consuming a regular diet with thin liquids, using a lipped plate for all meals, and, "Ensure pt [patient] is at proper positioning for all PO [oral] intake." R22's care plan, printed 7/1/25, identified all R22's current and potential problems along with interventions to address them. The care plan outlined R22 was dependent on staff for mobility using a Broda chair and listed an intervention which read, "Resident will have comfortable body alignment while in their chair." This intervention had an initiation date recorded, "01/06/2025." The plan continued and outlined R22 as being independent with eating after meal tray set-up, and listed R22 as having potential for inadequate oral intake due to dementia and being on hospice care. The plan directed, "Assist at meals as needed." On 6/30/25 at 5:24 p.m., the supper meal service on the locked unit was observed. R22 was pushed up to the table while seated in his Broda chair by nursing assistant (NA)-C and left there. R22's Broda chair was, again, in a reclined position and R22's buttock while seated in the chair was only 12-14 inches up from the ground. The table remained at the same height as prior with the table edge being even with R22's upper chest while he was seated in the Broda chair. NA-C returned to the table after a few moments and placed a lipped plate on the table in front of R22 before leaving the table again. R22 then, again, leaned forward nearly 12 to 14 inches or more from the reclined Broda chair and began eating his meal using the provided utensils. After several minutes, R22 was observed eating his meal and the Broda chair remained in a reclined position with R22 having to lean forward while eating to reach the cups and meal items. R22 then dropped his utensil on the ground with an audible noise to which NA-H responded to him from nearby, "Did you drop anything?" NA-H then retrieved the utensil and placed in onto the table, however, made no attempt to reposition R22 or improve his posture despite him leaning forward from the Broda chair-back to eat over 12 inches.	F0684	Continued from page 49 Results will be reviewed during monthly QAPI meetings to evaluate trends, staff adherence, and identify needs for additional training. The Rehab Director and DON and/or designee are responsible for the implementation, oversight, and continued compliance with this corrective action plan.	

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F0684 SS = D	Continued from page 50 Following, at 5:31 p.m., NA-H was interviewed and verified they had worked with R22 prior. NA-H explained R22 typically ate meals at the table in the dining room while seated in his Broda chair and, when asked to look at R22's posture, walked over and adjusted the back of the Broda chair to a more upright position which brought R22 to a more elevated position from which to eat his meal; however, the plate still was elevated and now appeared to be level with R22's mid-chest height. NA-H stated they keep the Broda chair in a reclined position "so he can't fall" from it. NA-H stated they had never seen or attempted to use any other tables, such as a bedside table, to provide a better posture for R22 to consume his meals. NA-H stated they were unsure why the Broda chair was left in the reclined position when R22 was provided his meal but reiterated the Broda chair-back should be raised to a vertical position while he's eating adding, "That's how he eat [sic]." When interviewed on 6/30/25 at 5:39 p.m., trained medication aide (TMA)-A stated they had worked with R22 and observed him seated at the table in the dining room. TMA-A acknowledged the seat of the wheelchair being approximately 12 inches or so from the ground and R22's plate being positioned mid-chest level despite the chair-back being raised forward. TMA-A stated the table could likely be adjusted and expressed they were unsure who, if anyone, evaluates a resident' eating posture or position adding, "I don't know that." TMA-A stated R22 had used the Broda chair for awhile and expressed they had never seen any other type of table used for him at meals to see if the positioning improved. TMA-A stated, at minimum, R22's Broda chair-back should be raised forward though at meals "so he can sit up while he's eating." TMA-A added, "How can you really enjoy your food [sitting back]?" R22's medical record was reviewed and lacked evidence R22 had been comprehensively evaluated or assessed for what, if any, alternatives or interventions were needed for his posture while seated in the Broda chair at meals despite him having to lean significantly forward from that chair to consume his meals. On 6/30/25 at 5:44 p.m., registered nurse unit manger (RN)-A stated the speech therapist would typically evaluate someone for eating posture or positioning, if needed. RN-A stated they had never seen R22 use a bedside table or anything else to provide a better posture with eating adding, "I've not observed that." RN-A stated they had not noticed R22's eating position while at the table prior and expressed no one of the floor staff had mentioned to them, either. RN-A	F0684		

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F0684 SS = D	Continued from page 51 verified R22's Broda chair-back should be moved forward for meals so he's not eating at a reclined position or having to lean forward while eating adding, "That's not comfortable for him." RN-A stated they'd reviewed if a bedside (lower) table would possibly improve his posture, too, adding aloud, "Thank you for catching that." When interviewed on 7/1/25 at 9:38 a.m., the director of nursing (DON) verified they were able to review R22's medical record and provided the Physician Order (dated 12/2024) as the only evaluation or documentation of his eating posture. DON stated staff should be, at minimum, bringing the chair-back forward during meals so R22 would be "sitting upright for meals." This was important to do "to make sure he's able to reach his food and eat comfortably." DON stated they had never noticed R22 to sit in a poor posture while at eats prior and expressed the Broda chair itself could be raised up, if needed, too. A facility' policy on wheelchair positioning or posture was requested, however, none was received. R258's quarterly minimum data set (MDS), dated 6/25/25, indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. The MDS further indicated R258 was dependent on staff for toileting, bathing and lower extremity dressing. R258's physician orders sheet, printed 7/2/25, indicated R258 had several medical diagnoses including lymphedema (a condition that causes swelling, usually in the arms or legs, due to a buildup of lymph fluid in the body's tissues) and congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs which often causes swelling in the legs and ankles). R258's electronic medical record (EMR) contained two orders for lower extremity swelling: TEDs (specialized stockings designed to prevent blood clots and reduce swelling, particularly in the legs and feet, by applying graduated compression) to bilateral lower extremities on for 12 hours off for 12 hours, dated 10/23/24 and lymphedema wraps (specialized bandages used to manage swelling by providing graduated compression, which helps move lymph fluid out of the affected area) to bilateral lower extremities daily, dated 9/17/22. R258's June treatment administration record (TAR) indicated nursing staff applied R258's lymphedema wraps	F0684		

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F0684 SS = D	Continued from page 52 once in the month of June on 6/17/25 (all other days were marked as "refused", "sleeping" or "hospitalized"). The TAR further indicated R258 TED stockiknngs were applied just once on 6/6/25 (all other days were marked as "refused", "sleeping" or "hospitalized"). R258 was hospitalized on 6/1/25 and 6/2/25. During observation and interview on 6/30/25 at 5:45 p.m., R258 was lying in bed with a sheet over her but her legs exposed. R258's bilateral legs appeared edematous and were without wraps or TED stockings. R258 stated she has not had her TED stockings on since she returned from the hospital in the beginning of June and has never worn lymphedema wraps. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she thought R258 had wraps for her legs but that she only administered medications for R258 and the nurses would do the wraps if she had them. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated R258 would often sleep during the day and be up at night, so when staff went in to do her treatments (i.e. wound care and TEDs) she would tell staff to "go away." During an interview on 7/2/25 at 9:22 a.m., the director of rehab (DOR) stated prior to R258's hospitalization the rehab staff had attempted to fit R258 for custom lymphedema wraps but she had refused the fitting appointment. The DOR stated nursing staff should be assisting R258 to apply her TED stockings daily to be worn for 12 hours on then off for 12 hours, stressing their importance to help reduce R258's edema and promote skin integrity, even if R258 was spending more time in bed post hospitalization. During an interview on 7/2/25 at 8:57 a.m., the third-floor manager and LPN-E stated prior to her hospitalization, R258 was "good about" wearing her TED stockings. LPN-E had not assessed why nursing staff were not able to apply R258's TED stockings and not assessed whether R258 would rather wear them at night while she was awake. A facility policy on edema management was request but not received.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F0686	It is the policy of The Terrace at Crystal to ensure that residents who are admitted without pressure ulcers do not develop them unless clinically unavoidable, and that residents with pressure ulcers receive the	08/26/2025

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F0686 SS = G	Continued from page 53 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: During observation, interview, and record review the facility failed to identify, implement, monitor and modify interventions to provide timely treatment and services to heal and to prevent further worsening of wounds. This failure resulted in harm for R254 when his bilateral heel pressure ulcers were not identified and addressed by facility until they progressed to stage three. Findings include: According to the national pressure injury advisory panel (NPIAP), pressure injury is defined as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. In addition, the evolution of a deep tissue pressure injury (DTI) develops from an exerted pressure about 48 hours before visible signs of purple or maroon skin. Then, about 24 hours later, the epidermis (layer of skin) lifts and reveals a dark wound bed. A stage three pressure ulcer/injury is defined as a full thickness loss of skin. R254's admissions Minimum Data Set (MDS) dated 7/17/24, and quarterly MDS dated 10/1/24, identified risk for developing pressure ulcers, had no pressure ulcers, no unhealed pressure ulcers, no unstageable pressure ulcer/injuries, and no deep tissue injuries. In addition, R254 had intact cognition, no impairment of upper and lower extremities, and was independent with self-care and mobility. R254's significant change in status (SCSA) MDS dated 11/22/24, identified two stage three pressure ulcers, with none of them present upon	F0686	Continued from page 53 appropriate treatment and services necessary to promote healing, prevent infection, and avoid new ulcer development. Resident #254 has been discharged. All current residents with identified pressure ulcers or at risk for skin breakdown were reviewed by the Wound Nurse and interdisciplinary team. Preventive strategies and treatment protocols reinforced and updated as needed to ensure alignment with best practices and resident-specific needs. The facility's "Pressure Injury Risk Assessment policy" was reviewed to make sure it supports early identification, routine skin monitoring, appropriate use of protective devices, and timely provider notification. Nursing staff received re-education on pressure ulcer prevention, proper documentation of skin assessments, timely communication of skin changes, and implementation of care plan interventions. Emphasis was placed on collaborative prevention efforts and prompt reporting of concerns. The DON and Wound Nurse/designee will conduct weekly wound audits and random skin integrity checks to ensure compliance with protocols. Audit results will be reviewed during monthly QAPI meetings to identify trends, reinforce best practices, and initiate corrective actions as needed. The Director of Nursing is responsible for overseeing ongoing compliance.	

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F0686 SS = G	Continued from page 54 his admission to facility. In addition, R254 had severe cognitive impairment and was dependent on staff for toileting, bathing, personal hygiene. Also, R254 required assistance with mobility including sit to lying and lying to sitting on side of the bed. R254's admission MDS care area assessments (CAA) dated 7/17/24, identified "Potential" risk factors for pressure ulcers. Section of form to identify "Supporting Documentation. Provide the basis/reason for items being checked, including the location & date & source" was left blank. R254's CAA for the 11/22/24, SCSA MDS identified "Actual" problem for Pressure Ulcer/Injury and, "Skin breakdown with risk for further breakdown and impaired healing related to terminal condition." The Care Plan Considerations identified current pressure ulcer would be addressed in the care plan with overall objective to "Slow or minimize decline." R254's medical diagnoses include diabetes, rheumatoid arthritis, depression, hypertension, and congestive heart failure (CHF). The Braden Scale for Predicting Pressure Ulcer Risk is an evidence-based assessment tool in health care used for predicting a patients' risk of developing pressure ulcers. It allows health care professional to implement preventive measures effectively. Scores of less than 9 indicate "Severe Risk", scores of 10-12 indicate" High Risk", scores of 13-14 indicate "Moderate Risk", and scores of 15-18 indicate a "Mild Risk". R254's Braden assessment scores (scale to assess patients' risk of developing pressure injuries) were: 7/11/24 score of 18, 9/27/24 score of 15, 10/6/24 score of 15, 11/7/24 score of 17, 11/14/24 score of 15, and 11/22/24 score of 16. R254's care plan with focus on Skin identified "resident have actual wounds to both heels and potential for impairment to skin integrity fragile skin." Date initiated was 8/15/24. CP Interventions identified "Reposition Frequently" and "Weekly treatment documentation to include measurement of each	F0686		

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F0686 SS = G	Continued from page 55 area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations" was initiated 1/5/25-four days before R254 expired. R254's provider progress notes (PN) dated 7/15/24, 7/16/24, 7/17/24, 8/21/24, 8/23/24 identified "No rash, or lesions" under Examination section of form. Provider PN dated 9/6/24 identified, "No breakdown in hands or heels" and to "monitor for acute skin care breakdown". R254's hospital discharge summary (DC) dated 9/23/24, identified hospitalization from 9/13/24 to 9/23/24 for urinary retention and urinary tract infection. DC summary identified, "no rashes, ulcerations on exposed skin surfaces". Upon admission to hospital R254 had bruising to coccyx which was identified 9/14/24, with no other skin issues identified. During review of PN dated 9/25/24 identified R254 readmitted to facility from hospitalization. PN failed to indicate any assessment or issues with skin integrity. PN dated 10/2/24 at 5:23 p.m., identified R254 "felt like[sic] had an [sic] heart attack, and would like to go to the hospital for checkup." Orders were received to send to hospital. PN dated 10/3/24 at 11:07 p.m., stated R254 returned from "hospital at 3:15 p.m." and failed to indicate any assessment or issues with skin integrity. R254's hospital DC summary dated 10/3/24, identified R254 hospitalized 10/2/24 to 10/3/24 for report of chest pain. During hospitalization on 10/2/24 a "Pressure Injury: Suspected Deep Tissue Injury" to left and right heels were first observed on 10/2/24 at 10:58 p.m., and both wounds were identified has being present "Prior to Admission". R254's weekly bath audits (BA) dated 10/7/24, 10/14/24, 10/21/24, 10/28/24, 11/4/24, 11/11/24, 11/17/24, 12/3/24, identified, "no new alterations in skin". BAs were marked as, "weekly wound assessment initiated and completed." R254's podiatry consultation noted dated 10/22/24, identified "ulcer heels" and "monitor pressure". R254 was admitted to hospice services on 11/14/24, with terminal diagnosis of congestive heart failure. R254's hospice admission note identified, "bilateral stage 3 pressure injuries on heels". R254's provider orders (PO) dated 11/22/24, initiated	F0686		

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F0686 SS = G	Continued from page 56 PO for left and right heel ulcers. The PO for left heel identified, “left Heel wound order: cleanse with vashe (wound cleanser), skin prep to area, santyl (topical medication used to clean and remove dead tissue) to wound bed and apply mepilex (a foam dressing) to area, change daily”. PO for right heel identified, “Right heel wound orders: cleanse with vashe, paint heel with betadine, cover with gauze 4x4 and wrap with kerlix, change daily”. During review of R254’s EMR, the documentation of R254’s left and right heel ulcers by infection control preventionist and facility wound nurse (IP) began on 11/12/24 by using the Skin and Wound Evaluation assessments. Measurements of wounds include: Left heel: 11/12/24: 1.5 centimeters (cm) long x 1.7 cm wide x 1.2cm deep. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. Notation of, “This is a new wound.” Right heel: 11/12/24: 5.5cm x 3.6cm x 2.2cm. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. R254’s provider PN dated 12/10/24, identified “Chief Complaint: f/u wound rounds.” PN stated pressure ulcers of left and right heel were “unstageable.” Left heel measurements were: 11/12/24: 1.73 cm x 1.27 cm, 11/15/24: 2.2cm x 1.3 cm, 11/22/24: 2.8cm x 2.6cm, 12/10/24: 3.5 cm x 4.4cm. Right heel measurements were: 11/12/24: 4.47cm x 3.0cm, 11/22/24: 4.7cm x 6.6cm, 12/10/24: 4.0cm x 6.2 cm. During review of R254’s Skin and Wound Evaluation assessment for 12/27/24, the left heel wound measurements were 2.1cm x 2.3cm x 1.2cm deep and the	F0686		

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F0686 SS = G	Continued from page 57 right heel measurements were 8.7cm x 4.4cm x 2.7cm deep. During interview with wound care provider (WP) on 7/1/25 at 8:15 a.m., WP stated facility wide wound care rounds were performed with infection control preventionist (IP) twice per week. WP stated IP developed a list of residents who needed to be seen each time. WP stated facility nurses “will tell [IP] of new wounds” and IP assessed and obtained new wound care orders. IP then added these residents to his bi-weekly wound care rounds for monitoring and managing of wounds. During interview with director of nursing (DON) on 7/2/25 at 7:37 a.m., DON stated she was familiar with R254 because DON was the nurse manager on the unit where R254 lived on during the entire time of his facility stay. DON reviewed 10/3/25 hospital DC summary and agreed the documentation identified bilateral heel DTI’s. DON reviewed R254’s electronic medical record (EMR) and stated she was unable to determine if R254’s DTIs were identified at the facility prior to R254’s hospitalization on 10/2/24. DON stated expectation of staff members who identify impaired skin issues to “report ASAP to nurse, the nurse should assess and update the provider and document [sic] it in progress note”. DON stated, first note of impaired skin issues with R254 was on 11/14/24, with the PO for wound care orders to both heels. DON stated R254’s CP “should have been updated and was not”. DON stated first indication of wound care for R254 was placed in CP on 8/15/24, but not acted on until 11/14/24, when the IP obtained the PO. DON stated importance of identifying and acting on impaired skin integrity “is to ensure appropriate interventions are initiated immediately”. DON stated she was unable to determine when R254’s DTIs occurred by looking at his EMR. During interview with LPN-B on 7/2/25 at 11:46 p.m., LPN-B stated expectation of staff to assess and “check [residents] skin upon hospital return” including feet and coccyx. LPN-B stated any new or developing skin issues should be addressed right away and provider should be contacted, orders received and notify the IP. In addition, a PN should be put in the EMR. LPN-B stated expectation of “all skin” to be checked weekly with the bath and documented in the “weekly bath audit”. During interview with LPN-A on 7/2/25 at 11:57 a.m., LPN-A stated expectation of staff to assess and “check skin” and to document in the EMR under the PN about skin condition. If there was a new skin injury, then	F0686		

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F0686 SS = G	Continued from page 58 staff were expected to “chart it and notify the wound team”. LPN-A stated CP interventions for skin care were changed and updated by the IP “when they review [the wounds]”. During interview with LPN-B on 7/2/25 at 12:53 p.m., LPN-B stated a “body audit should be done for all [residents] readmitting” to facility. LPN-B reviewed R254’s EMR and stated, “no there is nothing there.”. LPN-B stated she remembered R254 during his facility stay and stated “I remember seeing them [bilateral pressure ulcers to heels] two months before [R254] passed. Me and [IP] were doing something for [R254] and noticed it while changing his socks. I remember seeing it for the first time saying, ‘oh my God’. I did not document anything. That is [IP]’s job. IP is the wound nurse and should have done it,” and continued, “No, I do not see it was done”. During interview with medical director (MD) on 7/2/25 at 8:58 a.m., MD reviewed R254’s EMR and physician notes and stated, “I expect the facility to have assessed [R254’s] heels prior to [sic] admission to the hospital in October [10/2/24].” MD stated R254’s EMR lacked orders, progress notes, and other documentation to support identifying R254’s bilateral heel PU’s until they progressed to stage three. MD stated, “[it was] most likely avoidable.” During interview with IP on 7/2/25 at 8:28 a.m., IP stated he was familiar with R254 during his facility stay. IP reviewed R254’s EMR and stated, “[11/12/24] is when we first identified [R254’s] heel ulcers.” IP stated he did not obtain PO for R254 until 11/14/24, and IP failed to document in the PN. IP stated expectation of staff to “notify me ASAP” when there is a new or worsening skin issue, “then, I will assess and get orders from the [provider] and put the resident on ‘weekly wound rounds’”. IP stated, “we missed it and should have taken steps earlier to address [R254’s] wound to his heels.” IP reviewed R254’s hospital DC summary dated 10/3/24, and stated, “it shows there was identified DTI’s to both heels at the time. We [Facility] did not identify any concerns until 11/12/24”. IP stated R254’s bilateral heel wounds, “should have been addressed by us before 10/2/24 [when R254] was admitted to the hospital”. IP stated wound care rounds involve IP “putting names on paper for people who I look at for wound rounds and then do the rounds with the provider” and document in the EMR. IP stated the Braden documentation was used by the facility to determine pressure injury risk. During interview with hospice vice president of	F0686		

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F0686 SS = G	Continued from page 59 clinical operations (VP)-M on 7/2/24 at 11:23 a.m., VP-M reviewed R254's admission paperwork to hospice services on 11/19/24 and stated R254 had "two wounds on admission. Stage three right and left heel pressure ulcers." During interview with IP on 7/2/25 at 11:44 a.m., IP stated expectation of the nurse at facility to perform a skin integrity assessment every time a patient came back from hospital and write a PN in the EMR. IP reviewed R254's EMR and stated it failed to show a skin assessment was done and PN failed to identify any issues with skin integrity when R254 returned to the facility on 10/3/24. During interview with regional director (RD), administrator, and DON on 7/2/25 at 12:11 p.m., RD stated R254 "could have gotten it [DTI's] from the hospital or transport". Also, RD stated, "[facility] identified our documentation was not up to par" and that R254 "had a history of refusing care" despite no interventions to address any refusals. During interview and review of IP Wound Rounds notes (WRN) dated 7/1/24 to 9/17/24, and 12/3/24 to 1/3/25, with IP on 7/2/25 at 11:44 a.m., IP stated he was unable to find the WRN's for dates between 9/17/24 to 12/3/24. WRN for 8/20/24 identified a listing titled "Pressure Ulcer" with three resident names including R254 and no other information. IP reviewed his notes and EMR and was unable to determine rationale for listing R254 with PU on 8/20/24. WRN for 8/27/24 identified R254 being seen for "Rash-Ointment to be ordered." WRN dated 12/3/24, 12/6/24, 12/17/24, 12/20/24, 12/27/24, 1/3/25 identified R254 as being seen. During interview with hospice team leader (H)-TL on 7/7/25 at 9:48 a.m., H-TL identified R254's hospice nurse manager no longer works for facility and reviewed R254's hospice admission paperwork. H-TL stated R254 had two stage three PU's to his heels on admission to hospice services on 11/19/24 and stated, "facilities can just 'let them go' and not do a good job of preventing or lessening the progression of pressure ulcers" in residents who are on hospice. HT-L confirmed R254 passed away at the facility on 1/9/25. Facility policy titled Prevention of Pressure Injuries, revised April 2020 identified "Inspect the skin on a daily basis" and "Inspect pressure pointes (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.)". Facility policy titled Pressure Injury Risk Assessment, revised March 2020 identified purpose "to	F0686		

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F0686 SS = G	Continued from page 60 provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs)".	F0686		
F0688 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 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: Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 resident (R23) reviewed for limited range of motion (ROM). Findings include: R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). The MDS indicated R23 was not on a restorative nursing program during the look-back period (LBP).	F0688	It is the policy of The Terrace at Crystal to ensure that residents with limited range of motion (ROM) receive appropriate services and interventions to maintain or improve functional abilities and prevent further decline or the development of contractures. R23 care plan was reviewed and revised to include an individualized range of motion goals and appropriate interventions. Physical therapy was consulted to reassess the resident's needs and provide updated recommendations for ROM exercises and supportive positioning. All current residents with limited ROM or contracture risks were reviewed by therapy and nursing to ensure ROM interventions are in place. Facility policy, "Range of Motion Exercises policy" was reviewed and revised as necessary. Nursing staff, therapy staff, and CNAs received targeted education on recognizing residents at risk for ROM decline or contractures, performing and documenting passive and active ROM exercises and ensuring care plans are individualized. The Rehab Manager or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on residents identified with ROM needs to ensure care plans are up to date and interventions are implemented as recommended. Findings will be reviewed during the monthly QAPI meetings and corrective actions will be taken as needed. The Rehab Director and DON are responsible for ongoing compliance and ensuring that all residents receive services to prevent the decline of ROM or development of contractures.	08/26/2025

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F0688 SS = D	Continued from page 61 R23's care plan printed 6/30/25, indicated R23 required extensive assistance of two staff to turn and reposition in bed, extensive assistance of one staff to transfer between surfaces, encourage resident to participate to the fullest extent possible with each interaction, and physical and occupational therapy to evaluate and treat as per provider orders. A functional maintenance program directed nursing to assist patient with applying AFO (ankle-foot orthosis) foot brace to right foot and then ambulate 100 feet with CGA (contact guard assist) and quad cane (walking aid with a base which has four legs or prongs). The care plan identified R23 refused to walk and refused to wear the AFO brace with date of 1/4/25. R23's ROM and Mobility assessment dated 5/6/25, indicated had an impairment on onside of both upper and lower extremity and was not steady and only able to stabilize with staff assistance to move from a seated to standing position. The assessment indicated walking, moving on and off a toilet seat, and surface-to-surface transfer did not occur. R23 used a wheelchair. The assessment indicated direct care staff believed R23 was capable of increased independence in at least some ADLs and did not include interventions/exercises to ensure R23 maintained his ROM if needed. R23's physician order dated 11/16/21, included nurse to ensure resident wore AFO brace to his right foot when out of bed every shift with start date of 11/16/21. R23's Treatment Administration Record (TAR) dated June 2025, directed nurses to ensure R23 was wearing his AFO brace to right foot when out of bed every shift. All three shifts were marked as completed every day except for three morning shifts. R23's progress notes dated 12/13/25 to 7/1/25, indicated one refusal to wear AFO brace. R23's medical record did not indicate interventions/exercises for R23's right upper extremity. During observation and interview on 6/29/25 at 9:14 a.m., R23's right arm was in a sling and right-hand fingers were curled towards his palm. R23's right foot was on the wheelchair pedal and left foot was on the ground. R23 did not have a leg brace on. R23 stated staff did not complete exercises with him. During observation on 7/1/25 at 7:42 a.m., R23 was dressed and in his wheelchair. R23 had a sling on and no brace on his legs.	F0688		

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F0688 SS = D	Continued from page 62 During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his room in his wheelchair. R23 stated yes when asked if staff completed exercises with him today. R23 did not have a brace on his legs. When asked about the leg brace, R23 used his left foot to propel in his wheelchair to his closet and opened the closet. A leg brace was not found in his closet. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated they were unaware of any boot or brace for R23. NA-K stated he used to have a brace for his leg and was unsure if nursing stopped the brace. NA-K stated they completed range of motion with R23 but did not document the range of motion they completed. NA-K stated approximately four days ago they opened R23's right hand to clean it. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R23's care sheet, which indicated R23 did not walk and "AFO [right] foot when out of bed which is refused by resident". LPN-A stated staff should notify them if R23 refused the AFO brace, so LPN-A could write a progress note and let the provider or therapy know if needed. LPN-A observed R23's right hand and stated nursing could recommend therapy for R23. During interview on 7/1/25 at 12:30 p.m., NA-J stated R23's hand condition was unchanged since previous and had never seen a brace for his legs. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapy had not been recently involved with R23's right upper extremity or AFO brace. DOR expected to be notified of a change in AFO brace, and occupational therapy addressed concerns with residents' hand mobility. DOR stated R23 had MA (medical assistance) pending for insurance coverage, and the business office was involved with setting R23 up with a guardian since R23 was nonverbal. DOR reviewed R23's therapy file which included: -R23's Functional Maintenance/Restorative Nursing Program form undated (copy provided had bottom part cut off), indicated treatment recommendations to assist R23 with right foot AFO brace and walk patient 100 feet using a quad cane daily and six days per week. The goal of the recommendation was to reduce effects of debility, prevent deconditioning, and reduce risk of fall. -R23's Rehabilitation Screen dated 1/17/22, indicated R23 needed short distance ambulation with right AFO	F0688		

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F0688 SS = D	Continued from page 63 boot to reduce nursing dependency. -A physician order dated 8/24/22, directed physical therapy to evaluate and/or treat for strengthening with ambulation. -A physician order dated 1/14/24, indicated for a right AFO brace and a face-to-face for power wheelchair. -A physician order dated 1/22/24, directed physical therapy and/or occupational therapy to evaluate and treat R23 related to nerve pain and weakness in upper and lower right side. The order indicated R23 felt his upper and lower right side had a change from his baseline. No further information was provided. During interview on 7/2/25 at 10:38 a.m., LPN-E stated R23's AFO brace was important for R23's foot to help with support since R23 had a stroke. LPN-E stated the AFO brace was not in R23's room anymore, so staff were checking with therapy. LPN-E stated they were unsure how long R23's right-hand fingers had been curled and expected staff to notify nursing and therapy. During observation and interview on 7/1/25 at 11:38 a.m., LPN-A was slowly able to open R23's right-hand fingers and observe R23's palm. No skin breakdown was noted. LPN-A stated therapy should work with R23 to improve his finger mobility. During interview on 7/2/25 at 1:58 p.m., the director of nursing stated limited hand range of motion should be addressed by therapy and nursing should update the care plan and orders as indicated. The DON expected staff to follow-up immediately if a brace was found to be unavailable. The DON expected staff to prevent contractures. The facility Range of Motion Exercises policy dated October 2010, directed staff to verify if there was a physician's order for the exercise to perform and contact the provider to obtain treatment orders if there were no orders for the exercise. The policy directed staff to document the date and time the exercise was performed, the name and title of who performed the procedure, type of ROM exercise, whether the exercise was active or passive, how long the exercise was conducted, any problems or complaints made by the resident during the exercise, and reason why and intervention taken if the resident refused the treatment.	F0688		
F0689	Free of Accident Hazards/Supervision/Devices	F0689	It is the policy of The Terrace at Crystal to ensure	08/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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F0689 SS = D	Continued from page 64 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: Based on interview and document review, the facility failed to comprehensively assess and develop interventions as needed to reduce the risk of accidents or injury for 2 of 2 residents (R41, R38) reviewed with a history of substance abuse and suspected current use. In addition, the facility failed to implement interventions for 1 of 1 resident (R35) reviewed for falls. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's diagnoses list, dated 7/13/24, indicated R41 had several medical diagnoses including psychoactive substance dependence. R41's Associated Clinic of Psychology (ACP), dated 5/20/25, indicated facility staff informed the ACP practitioner of concerns of suspected substance use, which was also listed as a barrier to care on the ACP visit note. R41's electronic medical record (EMR) lacked any documented interventions, assessments, or monitoring protocols related to suspected substance use. Furthermore, there were no care plan elements or guidance in place outlining staff responsibilities or actions to take if substance use was suspected. The absence of such documentation and intervention planning presents a potential risk to R41's health and safety,	F0689	Continued from page 64 that all residents are provided with adequate supervision and assistive devices to prevent accidents, including those related to substance use and fall risk. R41 and R38 were reassessed on substance use history, current behavioral indicators, and risk factors related to unsafe behaviors. Care plans were updated. Social services contacted providers to coordinate substance abuse evaluations and mental health services, where applicable. R35, the care plan was reviewed and revised to reflect recent fall incidents. Room was searched and re-arranged for optimal safety. All residents with a history of substance abuse or falls care plans were reviewed to ensure appropriate accident prevention strategies were in place. Licensed nurses, CNAs, and social services staff received targeted education on identifying and documenting risks associated with substance use, implementing individualized safety interventions for residents with behavioral or fall risks and coordinating with interdisciplinary team members to ensure proper supervision and behavioral support The DON or will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on residents with substance use history or fall risk. Results will be reviewed during monthly QAPI meetings to identify trends and implement further corrective actions as needed. The Director of Nursing is responsible for ongoing compliance and ensuring that all residents are provided with safe environments and effective supervision.	

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F0689 SS = D	Continued from page 65 as well as to the safety and well-being of other residents and staff in the facility. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she had not seen R41 using drugs but had suspected it on more than one occasion. TMA-B stated when she suspected R41 of substance use, R41 would be doubled over in her chair with glassy eyes, pinpoint pupils and slurred speech. TMA-B stated, "you can tell she is on something" confirming she has reported the concern to the nurse manager more than once but "nothing is getting done." TMA-B stated something needed to be done because "anything could happen". During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and licensed practical nurse (LPN)-E stated she was aware R41 had a history of substance use and stated staff have reported smelling "burning" coming from R41's room at times. LPN-E confirmed there was no care planned interventions for suspected substance abuse, but should be, stating it would be expected that staff check on R41 every 15 minutes if they suspected she was using substances. R38's significant change Minimum Data Set (MDS) dated 6/23/25, indicated R38 had intact cognition with no delusions, hallucinations, or rejection of care behaviors. The MDS indicated R38 was independent with chair/bed-to-chair transfers and could wheel 150 feet in a wheelchair independently. The MDS indicated R38 was diagnosed with heart failure, kidney disease, diabetes, anxiety, and depression. R38's hospital note dated 1/4/25, indicated R38 was brought to the emergency department due to "abnormal movements". The note indicated R38 had reported to hospital staff that he had "smoked crack cocaine" two days prior. R38's care plan dated 1/6/25, included a care plan titled "substance use disorder" and indicated R38 had tardive dyskinesia (involuntary muscle movements) related to "cocaine" use, with the sole intervention being that the resident will be offered chemical use counseling as appropriate. During an interview on 7/1/25 at 9:50 a.m., R38 stated he had used methamphetamine (meth) once, but he didn't like it so did not plan to use it again. R38 stated he had smoked crack cocaine in the past but could not	F0689		

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F0689 SS = D	Continued from page 66 recall the last time this had occurred and claimed he had never smoked crack while residing at the facility. R38 stated he was trying to get himself "completely healthy" so he wasn't using anymore and only gets "98 bucks" a month, so he couldn't buy crack now even if he wanted to. R38 confirmed he had been offered chemical use counseling, but did not want the services. During an interview on 6/29/25 at 8:58 a.m., R153 stated R38 "does crack" at night. R153 stated he hears the "click, click, click, of the lighter" but has not seen R153 use crack cocaine. R153 stated he hadn't told staff about it, but "they should know". On 6/30/25 at 1:33 p.m., R153 stated that in the last week, R38 had asked him for money to buy "crack". R153 stated R38 would barricade the door with a dresser when he was "smoking crack," and R38 told him he would hurt him if he put his call light on while he was smoking. R38 stated the last time this happened was on either Friday (6/27/25) or Saturday (6/28/25) night. During an interview on 6/29/25 at 12:55 p.m., licensed practical nurse (LPN)-B confirmed she was the nurse in charge of R38's care this shift. LPN-B stated that facility staff had suspected that R38 was using illicit drugs, but she had never observed signs or symptoms of this herself. When asked what monitoring was in place regarding R38's suspected illicit substance use, LPN-B stated they "probably should" but did not currently have any monitoring in place or a plan for if illicit substance use was suspected. During an interview on 6/30/25 at 1:57 p.m. with the administrator and director of nursing (DON), the administrator stated they had not been notified of any allegations of R153's using crack cocaine, and the DON confirmed she had also not been aware of these allegations and had not seen any symptoms of intoxication or been notified of anyone finding any drug paraphernalia, and was unsure if further assessments had been completed regarding R38's illicit substance use. During an interview on 7/2/25 at 10:01 a.m., the DON stated if a resident had a known history of illicit substance use, she would expect this to be care planned and assessed for, as well as implementing monitoring for signs or symptoms of substance abuse as well as collaborating with the provider for any additional orders if needed. The DON stated this monitoring would be outlined in either the care plan or orders. R38's medical record was reviewed, and it did not indicate that monitoring for illicit substance use was in place or that a comprehensive assessment of R38's substance	F0689		

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F0689 SS = D	Continued from page 67 abuse disorder had been completed. The facility's Substance Abuse Policy dated 6/29/25, indicated if a resident had a substance abuse disorder or displayed the potential for a substance abuse disorder, the facility would assess the residents to determine substance abuse disorder "triggers", therapies/support available, and the resident's willingness to participate in substance use disorder services. The policy indicated that facility staff would assess for substance abuse disorders and triggers upon admission, readmission, and quarterly. The policy indicated that, based on assessment outcomes, an individual care plan would be developed and provide approaches for reducing triggers for substance use. The policy indicated it was "essential" to monitor if a resident who was suspected of illegal drug use was a danger to themselves, others, and /or staff. R35 Falls R35's annual assessment dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of osteoporosis, asthma, Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required staff assistance with most activities of daily living. R35's care plan printed 6/29/25, indicated R35 was independent to turn and reposition in bed and transferred with staff supervision. R35 was at risk for fall related to Alzheimer's disease and safety awareness. The care plan indicated R35's last fall was 5/20/24. The care plan's fall interventions included: -Anticipate and meet the resident's needs dated 1/29/24. -Be sure call light within reach and encourage resident to use it for assistance as needed dated 5/16/24. -Physical therapy to evaluate dated 5/20/24. -Physical therapy to evaluate and treat as ordered or PRN (as needed) dated 10/16/24. -Obtain order for physical therapy to evaluate and treat for 12/16/24 fall dated 12/18/24. -Keep walker next to bed for fall on 12/1/24 dated 1/28/25. R35's Resident Fall Risk assessment dated 6/25/25, indicated R35 was at "high risk" for falls related to	F0689		

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F0689 SS = D	Continued from page 68 intermittent confusion, history of one to two fall in the past three months, ambulatory and incontinent, took one or two of the medications indicated in the assessment currently and/or within the last seven days, and had one or two of the indicated predisposing diseases. R35's progress notes indicated: -On 6/13/25 at 6:30 p.m., R35 was found on the floor next to the nursing station. R35 had her shoes on and stated she tried to stand up and twisted her leg and sat on the floor. R35's vital signs were noted, and R35 stated she did not have pain. R35 was able to move her upper and lower extremities without pain. R35 was helped to wheelchair with Hoyer lift and two nursing assistants. Family member (FM)-R, nurse manager, and provider were called. Neurological checks were started. -On 6/16/25 at 9:52 a.m., an interdisciplinary note indicated R35 was demented and forgot good body mechanics during movements. Physical therapy was requested to strengthen her mobility. R35's Un-witnessed Fall risk management assessment dated 6/13/25, indicated an incident description and immediate action taken which repeated information from the progress note dated 6/13/25. The assessment indicated no predisposing environmental factors, physiological factors including confusion and fear of falling, and situational factors of ambulating without assistance and using a walker. R35's electronic health record did not indicate therapy involvement after her fall. During interview on 06/29/25 at 10:56 a.m., FM-R stated R35 fell about a couple weeks ago, and R35 had no pain and did not need to be sent to the hospital. FM-R stated they did not know about any new intervention the facility implemented, and the facility continued with the current fall interventions. During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated staff stayed with residents who they found on the floor and called the nurse. NA-A stated the nurse assessed the resident and determined if 911 needed to be called or if staff could move residents using a Hoyer lift. NA-A stated fall interventions were noted in residents care plans and staff read the care plans every day. NA-A stated R35 was "not really" a fall risk but always made sure R35 had her walker and reminded R35 to lift her feet.	F0689		

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F0689 SS = D	Continued from page 69 During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses were called when a resident had an unwitnessed or witnessed fall. RN-A stated nurses took residents' vital signs, performed neurological checks, checked for injuries and range of motion. Nurses determined if the resident was safe to move or if 911 was needed. RN-A stated nurses notified the family, manager, and provider. A risk management assessment was completed of each fall to describe the situation and what interventions were implemented. RN-A stated R35 was a fall risk and stayed close to staff for monitoring. RN-A stated fall interventions prevented R35 from future falls. RN-A stated nurses obtained therapy orders if therapy was a fall intervention, so therapy could work on strengthening with residents. RN-A thought R35 was being seen by therapy. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapies most recent encounter with R35 was in September of 2024 for speech therapy. DOR stated she was at a meeting where therapy was discussed after her last fall but did not see any orders come through to start therapy with R35. DOR stated therapy orders from the provider came through nursing or the health unit coordinator and they usually received a therapy order within a couple days after discussed, and indicated R35's fall risk management was signed on 6/17/25. During interview on 7/2/25 at 11:38 a.m., licensed practical nurse (LPN)-B reviewed R35's risk management assessment related to R35's fall on 6/13/25. LPN-B stated an immediate intervention should have been implemented and verified R35 had no current therapy orders. LPN-B stated nurses were able to obtain therapy orders within 24 hours unless the order was needed over the weekend. LPN-B stated fall interventions were important to prevent falls, and physical therapy would help strengthen R35. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to implement immediate fall interventions, review and discuss falls, and update the care plan. The DON stated staff were able to get therapy orders timely to give to the therapy department. The DON stated implementation of fall interventions were important to prevent residents from repeated falls. The facility Falls - Clinical Protocol dated November 2022, directed the staff and physician to assess residents at risk for falls and residents who have fallen to identify pertinent interventions to try to	F0689		

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F0689 SS = D	Continued from page 70 prevent subsequent falls and to address the risks of clinically significant consequences of falling. The facility Falls and Fall Risk, Managing policy dated November 2022, directed staff to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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: Based on observation, interview and document review the facility failed to recognize and respond to a resident's weight gain in the facility to ensure they maintained acceptable parameters of nutritional status, such as desirable body weight, for 1 of 2 residents (R31) reviewed for nutritional status who gained 35% of their weight since admittance to the care facility. Findings include: R31's annual Minimal Data Set (MDS), dated 4/26/25, R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood	F0692	It is the policy of The Terrace at Crystal to ensure that residents maintain acceptable parameters of nutritional status, including body weight, through comprehensive assessments, interdisciplinary care planning, and appropriate clinical response. R31's nutritional history, clinical status, weight trends, and dietary orders were reviewed. The care plan was updated to reflect goals. Dietary services revised the resident's meal plan, and the physician was notified to evaluate for potential contributing factors. All residents who experienced a significant weight change (gain or loss) of 5% in one month, 7.5% in three months, or 10% in six months were reviewed and care plans updated to address weight change. Registered Dietitian and nursing staff received education on recognizing and reporting clinically significant weight changes, ensuring prompt interdisciplinary communication and clinical response and documenting weight trends, assessments, and nutrition-related interventions in the EHR. The Dietary Manager and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on resident weights. These findings will be reviewed during QAPI meetings to identify opportunities for system-wide improvements in nutritional care and monitoring practices. The Director of Nursing is responsible for ensuring ongoing compliance with F-692 and maintaining a system of early detection and intervention to promote resident nutritional well-being.	08/26/2025

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F0692 SS = D	Continued from page 71 pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes. R31's weights, listed in the electronic medical record (EMR), indicated R31 weight 165 pounds at admission to the care center and most recent weight was listed as 231 pounds, 66 pounds and a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet. R31's most recent Nutrition Data, dated 4/26/25, indicated R31's weight was "up 62.8 pounds over 6 [six] months" but lacked any interventions to address R31's significant weight gain indicating "RD [registered dietician] to follow PRN [as needed]" R31's EMR lacked any follow up from dietary or nutrition services regarding R31's weight gain. During an interview an on 6/29/25 at 10:35 a.m., R31 voiced concerns about the food quality she had been receiving at the care facility, stating it was not an appropriate diabetic diet and she had gained at least 35 pounds since being there. R31 voiced frustration at working hard to lose 60 pounds before coming to the care facility and had not had a dietician reach out about her weight gain or concerns about the food she had been receiving. During an interview on 7/1/25 at 1:02 p.m., the dietary manager (DM) stated she was aware of R31's concerns regarding the food but that R31 had chosen to exercise their "resident rights to eat what [they] want" confirming she had not spoken with R31 about their weight gain but will plan to now. During an interview on 7/2/25 at 8:57 a.m., third-floor manager and licensed practical nurse (LPN)-E confirmed she had heard complaints from R31 about the terrible food, and after review of R31's EMR, confirmed R31 had gained 66 pounds since admission. LPN-E stated the dietician was usually on top of nutritional status and should have recognized R31's significant weight gain and followed up with R31. A facility policy titled Weight Assessment and Intervention, revised 2/2022, indicated "undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes: a. the resident's target weight range (including rationale if different from ideal body weight);	F0692		

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F0692 SS = D	Continued from page 72 b. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake; c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated."	F0692		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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: Based on observation, interview and document review the facility failed to ensure a resident's pain was adequately controlled and failed to implement non-pharmacological pain interventions (i.e. heat, ice, massage, aromatherapy) if needed for adequate pain control for 1 of 2 residents (R41) reviewed for pain. Findings include: R41's quarterly Minimum Data Set (MDS), dated 5/29/25, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. The MDS lacked a pain assessment. R41's diagnoses, dated 7/3/24 indicated in R41 had several medical diagnoses including person injured in unspecified motor-vehicle accident, traffic, subsequent encounter; intervertebral disc degeneration lumbosacral region with discogenic back pain and lower extremity pain; and dorsalgia (back pain). R41's electronic medical record (EMR) contained several orders for medication and monitoring that included; oxycodone oral capsule 5 milligrams (mg) - Give 5 mg by mouth every four hours as needed for breakthrough knee pain - Max 2 doses per day, dated 6/11/25, Gabapentin	F0697	It is the policy of The Terrace at Crystal to ensure residents receive appropriate and effective pain management, including pharmacological and non-pharmacological interventions, to support comfort and quality of life. R41's pain history, pain assessments, and treatment plan were reviewed and revised in the care plan. The resident's physician was notified, and medication orders were adjusted to better manage the resident's reported pain. A full audit of residents with active pain care plans will be completed to verify that all residents have individualized, up-to-date pain interventions including both pharmacologic and non-pharmacologic methods documented and implemented as appropriate. Nursing and direct care staff received education on recognizing signs and symptoms of pain, timely documentation and reporting of pain episodes, utilizing available non-pharmacologic interventions and updating the care plan. The Director of Nursing and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months reviewing documentation for residents with pain-related diagnoses to ensure that pain assessments are completed, and interventions are individualized. Audit findings will be reviewed in the facility's QAPI meetings to evaluate effectiveness and make additional process improvements. The Director of Nursing is responsible for ensuring that pain management protocols remain compliant with regulatory expectations and that staff are trained and supported in delivering compassionate, comprehensive pain care.	08/26/2025

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The Terrace at Crystal LLC	3245 VERA CRUZ AVENUE NORTH , CRYSTAL, Minnesota, 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
F0697 SS = D	Continued from page 73 Oral Capsule - Give 300 mg by mouth two times a day for pain, dated 11/25/24, and pain monitoring every shift. R41's EMR lacked any documented evidence of pain monitoring every shift. The EMR further lacked any documented evidence of staff offering R41 non-pharmacological interventions for pain including what, if any was offered, accepted or effective to help alleviate R41's pain. R41's Pain Assessment, dated 6/23/25, indicated R41 had moderate pain over the past five days however, the section for non-medication interventions for pain was left blank. R41's Associated Clinic of Psychology note, dated 4/23/25, indicated R41 let the clinician know she was "struggling with pain" with the clinician encouraging R41 to "talk with her doctor abut pain to help mitigate." R41's care plan, dated 1/5/25, indicated R41 was at risk for pain related to previous lower extremities fractures second to motor vehicle accident. The care plan contained the following interventions, dated 7/8/24, anticipate R41's need for pain relief and respond immediately to any complaint of pain, pillows under legs when in bed, and pain meds as ordered. During observation and interview on 6/29/25 at 3:10 p.m., R41 was in visible pain and started to cry stating she struggled with pain before her car accident, in which she broke both her legs and an arm, which has exacerbated her pain, stating somedays the slightest movement is "excruciating". R41 stated she can receive 5mg of oxycodone twice a day and tells staff it is not working to control her pain but staff "look right through" her. R41 further stated she cannot sleep because of her pain and choses to sleep in her wheelchair because it is more comfortable than sleeping in bed. During an interview on 7/1/25 at 9;36 a.m., trained medication aide (TMA)-B stated she had been working at the facility for approximately two years. TMA-B stated the nursing staff ask R41's pain level when they administer her as needed oxycodone but not routinely. TMA-B also stated she had not seen any	F0697		

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F0697 SS = D	Continued from page 74 non-pharmacological pain interventions being used, stating nursing staff “just throw narcs [narcotics] at them [residents].” During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated R41 was working with the “pain doctor” for her pain but that the facility did not attempt to use non-pharmacological interventions for pain. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated she had “just recently” started putting non-pharmacological pain interventions on the treatment administration records for residents who had pain. LPN-E confirmed R41 did have pain but did not currently have staff monitoring her pain every shift and was not receiving any non-pharmacological pain interventions. A facility policy titled Pain Assessment and Management, revised 3/2020, indicated "non-pharmacological interventions maybe appropriate alone or in conjunction with medications" and include environmental (i.e. room temperature), physical (i.e. ice or heat), and cognitive or behavioral interventions (i.e. relaxation, music).	F0697		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to identify triggers or attempt to identify triggers to avoid potential re-traumatization, and failed to develop a care plan to include individualized trauma-informed approaches for 1 of 1 residents (R36) who had a history of trauma. Findings include:	F0699	The Terrace at Crystal is committed to providing trauma-informed care that recognizes and responds to residents’ past experiences and promotes a sense of safety, autonomy, and dignity. R36’s psychosocial history was reviewed and updated the care plan to include individualized, trauma-informed interventions. A full review of current residents with documented or suspected trauma histories will be conducted to ensure care plans reflect individualized trauma-informed practices. All nursing, social services, and direct care staff received education on the principles of trauma-informed care and the regulations The Social Services Director and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on individualized trauma-informed care plans are developed when indicated.	08/26/2025

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F0699 SS = D	Continued from page 75 R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). R36's diagnosis report, printed 7/2/25, included the following pertinent medical diagnoses: post-traumatic stress disorder, alcohol dependence, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, unspecified affective mood disorder, and chronic pain. During an interview on 6/29/25 at 10:40 a.m., R36 stated she had PTSD and had known triggers. R36 stated no staff at the facility had ever talked to her about her triggers or her trauma. R36 stated her triggers included when the staff started getting loud outside the room, when the staff came in and poked her to wake her up, and when staff came in and talked loudly to her. R36 stated again that no staff had ever talked to her about this before or asked her if there aware certain things that triggered her, and stated she would be willing to talk to staff about triggers. R36's care plan, printed 7/2/25, indicated resident reports a history of trauma related to experiencing an abusive husband/relationship and vulnerability of not being able to take care of herself. Interventions included to assist resident with identifying her personal strengths, observe resident for isolation and seclusion, and provide comfort and reassurance for resident. The care plan lacked identification of any triggers, or plan to help identify any triggers to help better care for resident. R36's Social Service Primary Care PTSD Screen, dated 2/21/24, indicated R36 was asked four questions on the PTSD screening and responded "yes" to all four questions, indicating they have had nightmares about it/thought about when they didn't want to, went out of their way to avoid situations that remind them of it, were constantly on guard, watchful or easily startled, and felt numb or detached from others, activities or surroundings. R36's Social Service Trauma Informed Care History, dated 2/21/24, identified the following information. R36 was able to identify the most difficult time in their life and indicated they had been through a life threatening or traumatic event. The following questions had "unknown" as a response: what helped get you	F0699	Continued from page 75 Findings will be reviewed monthly in the facility's QAPI meetings to assess effectiveness and guide further training or procedural adjustments. The Social Worker and Director of Nursing are responsible for ensuring ongoing compliance.	

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F0699 SS = D	Continued from page 76 through those difficult times, and what are some things that you do now to help you manage consequences of have gone through tough times. When asked about triggers, the answer typed in the box was "none." The electronic medical record (EMR) lacked follow-up assessments when R36 was readmitted to the facility, during quarterly, or annual assessment to help identify triggers. R36's care guide, printed 6/30/25, was reviewed and lacked evidence of any triggers or identification of possible triggers. During an interview on 6/30/25 at 5:16 p.m., nursing assistant (NA)-F stated they were familiar with R36. NA-F stated R36 did not have any mental health concerns, PTSD, or triggers, adding "nothing like that." During an interview on 7/1/25 at 9:41 a.m., trained medication aid (TMA)-A stated if a resident had a history of PTSD and had triggers it would be important to know what their triggers were to better care for them. TMA-A stated their triggers would be on the care sheets if a resident had PTSD. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and worked with her often. LPN-A stated she was unsure if R36 had PTSD, proceeded to verify she did on the diagnosis list, and stated R36 did not have any triggers. LPN-A stated that if R36 had any triggers, they would document that in a progress note. During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated she believed R36 had a diagnosis of PTSD, verified the diagnosis on R36's diagnosis list, and stated she was not aware of any triggers for R36. LPN-E stated she would think if she had any triggers, it would be on her care plan. LPN-E reviewed her care plan and stated there were no identified triggers on her care plan. LPN-E stated there was a section on the care plan for trauma informed care, but verified it did not identify triggers or plan to identify triggers to help better care for R36. LPN-E did not answer when asked about who assessed residents for triggers from PTSD. On 7/2/25 at 11:37 a.m., director of nursing (DON) stated if a resident had PTSD they needed to be assessed for triggers, and those triggers would be documented on the care plan to help better care for the resident. DON stated assessments for triggers were done	F0699		

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F0699 SS = D	Continued from page 77 upon admission, quarterly, annually, and as needed, and stated these assessments would help identify any triggers, and behaviors would also be monitored. A facility policy titled Trauma Informed Care, revised 3/19, identified "nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization."	F0699		
F0755 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 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). 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: Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in	F0755	The Terrace at Crystal remains committed to providing timely, resident-centered pharmaceutical services that support the highest level of care and safety. R10, the physician-ordered FORM medication was re-ordered and administered without adverse effects. The resident's current medication profile was reviewed to ensure all active orders are aligned with physician intent and administered as scheduled. All residents will be reviewed to confirm that physician-ordered medications were in stock and appropriately re-ordered within required timelines. All licensed nursing staff received education on procedures for monitoring medication reorder alerts and refill notifications, communication protocols with the pharmacy provider and timely follow up The facility's contracted pharmacy provider will also be contacted to review and enhance communication workflows related to medication refill alerts and early warnings for low stock or expired orders. The DON or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on medication orders, focusing on timeliness of refills and compliance with reorder protocols. Director of Nursing is responsible for ensuring timely medication management systems are fully operational and continually reviewed for quality and safety.	08/26/2025

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F0755 SS = D	Continued from page 78 administration and reduce the risk of complications for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25, and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25, and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given 6/1/25, through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25, and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered.	F0755		

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F0755 SS = D	Continued from page 79 -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone. -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress note dated 6/20/25 at 4:19 p.m.,	F0755		

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F0755 SS = D	Continued from page 80 indicated R10's provider had been contacted to request a new prescription for her 2.5 mg order of oxycodone. R10's progress note dated 6/30/25 at 9:56 a.m., indicated a call was placed to the provider to get a new prescription for her oxycodone. R10's progress note dated 6/30/25 at 11:58 a.m., indicated that a voicemail was received from the provider indicating a new prescription [did not indicate what medication] was sent to the pharmacy. R10's progress notes were reviewed dated 6/1/25 through 6/30/25, and did not indicate any further requests for oxycodone were made. R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain documented. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still didn't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated she had trouble getting a new	F0755		

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F0755 SS = D	Continued from page 81 prescription from the provider, and when she did, sometime last week, she thought the pharmacy had not accepted it due to the way the dosage was written. LPN-E stated nursing staff had used oxycodone from the emergency supply until the facility ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E confirmed she had reviewed R10's medical record and the first time she saw that a new prescription for the oxycodone had been requested from the provider was on 6/20/25, although the medication ran out on 6/19/25, and she did not see that the medication was requested from the pharmacy until 6/27/25. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would have missed fewer doses of the medication or not missed any doses at all. During an interview on 7/1/25 at 12:38 p.m., the dispensing pharmacist (DP) stated she had reviewed their records for R10 and did not see any requests for oxycodone to be dispensed until 6/28/25, including the week before 6/19/25. The DP stated they had sent a new card of medication yesterday (6/30/25), but she would have expected a request from the facility before the medication was needed as it took time to prepare the medication. During an interview on 7/2/25 at 10:00 a.m., the director of nursing (DON) stated she expected nursing staff to reorder the medication from the pharmacy when the medication card only has the far-right column left in the package, or about 8 doses. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available.	F0755		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs	F0757	The Terrace at Crystal remains committed to ensuring	08/26/2025

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F0757 SS = D	Continued from page 82 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident was free from unnecessary medication by failing to attempt to decrease a resident's nicotine patch (a known psychotropic medication) despite the consulting pharmacist's and Centers for Disease Control and Prevention's recommendations for 1 of 5 residents (R7), and failed to monitor, assess, and clarify an antibiotic without an end date for 1 of 5 residents (R25) reviewed for unnecessary medications. Findings include: R7's quarterly Minimum Data Set (MDS), dated 4/26/25, indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications.	F0757	Continued from page 82 all residents are free from unnecessary medications by promoting safe, appropriate prescribing practices and thorough medication reviews. R7 nicotine replacement therapy was reassessed. The resident's care plan was updated to ensure treatment goals align for step-down dosing. A tapering plan was implemented based on clinical appropriateness and resident preferences. R25, the antibiotic order lacking an end date was reviewed, clarified with the prescribing provider, and appropriately updated. The MAR was corrected to reflect the clarified order, including stop dates and monitoring parameters. All current residents with active orders for psychotropic medications and antibiotics were reviewed to verify clinical indication, ongoing need, presence of stop dates, dose review timelines, and supporting documentation, evidence of pharmacist review and provider communication as required Licensed nurses and unit managers received education on proper documentation and monitoring requirements for antibiotics and psychotropic medications, the importance of following pharmacist recommendations and clarifying any orders lacking duration, clinical rationale, or appropriate reassessment intervals The facility revised its protocol to require all new psychotropic and antibiotic orders to be reviewed by the nurse manager within 24 hours to confirm indication, end date (if applicable), and alignment with regulatory expectations. The Director of Nursing (DON) and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months for the next 30 days to monitor compliance with unnecessary medication reviews. Audit results will be presented during monthly QAPI meetings for trend analysis and ongoing process improvements. Director of Nursing is responsible for ensuring safe and compliant medication practices are in place and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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F0757 SS = D	Continued from page 83 R7'S electronic medical record (EMR) contained an order, dated 3/8/24, for a Nicotine Transdermal Patch 24 Hour 21 milligrams (MG) per 24 hours (Nicotine) - Apply one patch transdermal (on the skin) every 24 hours for nicotine dependence in remission. R7's most recent smoking review, dated 5/6/25, indicated that R7 was currently smoking and intended to continue to smoke. R7 was also on the facility provided list of residents who smoke. R7's care plan, dated 5/12/25, indicated R7 was a "current smoker, trying to quit, resident received Nicotine Patch each morning will sometimes refuse it." R7's monthly medication regiment reviews (MRR), dated 2/21/25, 3/24/25, 4/24/25, and 5/23/25 all indicated a pharmacist recommendation to decrease R7's nicotine patch and to discontinue it if resident was still choosing to smoke. The consultant pharmacist (CP)-A gave a rationale of nicotine being a psychotropic medication intended to help a person quit smoking by reducing nicotine dependence and manage withdrawal symptoms. CP-A further indicated the CDC advises nicotine patch doses should be lowered overtime (8-12 weeks) with a goal of stopping use of the nicotine patch completely. On the MRR dated 5/23/24, the provider had checked "agree". A handwritten note on the MRR from LPN-E, dated 5/29/25, indicated "resident [R7] refused to have patch decreased, stated that the patch keeps him from smoking, the he has not smoked in long time. Provider updated." During an interview on 6/30/25 at 5:41 p.m., trained medication aide (TMA)-C stated R7 was currently still smoking. During an interview on 6/30/25 at 5:47 p.m., trained medication aide (TMA)-D stated R7 was currently still smoking. During an interview on 7/1/25 at 8:06 a.m., R7 stated he has not smoked "in a couple of months." During an interview on 7/1/25 at 9:36 a.m., TMA-B stated she had worked at the facility for a few years and stated R7 "smoked heavily" and would still go outside to smoke daily. During an interview on 7/1/25 at 1:46 p.m., CP-A stated she had issued the recommendation to decrease R7's nicotine patch and had received a response in June from her May recommendation that the provider had agreed to	F0757		

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F0757 SS = D	Continued from page 84 decrease the dose but R7 had refused. The CP stated the intent of a nicotine patch was to assist a resident to quit smoking and was safer than smoking however, staff or R7 would not know how effective the patch was in helping R7 quit if it was not reduced, stating ideally it would be nice to reduce the dose, and ideally R7 would not be on the patch forever. CP-A further stated there were alternatives to the nicotine patch that R7 could try such as nicotine gum or lozenges to attempt to decrease R7's nicotine patch. CP-A further stated the patch should be discontinued if R7 was still smoking. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated R7 had told her he was not smoking however R7 was outside a lot, so she was unsure if R7 was still smoking or not. LPN-E stated they had tried to discontinue or reduce R7's nicotine patch but he refused and had been on the patch for a "long time" and "demanded it." LPN-E stated she had sent the provider messages that R7 was still on the nicotine patch but did not know what the provider's response was. A facility policy titled Tapering Medications and Gradual Dose Reduction, revised 4/2007, indicated attempted tapering of psychopharmacological medications shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. R25 R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R2's diagnoses included hypertension, diabetes mellitus, neurogenic bladder, aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received an antibiotic medication. R25's care plan printed 6/29/25, indicated R25 directed staff to administer antibiotic medications as ordered by physician, monitor/document side effects and effectiveness, monitor/document/report as needed adverse reactions to antibiotic therapy, and monitor/document/report as needed signs/symptoms of secondary infection related to antibiotic therapy. R25's care plan indicated R25 had legal blindness from history of traumatic brain injury. The care plan directed staff to arrange consultation with eye care practitioner as required and monitor/document/report as needed any signs/symptoms of acute eye problems.	F0757		

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F0757 SS = D	Continued from page 85 R25's current physician order, directed staff to give one drop of moxifloxacin hydrochloride (an antibiotic used to treat various bacterial infections) ophthalmic solution 0.5% (percent) in the right eye two times a day for bacterial conjunctivitis (also known as "pink eye"; inflammation or infection of the eyes) with a start date of 6/9/25. The order did not specify an end date. R25's medication and treatment administration record (MAR and TAR), progress notes, and provider, clinic, and hospital notes were reviewed from April 2025 to July 2025 and indicated: -4/20/23, staff were directed to write a progress note per shift on any behaviors, change in condition or any other matters related to R25. -4/11/25 to 6/3/25, staff were directed to assist R25 with a warm compress and gentle eye care to right eye twice a day to remove debris and drainage until resolved. -On 4/13/25 at 11:32 a.m., an order administration note indicated nursing waited for delivery for polymyxin B-Trimethoprim ophthalmic solution (an antibiotic combination used to treat bacterial infections of the eye) to instill one drop in right eye four times a day for conjunctivitis. Progress notes did not describe how the eye looked. At 11:47 a.m., an order administration note indicated the eye drop was administered with no other details about R25's eye. -4/16/25, indicated R25 was sent to the emergency department for concern of cornea injury and was unable to open eyes and had severe pain. -R25's After Visit Summary from Methodist Hospital dated 4/16/25, indicated R25 was seen for acute conjunctivitis of right eye and directed the facility to give moxifloxacin as prescribed. -4/17/25 to 4/18/25, staff were directed to apply one drop of moxifloxacin to right eye every hour while awake for seven days until 4/23/25 for conjunctivitis. -4/19/25 to 4/25/25, staff were directed to apply one drop of moxifloxacin to right eye twice a day for conjunctivitis. -5/2/25, R25 had an appointment at M Health Fairview Ophthalmology.	F0757		

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F0757 SS = D	Continued from page 86 -R25's The Terrace at Crystal – Clinical Referral dated 5/2/25, indicated R25 had a stable ocular exam from a physician. Orders listed included moxifloxacin twice a day and did not indicate an end date. A note with initials dated 5/2/25, indicated orders were already in R25's electronic health record. A second check by a nurse was dated 5/2/25. -5/6/25 to 5/18/25, staff were directed to apply one drop of moxifloxacin to right eye two times a day for central corneal opacity (a condition where the clear front part of the eye becomes cloudy or scarred and causes vision loss and a milky appearance) of the right eye. -On 5/23/25, R25 had an appointment with M Health Fairview Ophthalmology and was in the hospital on 5/23/25. -R25's Discharge Orders and paperwork dated 5/31/25, indicated R25 had bacterial keratitis (inflammation of the cornea, the clear, dome-shaped front surface of the eye) and to continue moxifloxacin. -5/31/25 to 6/2/25, staff were to apply one drop of moxifloxacin to right eye two times a day for central corneal opacity. -6/2/25 to 6/5/25, staff were directed to apply one drop of moxifloxacin to right eye two times a day for bacterial conjunctivitis. -R25's Methodist Hospital Discharge Summary dated 6/9/25, indicated R25 had keratitis of the right eye due to bacteria and exposure keratitis. The discharge summary directed staff to continue previous ophthalmologic medications, which included moxifloxacin to the right eye twice a day for bacterial conjunctivitis. The order did not include an end date. -R25's Twin Cities Physicians' provider note dated 6/26/25, indicated R25 had diagnoses of dry eyes and traumatic blindness, did not list ophthalmology on a list of specialists, and had clear eyes with no drainage. The provider note did not address R25's moxifloxacin. During observation on 6/29/25 at 10:13 a.m., R25 had a clear substance over her right eye. During observation on 6/30/25 at 5 p.m., R25's right eye color had a lighter blue hue and no redness or inflammation to the whites of her eye.	F0757		

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F0757 SS = D	Continued from page 87 During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated R25's eye looked the same and unchanged compared to previous observations, and the nurses placed drops in R25's eye. NA-A stated the nurses, nurse manager, or health unit coordinator followed up on eye appointments. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses transcribed given orders for antibiotics into the resident's electronic health record, checked resident diagnoses and allergies, and sent the order to the pharmacy. RN-A stated antibiotic orders had a frequency and duration. RN-A stated nurses should contact the provider if an end date if not given. RN-A stated they checked the resident temperature until the end of an antibiotic course. RN-A stated R25's eye was "bad" at some point and now improved. RN-A stated the facility had an infection control nurse who reviewed antibiotics and was the best person to ask about any antibiotics. During interview on 7/2/25 at 12:26 p.m., the infection preventionist (IP) stated staff monitored for side effects and effectiveness of antibiotics and looked for if symptoms resolved. The IP nurses monitored antibiotic use and infectious symptoms via progress notes until the antibiotic ended. The IP stated antibiotics should be stopped or discontinued if the provider assessed the resident and saw the resident did not need the antibiotic any longer. The IP stated the moxifloxacin order came from the hospital and would have to look at R25's paperwork to see when R25's next appointment was when asked about the lack of end date for the moxifloxacin. During interview on 7/2/25 at 1:23 p.m., nurse practitioner (NP)-A stated R25 followed an eye doctor who prescribed the moxifloxacin and directed surveyor to talk to nursing about R25's visit with the eye doctor. During interview on 7/2/25 at 1:36 p.m., medical records/health unit coordinator (HUC) stated R25 did not have another appointment scheduled for the ophthalmologist. The HUC searched through R25's medical record and was unsure if R23 went to the appointment on May 23rd, since R23 was in the hospital. The HUC called the clinic and clarified another appointment was only as needed and asked the clinic to fax the facility information from R25's last appointment. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected antibiotic orders to have a stop date or staff to update the provider to ensure if	F0757		

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F0757 SS = D	Continued from page 88 provider wanted the antibiotic continued or stopped. The DON stated residents on antibiotics should be monitored for sign and/or symptoms of infection, side effects, and medication effectiveness. The facility Antibiotic Stewardship – Orders for Antibiotics policy dated December 2016, directed antibiotic orders to include drug name, dose, frequency of administration, duration of treatment with start and stop date or number of days of therapy, route of administration, and indications for use. The policy indicated empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate, and staff and the practitioner would document the specific criteria to support the suspicion in the resident's clinical record. The policy directed the admitting nurse to review discharge and transfer paperwork for current antibiotic orders and to ensure the orders included all drug and dosing elements.	F0757		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors when a narcotic pain medication was not administered as ordered for 1 of 5 (R10) residents reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following	F0760	The Terrace at Crystal is committed to ensuring that all residents are free from significant medication errors and that medications are administered safely, accurately, and as ordered by the prescriber. For Resident #10, whose prescribed narcotic pain medication was not administered as ordered, the medication incident was promptly investigated. The attending physician notified. The MAR was reviewed, and the missed dose was documented appropriately. Audit of all residents receiving narcotic medications will be conducted to ensure that all pain medications were available in the medication cart/supply, that their MARs accurately reflected physician orders, and that the medications were administered and documented appropriately. All licensed nurses will be re-educated on the facility's medication administration policy and procedure, emphasizing the importance of administering medications as ordered, proper documentation and notification for missed or delayed doses, and timely communication with the provider and responsible party in the event of a medication error. The DON or designee will conduct random medication administration audits weekly for 4 weeks, and then monthly for 2 months focusing on residents receiving scheduled narcotic medications. Any discrepancies will be immediately addressed, and findings will be reviewed in clinical stand-up meetings and monthly QAPI.	08/26/2025

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F0760 SS = D	Continued from page 89 orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25 and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25 and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given 6/1/25 through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25 and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered. -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone.	F0760	Continued from page 89 The facility's QAPI committee will monitor for trends and ensure corrective actions are effective in preventing recurrence. Director of Nursing is responsible for ensuring compliance with safe medication practices and prevention of significant medication errors.	

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F0760 SS = D	Continued from page 90 -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain noted. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain.	F0760		

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F0760 SS = D	Continued from page 91 During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still don't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated nursing staff had used oxycodone from the emergency supply until they ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed, when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would have missed fewer doses of the medication or not missed any doses at all. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	The Terrace at Crystal is committed to ensuring medications are safely labeled and stored according to federal and state regulations to prevent errors and promote resident safety. For Resident #3, immediate corrective action was taken. The inhaled medication was returned to its original packaging, and the oral medication was relabeled with appropriate identifiers. The nurse involved received immediate re-education. A facility-wide audit was conducted on all medication carts and storage areas to ensure inhaled medications	08/26/2025

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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, Minnesota, 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
F0761 SS = D	Continued from page 92 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed inhaled medications were stored in their correct packaging to prevent potential administration error for 1 of 5 residents (R3); and failed to ensure prescribed oral medications were labeled with minimum identifiers to ensure correct administration (i.e., right patient, right medication) for 1 of 5 residents (R3) observed to received medication during the survey. Findings include: INCORRECT STORAGE: R3's Medication Administration Record (MAR), dated 7/2025, identified R3's current physician ordered medications, directions for their use, and staff spaces to record their administration or refusal. The MAR included an order for Mometasone (a steroid medication) 50 micrograms (MCG) with directions to administer 2 sprays in each nostril once daily for a respiratory infection. The MAR listed a start date for this medication as, "06/13/2025," and scheduled administration time of 8:00 a.m. On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3. LPN-B removed various oral medications from the cart while comparing them to R3's MAR which was displayed on a laptop computer on the cart. LPN-B stated R3 had a steroid inhaler (Mometasone) scheduled to be given and then removed a clear bag with a pharmacy label attached which had R3's name listed and read, "Nasal Decong Spr	F0761	Continued from page 92 were stored in their original packaging, oral medications were labeled with at least two resident identifiers, and any unlabeled or improperly stored medications were removed and replaced as necessary. All licensed nurses were re-educated on medication storage and labeling procedures, the importance of accurate labeling to prevent medication errors, and protocols for identifying and resolving discrepancies during routine checks. The Director of Nursing or designee will perform random audits three times weekly for four weeks and then monthly for two months to verify proper labeling and packaging of medications during active med passes. Any variances will result in immediate retraining and documentation of corrective action. The facility’s QAPI committee will review audit outcomes monthly, track trends, and make policy updates or additional training recommendations as needed. Director of Nursing is responsible for ongoing compliance with F-761 medication labeling and storage regulations.	

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F0761 SS = D	Continued from page 93 [spray] 0.05%," which had directions, "2 DROP IN BOTH NOSTRILS EVERY 12 HOURS AS NEEDED FOR CONGESTION." LPN-B continued to search the upper row of the medication cart before finding another clear bag with a pharmacy label attached which had R3's name listed and read, "Mometasone [steroid medication; used for asthma] Spr 50 MCG [micrograms]," with directions listed reading, "INSTILL 2 SPRAYS IN EACH NOSTRIL ONCE DAILY." However, this bag was empty with no medication or inhaler inside. LPN-B reviewed R3's MAR and verified the Mometasone was scheduled to be given; however, the inhaler wasn't in the bag. LPN-B searched the drawer and then reviewed the nasal decongestant bag. LPN-B opened the bag and expressed the Mometasone inhaler had been placed in the wrong bag. The steroid medication was placed in the nasal decongestant bag and not the correct one. LPN-B stated they were unsure how long the medication had been stored like that and, when questioned how medications could end up stored in the wrong pharmacy labeled containers, responded aloud, "Carelessness." LPN-B stated the medications should be stored in their correct pharmacy packaging so "there's no confusion." LPN-B verified trained medication aide (TMA) staff worked on the medication carts within the building, and they reiterated correct storage of the medication was necessary to reduce the risk of residents getting the wrong medications. When interviewed on 7/1/25 at 9:42 a.m., the director of nursing (DON) stated nasal medications typically come in a "little zippy bag" from the pharmacy and should be kept in them. DON stated the correct medication should be kept inside the correct bag from the pharmacy to help ensure "accurate administration" and so staff were "giving what they're supposed to be giving." DON acknowledged medications stored in the wrong bags could lead to a medication error as the two medications (i.e., nasal decongestant / Mometasone) were different medications for different purposes. On 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A was interviewed via telephone, and they explained Mometasone was a "longer acting" medication and meant more for "ongoing therapy" versus a nasal decongestant medication. CP-A stated inhalers typically arrived to the care center in a plastic bag from the pharmacy and were usually kept inside the same bags once in the medication carts. CP-A stated staff should use one inhaler at a time to ensure they're placed back into the correct bags when done. CP-A stated having the correct inhaler stored in the correct bag helped "the double checking" when doing medication administration to ensure the right medication was being given at the right time.	F0761		

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F0761 SS = D	Continued from page 94 A facility provided Medication Storage In The Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements and, " ... Medications are kept in these containers." The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." MEDICATION NOT LABELED: R3's Order Summary Report, signed 5/15/25, identified R3's physician orders along with their administration instructions. This included an order which read, "Nicotine Polacrilex Mouth/Throat Gum ... Give 4 mg [milligrams] by mouth every 1 hours as needed for withdrawal symptoms." The order had a start date recorded, "04/11/2025." On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3 who was seated in their doorway. R3 stated they wanted their nicotine gum and LPN-B expressed they would get it. LPN-B opened the medication cart and removed a white-colored package which was labeled, "Rubgy [brand name] Nicotine Gum ... Stop Smoking Aid 4 mg," and provided it to the surveyor for review. The package was commercial and there were no pharmacy labels attached to it; nor was there any written identifier(s) to demonstrate whom the medication was for (i.e., R3). LPN-B verified the package was opened with several doses removed, and it lacked any pharmacy labeling expressing aloud, "I'm not sure why her name isn't on it." LPN-B verified the medication was not considered a "stock med" and expressed they were unsure when it had been filled or sent by the pharmacy since it wasn't labeled. LPN-B stated they believed it to be R3's supply though but verified all medications, including nicotine gum, should be labeled from the pharmacy. This was important "so we know whose it is and they [residents] get the right meds." LPN-B then removed one piece of the nicotine gum and provided it to R3. Following, at 8:27 a.m., registered nurse unit manager (RN)-A approached the mobile medication cart and LPN-B asked them aloud, "Do you know why this [gum] wouldn't be labeled from the pharmacy?" RN-A stated all medications come with a pharmacy label which should remain on the box or package. RN-A stated if staff locate a medication which doesn't have a label, then the pharmacy should be contacted for instructions on how to correct it. RN-A verified nicotine gum was considered a medication and should be labeled from the	F0761		

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F0761 SS = D	Continued from page 95 pharmacy as "we want to make sure we're giving the right medication with the right patient" adding the label helps staff to ensure the medication inside the package is correct. Later, on 7/1/25 at 8:58 a.m., RN-A stated they had just contacted the dispensing pharmacy who verified the nicotine gum should be labeled adding, "Normally, yes [should be]." RN-A stated the pharmacy was unsure why the medication was not labeled, and they were going to send a "new package" out to correct the issue. RN-A stated they told the pharmacy to investigate the situation "on their end." On 7/1/25 at 9:42 a.m., the director of nursing (DON) was interviewed. DON verified nicotine gum was considered a medication since it was listed on the MAR, and they expressed the medication should come with a pharmacy label. DON stated if staff discovered a medication that was not labeled, then they should contact the pharmacy and "get the right label on it." DON stated having medications labeled with correct information was important as it was "an identifier" to help staff know they're giving the right medication to the right person. When interviewed on 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A verified nicotine gum would be considered a medication and typically would be labeled from the pharmacy with patient name and directions for administration. CP-A explained some nicotine gum brands come wrapped in a plastic film which sometimes has the label attached and, upon being removed, the label gets destroyed at the same time. CP-A verified the medicated gum should be labeled with, at minimum, the patient's name so staff know whose it was. CP-A stated if staff found a medication without a label, then they could contact the pharmacy who could help them resolve it. Further, CP-A stated it was important to ensure medications were labeled with basic information to help "make sure it's getting to the right patient" and help reduce the risk of error. A facility provided Medication Storage in the Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements. The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." An additional facility provided Medication Ordering and Receiving from Pharmacy policy, dated 5/2022, identified medications would be labeled in accordance with facility requirements and state and/or federal law. The policy outlined labels were to be permanently affixed to the	F0761		

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F0761 SS = D	Continued from page 96 outside of the prescription container and if the label didn't fit directly onto the product then it could be affixed to the outside container adding, " ... the resident's name, at least, must be maintained directly on the actual product container."	F0761		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 3 of 3 residents (R12, R8, R153) who complained about cold food at meals. This had potential to affect a total of 25 residents identified to reside on the unit where the meals were served and sample tray tested. Findings include: R12's quarterly Minimum Data Set (MDS), dated 1/18/25, identified R12 demonstrated no delusional thinking. However, the section to record R12's cognition was dashed with, "Not Assessed [See F638]." On 6/29/25 at 10:53 a.m., R12 was interviewed about his quality of life at the care center. R12 complained about the food and described it as "garbage," and "nasty." R12 stated the meals were often served cold and he wanted warm food to eat. R8's quarterly MDS, dated 6/20/25, identified R8 demonstrated no delusional thinking. On 6/29/25 at 10:23 a.m., R8 was interviewed and expressed aloud, "The food sucks." R8 explained the kitchen rarely seemed to have meat products but rather just carb-filled food items which he disliked due to having diabetes. R8 explained the food was often served cold adding this occurred, "Most of the time." R8 stated "most of the time" the meals delivered via room tray	F0804	The Terrace at Crystal is committed to ensuring all meals are served in a timely manner, at appropriate temperatures, and in a palatable form that promotes quality of life, dignity, and nutritional intake for all residents. R12, R8, and R153 were offered fresh meals and their concerns were documented and addressed. A facility-wide audit of current food service practices will be conducted. This included tray line procedures, meal delivery timing, and temperature holding techniques from kitchen to point-of-service. Hot and cold holding equipment were inspected to ensure proper functioning. Dietary and nursing staff received education on the importance of timely meal delivery to maintain temperature and palatability Thermometers were calibrated, and a standardized Meal Temperature Monitoring Log was implemented. The Dining Services Manager and/or designee will conduct audits 1x per week for 2 months, then monthly for 2 months ensuring trays meet temperature and presentation standards. QAPI will review food quality and resident satisfaction during monthly meetings. Trends and corrective actions will be monitored and documented. The Administrator and Dining Services Manager are responsible for maintaining ongoing compliance with F-804 food service and palatability standards.	08/26/2025

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F0804 SS = E	Continued from page 97 were often served cold and the aides rarely would heat it up even if asked adding, "The aides don't do [expletive] here." R8 reiterated his displeasure with the meal service and stated, "This place just sucks." R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25, but a cognitive assessment had not yet been completed. During an interview on 6/29/25 at 8:50 a.m., R153 stated the food was "garbage," tasted like "dog food," and was always "freezing cold" when it should be hot. On 6/29/25, the following observations and interviews occurred: -At 11:52 a.m., cook (CK)-A stated they already temped the food for lunch. CK-A stated the temped the pork loin which was above 170 degrees Fahrenheit and did not need to temp the cabbage, potatoes, or other items. CK-A was unsure of where to write down the food temperatures. Dietary aide (DA)-C stated the food carts were already brought upstairs for service. DA-A was still in the kitchen collecting serving items with food in pans and covered on their cart. -At 12:03 p.m., DA-A stated they went to the second floor as soon as possible to turn on the steam table and ensure serving items were stocked. DA-A started to scoop food onto plates and serve to residents in the dining area. DA-A was not observed to temp the food before service. -At 12:42 p.m., some room trays were set up and plated on the cart and others were not. DA-A was not in the dining area. -At 12:47 p.m., DA-A returned to the dining area with a sandwich. -At 12:55 p.m., DA-A stated they plated up the last room tray. A test tray was requested, plated, and placed on the cart. Some room trays were already brought to rooms and other rooms trays were still on the cart. -At 12:59 p.m., there were still room trays on the cart and DA-A went to the kitchen on the first floor to bring up a resident's alternative meal option. -At 1:02 p.m., DA-A plated a meal for a new resident. -At 1:05 p.m., the test tray was taken for another resident.	F0804		

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F0804 SS = E	Continued from page 98 -At 1:09 p.m., DA-A stated the last tray on the cart could be used as a test tray instead of the initial one which was taken for a resident. The director of nursing (DON) sampled the pork loin, potatoes, and cabbage. The DON stated the pork loin and cabbage could be a "little warmer". During interview on 6/29/25 at 1:31 p.m., DA-A stated they heard about complaints of cold food. DA-A stated they asked others about temping food once on the steam trays and were told they did not need to temp the food. During interview on 7/1/25 at 2:20 p.m., CK-C stated they temped all the food to ensure the food was hot or cold and had a temperature log they filled in. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to temp and track all food and temp again after placed in the steam tables. CD stated temping food was important to ensure food was cooked appropriately and prevent food poisoning. During follow-up interview on 7/2/25 at 10:22 a.m., CD reviewed the temperature log and verified the pork loin and cabbage were not items listed as temped on 6/29/25 for lunch. CD expected food to be served at appropriate temperatures to avoid bacteria growth, and residents liked hot food. The facility Food: Quality and Palatability policy dated 2/2023, indicated food would be palatable, attractive, and served at a safe and appetizing temperature. The facility Time and Temperature Control and Recording policy undated, directed staff to record final cooking temperatures on the Cooking Temperature Log and check good temperatures when food was placed in steam table or hot holding unit and at least every two hours thereafter.	F0804		
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by:	F0805	The Terrace at Crystal is committed to providing all residents with diets that meet their individual nutritional needs and physician-ordered dietary texture requirements to ensure safety, adequate nutrition, and quality of life. R35's diet order was reviewed and corrected with dietary staff to ensure compliance. A facility-wide audit was conducted to review all residents with texture-modified diets to verify orders were accurately followed and residents received	08/26/2025

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F0805 SS = D	Continued from page 99 Based on observation, interview, and document review, the facility failed to provide the ordered diet texture for 1 of 2 residents (R35) reviewed for dietary texture. Findings include: R35's annual Minimum Data Set (MDS) dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. R35's Terrace at Crystal Rehabilitation Screen/Update dated 9/11/24, indicated R35 was evaluated by a speech language pathologist (SLP) to assess possibility of upgrading diet texture. SLP reported R35 was unsafe to upgrade diet and remained on a dysphagia puree diet plan. During observation on 6/29/25 at 12:03 p.m., dietary aide (DA)-A scooped food onto plates from the steam table and brought meals to the residents seated in the dining area. During observation and interview on 6/29/25 at 12:17 p.m., nursing assistant (NA)-E stated R35 could not eat "this". R35 was seated at a dining room table and had a full piece of uneaten pork loin on her plate. NA-E stated R35 was not able to chew the pork loin. R35's pork loin was replaced with minced meat with gravy over the meat. The staff returned to assisting other residents, and R35 ate independently with no difficulties. R35's meal ticket next to her plate indicated R35 had a regular diet and pureed texture. During interview on 6/29/25 at 12:51 p.m., DA-A stated they did not have pureed pork today and confirmed they served mechanical cut-up pork and no pureed pork, which included R35.	F0805	Continued from page 99 appropriate food consistencies as ordered by the care plan and physician. The Dietary Manager reviewed and revised policies and procedures related to diet texture preparation, verification, and delivery to reinforce compliance with physician orders. Dietary and nursing staff will receive education on the importance of following diet texture orders, proper communication protocols and the verification processes before meal delivery to confirm diet texture compliance. Audits will be conducted 1x per week for 2 months, then monthly for 2 months requiring modified diet textures for three months. Audit results will be reviewed in monthly QAPI meetings to identify trends and the need for further training. The Dietary Manager and DON/designee are responsible for oversight and compliance with dietary texture orders and related care planning.	

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F0805 SS = D	Continued from page 100 During interview on 6/29/25 at 1:31 p.m., DA-A stated they served resident meals according to their meal tickets, which indicated what diet and texture of food the resident was ordered. DA-A stated sometimes they were not given pureed food to serve and only ground food. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's diet but would reference the meal ticket. NA-A stated they would tell a server if they noticed a resident was not served the correct diet. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets listed diet texture, allergies, and preferences. RN-A stated it was important to follow diet orders to prevent choking for residents with dysphagia. During interview on 7/1/25 at 2:20 p.m., cook (CK)-C stated managers explained to the cooks the diet and textures they needed to prepare for the residents. CK-C stated they had a spreadsheet which described which diets residents were on. When asked to see the spreadsheet, CK-C showed a book with dietary updates related to new residents or changes in diets. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to serve residents the correct texture of food according to the meal tickets. CD stated food could be a choking hazard for a resident if not served the correct texture. During interview on 7/1/25 at 2:57 p.m., the culinary district manager (CDM) expected pureed food to be pudding consistency and not lumpy or too runny. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to follow diet orders. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident.	F0805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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F0805 F0806 SS=D SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food allergens and/or preferences were followed for 3 of 4 residents (R258, R35, and R37) reviewed for food allergens/preferences. Findings include: R258 R258's quarterly minimum data set (MDS), dated 6/25/25, indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. R258's face sheet, printed 7/2/25, indicated R258 had several allergies including cornstarch, gluten, and soybean Oil. R258's care plan, dated 6/19/25, indicated "resident [R258] has reported food intolerances that cause abdominal pain (corn starch, dairy (butter, American Cheese & Hard Cheeses ok), egg whites (ok if cooked into things), gluten, soy, soybean oil." The care plan contained an intervention, dated 2/10/25, that directed staff to not serve "corn starch, dairy (butter, American Cheese & Hard Cheeses are ok per Debra), egg white (ok if cooked into something), gluten, soy, or soybean oil" unless requested. R258's meal ticket, used by the kitchen staff to	F0805 F0806	The Terrace at Crystal is committed to ensuring that all residents' food allergens and dietary preferences are respected and followed to promote safety, satisfaction, and overall well-being. R258, R35, and R37, dietary orders were reviewed and updated, and affected residents were provided with meals that met their specific allergen restrictions and preferences. A facility-wide audit was conducted to review all residents with documented food allergies and preferences. The Dietary Manager reviewed the facility policy on food allergen management and resident preference documentation to ensure clear procedures are in place for communication and compliance. Education was provided to dietary staff, nursing staff, and IDT on the importance of accurately identifying and adhering to resident food allergens and preferences and communication and verification protocols to prevent allergen exposure and ensure resident satisfaction. Audits will be conducted 1x per week for 2 months, then monthly for 2 months of 10% of residents with food allergens and preferences for three months. Audit findings will be reviewed at monthly QAPI meetings to identify trends and determine if additional training or process improvements are needed. The Dietary Manager and DON/designee are responsible for oversight and ensuring compliance with food allergen and preference protocols.	08/26/2025

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F0806 SS = D	Continued from page 102 communicate allergies, preference, and diet type, also indicated R258's allergy/preference to not have foods cooked in soybean oil. During observation and interview on 6/29/25 at 10:14 a.m., R258 was in her room, lying in bed with her breakfast tray on the overbed table. On the tray were what appeared to be two, untouched fried eggs. R258 stated the food at the facility was "a joke" and that she had allergies that were still served to her, including gluten and soybean oil. R258 stated the eggs were "the worst" and always cooked in soybean oil and "sometimes you lift them [the eggs] up and they are just greasy with oil." R258 stated if she eats things cooked in soybean oil it causes her to have extreme upset stomach and that if she didn't buy her own food, she "would not get enough to eat." R258 confirmed the dietary manager was aware. During an interview on 6/29/25 at 3:08 p.m., cook (CK)-A stated they use an Arrezzio 90/10 Vegetable and Olive Pomace Oil Blend. The oil blend contains 90% soybean oil and 10% olive oil. During observation on 07/01/25 at 8:51 a.m., an Arrezzio oil container was sitting next to cracked eggs in the kitchen. During an interview on 7/1/25 at 2:20 p.m., (CK)-C stated they used the Arrezzio oil for cooking and did not know of any residents who needed a different kind of oil. CK-C stated they used the oil for frying eggs, deep frying foods, and chicken breasts. CK-C stated they used butter for frying eggs at times, to grease pans, and to make cookies. During interview on 7/2/25 at 7:23 a.m., CK-B stated they used the Arrezzio oil for food like eggs unless a resident specifically stated they wanted their eggs fried with butter. CK-B stated there were two residents who requested butter instead of oil for cooking but one of those residents passed away and the other resident did not reside in the facility anymore. CK-B stated they were not aware of any current residents for whom they should avoid cooking with the oil. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated they knew of one resident, R258,	F0806		

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F0806 SS = D	Continued from page 103 who could not have soybean oil and expected staff to cook her meat and steam eggs without the soybean oil. R35 R35's annual Minimum Data Set (MDS) dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. The care plan indicated eggs caused R35 to have an upset stomach unless the eggs were cooked into food. The care plan indicated R35's preference to avoid strawberries and nuts, and R35 liked fish patties with tartar sauce, chicken, turkey porkchops, and applesauce. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. During observation and interview on 7/1/25 at 8:32 a.m., R35 sat at a dining room table and ate breakfast. Dietary aide (DA)-E stated R35's plate had pureed biscuit, pureed scrambled eggs, and oatmeal. The meal ticket next to R35 indicated "Allergies: *Strawberry Allergen*, Egg Yolk, Treenuts, Soy/Soybean Oil, *Peanut Allergen*". The meal ticket indicated "No eggs at breakfast" under the listed allergies and "NO EGGS" under the listed breakfast items. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's allergies but would reference the meal ticket. NA-A stated they would change a resident's plate if they noticed a resident was not served the correct meal. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets listed diet texture, allergies, and preferences. During interview on 7/2/25 at 10:22 a.m., the culinary director (CD) expected staff to follow residents' meal tickets and should not plate items listed as an allergy for a resident since staff may not know if the food	F0806		

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F0806 SS = D	Continued from page 104 item was an allergy or preference. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to not serve food listed as an allergy to residents for safety reasons. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. R37 R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care and was independent with eating after set-up assistance. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood. R37 stated the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated he did not eat it, but it happened again just a few days ago. R37 stated he had followed up with the social worker when this happened as it continued to happen. R37's allergy list, printed 7/2/25, lacked identification of allergy to shellfish, seafood, or fish. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: -Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions:	F0806		

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F0806 SS = D	Continued from page 105 -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions." R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences.	F0806		

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F0806 SS = D	Continued from page 106 R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." Grievance log for June 2025 indicated a grievance was filed by R37 on 6/24/25 regarding food concerns. On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants use the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they are familiar with R37 and work with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic to. CDM stated that he encouraged residents and staff to fill out grievances as this was a great way to track concerns. CDM reported R37 should not receive any sort of seafood or fish products as it was documented that he has an allergy to seafood, shellfish and fish. During an interview on 7/02/25 at 8:06 a.m., licensed social worker (LSW)-A stated she had met with R37 on 6/24/25 regarding concerns with R37's supper on 6/24/25. LSW-A stated R37 was served shrimp for dinner and verified R37 had an allergy to shellfish and should not have been served shrimp due to his allergy. LSW-A stated she had seen his dinner plate, reviewed his meal ticket, and he had not received the food that was on the meal ticket. LSW-A stated she filled out a grievance form regarding this and notified the administrator and director of nursing. LSW-A stated the	F0806		

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F0806 SS = D	Continued from page 107 grievance form was given to the dietary manager to address. LSW-A stated dinner was purchased for R37 on 6/24/25 as the kitchen was closed when R37 had come to talk to her about the meal that was given to him. During an interview on 7/02/25 at 8:20 a.m., culinary director (CD) stated she had received a grievance regarding R37 receiving a shrimp dinner on 6/24/25, which he should not have received. CD stated she followed up with R37 and staff involved. CD stated staff are to follow the meal tickets and verified in this instance they did not. R37 was to get the alternative meal, due to shellfish allergy, and R37 was served shrimp. CD stated she has provided education to dietary staff regarding the importance of following meal tickets upon receiving the grievance form. CD stated R37 has an allergy to shellfish, seafood and fish and when asked what type of allergy stated, "probably his throat swells up, probably would need an epi-pen or something." CD verified the allergy was listed on the meal ticket. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated that residents' food allergies should be listed under resident's allergies. DON verified R37's food allergies were not listed in his allergy list. The facility Food Allergies and Intolerances policy dated August 2017, directed staff to ensure residents with food intolerances and allergies were offered appropriate substitutions for foods they cannot eat. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident. The facility Dining and Food Preferences policy dated 10/2022, indicated individual tray assembly tickets identified all food items appropriate for the resident based on diet order, allergies & intolerances, and preferences.	F0806		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.	F0808	It is Terrace at Crystal's policy to ensure that therapeutic diets are prescribed by the attending physician or delegated licensed/registered dietitian, accurately ordered, implemented, and monitored to meet the specific medical and nutritional needs of each resident. R36's dietary orders were immediately updated to reflect the hospital discharge instructions for a	08/26/2025

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F0808 SS = D	Continued from page 108 §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a therapeutic diet was ordered upon return to facility per orders on hospital discharge for 1 of 1 residents (R36) reviewed for therapeutic diets. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). R36's progress note dated 4/16/25 at 5:21 p.m., indicated resident was readmitted from the hospital and had new and changed orders and to see the facility electronic medical record (EMR). R36's Hospital Discharge Summary, dated 4/16/25, indicated R36 required a consistent carbohydrate diet. During an interview on 6/29/25 at 10:37 a.m., R36 stated she was diabetic and when asked about the facility food, R36 stated "I know it is not diabetic friendly." R36 stated "I want to eat better so I don't have so many problems." R36's order summary, dated 6/30/25, indicated R36 was on a regular diet, regular texture with liquids with a start date of 4/18/25 (2 days after hospital discharge). Review of R36's paper chart or EMR did not contain an order for a regular diet. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36. LPN-A stated when a resident came back from the hospital or admitted to the facility the floor nurse entered all the orders, including diet orders, and a second nurse verified all the orders. LPN-A verified R36 was diabetic, required insulin to manage blood sugar, and stated R36 was "all over with her blood	F0808	Continued from page 108 consistent carbohydrate diet, and the resident's meal plan was adjusted accordingly. The resident and/or their representative were informed of the correction. A comprehensive audit was conducted for all current residents, regardless of admission date, and for all residents to verify that therapeutic diet orders were accurately obtained, entered into the EMR, and implemented upon admission or readmission. Missing or incorrect orders were corrected immediately. The facility's policy titled "Therapeutic Diets" was reviewed and revised as necessary. Nursing, dietary, and interdisciplinary team members received re-education on policy, emphasizing the importance of reviewing hospital discharge paperwork, verifying diet orders, and timely entry into the EMR. Licensed nurses were educated on the requirement that all therapeutic diet orders must be entered and verified prior to meal service, with any discrepancies immediately clarified with the provider. The DON/designee will audit all current residents' diet orders to ensure accuracy, followed by ongoing audits of all new admissions and readmissions from the hospital 1x per week for 2 months, then monthly for 2 months. Results of audits will be presented during monthly QAPI meetings to assess compliance, identify trends, and determine if additional corrective actions or staff education are required. The Dietary Manager and DON and/or designee are responsible for oversight of therapeutic diet accuracy and compliance.	

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F0808 SS = D	Continued from page 109 sugars." LPN-A stated R36 was on a regular diet and not a diabetic diet. On 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated R36 was on a regular diet and as far as they were aware was not on a diabetic diet. LPN-E reviewed R36's EMR and verified she had many high blood sugars over 400 mg/dL (milligrams per deciliter) in June. During a follow up interview with LPN-E on 7/2/25 at 8:46 a.m., LPN-E verified the hospital discharge paperwork dated 4/16/25 included an order for a consistent carbohydrate diet, and R36 did not have any diet entered into the EMR when she returned from the hospital on 4/16/25 until a regular diet order was entered on 4/18/25. LPN-E was not able to find an order for a regular diet in the EMR. During an interview on 7/2/25 at 11:49 a.m., director of nursing (DON) stated the expectation when a resident admitted or readmitted to the facility was the orders were entered into the EMR, including diet orders, and then checked by another nurse. DON stated the unit managers should also be looking over all the orders to ensure accuracy. DON was unable to locate an order for a regular diet for R36. On 7/2/25 at 12:56 p.m., LPN-E stated they did not have an order for a regular diet for R36, and R36 should have been ordered the diabetic diet. LPN-E stated they followed up with the provider regarding this and the provider was going to put an order in for a consistent carbohydrate diet. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated the facility spoke with her today upon her arrival to the facility about a diet order for R36. NP-A stated she was going to put an order in for a low carbohydrate diet for R36. NP-A stated, "if she is compliant with the diet, it should help with her blood sugars." A facility policy titled Therapeutic Diets, revised 10/22, indicated a licensed nurse accepts the diet order form the authorized prescriber.	F0808		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	The Terrace at Crystal is committed to maintaining the highest standards of food safety and sanitation to protect all residents from foodborne illness and contamination. Identified areas were immediately corrected including	08/26/2025

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The Terrace at Crystal LLC	3245 VERA CRUZ AVENUE NORTH , CRYSTAL, Minnesota, 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
F0812 SS = F	Continued from page 110 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure opened dairy products (i.e., milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. In addition, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to These findings had potential to affect all 51 residents within the care center. Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, "How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?]," dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on	F0812	Continued from page 110 improving food storage, handling, and preparation, including proper dating of food and milk, refrigerator temperature monitoring, hair covering usage, and dish sanitation per policy. A complete cleaning and reorganization of all food storage and preparation areas were conducted. A comprehensive audit of food safety practices, including storage, labeling, refrigerator/freezer temperatures, hair covering compliance, and dish sanitation processes, was conducted across all units affecting all 59 residents. Any non-compliant items or practices were corrected, and appropriate documentation was updated. The facility's policies titled "Labeling and Dating," "Refrigerator and Freezer Temperature Monitoring," "Hair Restraint Use in Food Service," and "Dishwashing and Sanitation" were reviewed and revised as necessary. All dietary and relevant staff received education on proper food handling, labeling and dating, refrigerator temperature monitoring, hair covering requirements, and dish sanitation procedures, with return demonstrations to verify competency. Audits on food safety, including labeling and dating of all consumables, refrigerator and freezer temperature logs, hair covering use, and dish sanitation practices, will be conducted once per week for two months, then monthly for two months. Audit results will be reviewed during monthly QAPI meetings to assess compliance, address deficiencies, and determine if additional interventions or education are necessary. The Dietary Manager, Maintenance Director, and DON share responsibility for oversight of food safety, storage, and sanitation compliance.	

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F0812 SS = F	Continued from page 111 the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, "06-19-25 [10 days prior]." The milk container had a commercial stamp along the collar which outlined a 'best by' date of, "06/29/25." DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used "three days" after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, "I don't know." On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, "06-25-25 [five days prior]." DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been "rubbed off" by them just before they brought the cart up. DA-B stated the black writing read "6/9" before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, "I'm not sure." DA-B verified the milk was intended to be used for the supper meal service that evening. Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed.	F0812		

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F0812 SS = F	Continued from page 112 They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to "the number of diseases that come with it [using milk beyond that range]," adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart. On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, "Refrigerator Temperature Log," which was dated, "June 2025." The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, "06-24-25." However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, "I don't check this." DA-A verified the milk was beyond the 'best by' date and was not dated when	F0812		

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F0812 SS = F	Continued from page 113 opened, and they expressed there was enough milk in the container to serve "seven or eight" people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was "a resident fridge" used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated "the kitchen, not us" was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, "05/23/25," and "Gravy." The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, "I think it's gravy." NA-D verified the condition of the food product and dates on the tinfoil. One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, "Yea," when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, "Obviously no one was doing it." LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked "disgusting." LPN-B stated many of the food items in	F0812		

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F0812 SS = F	Continued from page 114 the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, "So things like that [surveyor findings] don't happen." On 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more "daily oversight" of tasks like that to ensure they get done. CDM explained there was a "monthly routine" to check the unit refrigerators for food dates and expirations but added, "Some people can be forgetful." CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, "Especially with the vulnerable base we have." On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, "The nursing staff will discard perishable foods on or before the 'use by' date," adding further, "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor ...)."	F0812		

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F0812 SS = F	Continued from page 115 INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished	F0812		

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F0812 SS = F	Continued from page 116 up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and "use by" date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung.	F0812		
F0880 SS = D	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.	F0880	It is the policy of The Terrace at Crystal to maintain strict adherence to current infection control standards to protect residents, staff, and visitors from infectious diseases and promote a safe care environment. For Resident #153, personal care practices were reviewed to ensure adherence to current infection control standards. Immediate corrective action was taken, including individual coaching and re-education of the involved staff on proper hand hygiene, use of	08/26/2025

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F0880 SS = D	Continued from page 117 §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 §483.71 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 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	F0880	Continued from page 117 personal protective equipment (PPE), and safe resident care techniques. Infection prevention measures were reinforced to support continued compliance with facility protocols. Residents residing in the facility have the potential to be affected by this practice. A facility-wide audit of personal care and infection control practices was conducted across all resident care areas to identify any other potential breaches. Any issues found were immediately corrected and documented. The “Handwashing/Hand Hygiene policy” was reviewed and revised as necessary. The policy reviews current infection control guidelines and standards of practice required procedures for resident personal care to minimize infection risks and staff responsibilities for compliance with infection prevention protocols. All nursing and direct care staff received comprehensive training and retraining on infection control best practices, including hand hygiene, PPE use, and environmental cleaning. Weekly observational audits of infection control compliance during personal care activities for 4 weeks and monthly for 2 months or until full compliance Audit findings and staff compliance reports during will be reviewed during monthly QAPI meetings. The Infection Control nurse and/or designee are responsible for compliance.	

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F0880 SS = D	Continued from page 118 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: Based on observation, interview, and document review, the facility failed to ensure current infection control standards of practice were followed when performing resident personal care for 1 of 4 residents (R153) observed for personal care. Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's Medical Diagnosis list dated 6/23/25, indicated R153 was diagnosed with diabetes, a stroke, and heart disease. R153's care plan dated 6/30/25, indicated R153 required the assistance of one to two staff members for bed mobility and dressing, and the assistance of two staff members for toileting and transferring. During an observation on 7/1/25 at 8:27 a.m., R153 was observed lying in bed. Nursing assistant (NA)-I and NA-J were observed assisting R153 with personal care. NA-I, with gloved hands, was observed to assist R153 with perineal care while R153 was lying on his back. NA-J was observed to assist the resident in rolling towards her, while NA-I completed perineal care on the backside. NA-I was observed, still with gloved hands, to assist the resident to apply a new pad and put on shorts. Then both aides assisted R153 to sit on the edge of the bed. NA-J was observed to position a motorized stand aide while NA-I, with gloved hands, assisted the resident to position his hand and feet on	F0880		

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F0880 SS = D	Continued from page 119 the machine. NA-J was observed to complete hand hygiene and then leave the room. NA-I with gloved hands, assisted R153 to position himself in the wheelchair and readjust his glasses. NA-I took off his gloves, gathered the trash, and left the room. NA-I was not observed to complete hand hygiene during this observation or to change gloves. During an interview on 7/1/25 at 8:50 a.m., NA-I stated he had completed hand hygiene and applied gloves before entering R153's room, taken off his gloves before leaving the room, and then, after he had thrown away the trash, he completed hand hygiene. NA-I confirmed he had otherwise not completed hand hygiene while completing R153's care. NA-I stated he was taught to complete hand hygiene before and after care but had not been told that he also needed to complete hand hygiene during care. During an interview on 7/2/25 at 9:58 a.m., the director of nursing (DON) stated staff were expected to complete hand hygiene before applying gloves, when changing gloves, after glove use, and after a task like perineal care to prevent "cross-contamination". The facility Handwashing/Hand Hygiene policy dated 8/19, indicated staff were to complete hand hygiene before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, and after removing gloves.	F0880		
F0921 SS = F	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: During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair which had the potential to affect all 51 residents, staff, and visitors of the facility. In addition, the facility failed to ensure the dish machine in the main kitchen was kept in a clean and sanitary manner and free of debris.	F0921	Facility Response F-921 It is the policy of The Terrace at Crystal to maintain a clean, sanitary, and safe environment for all residents, staff, and visitors. Areas of concern, including the dish machine, dusty fans, and marked walls, were cleaned or addressed. Staff were reminded of expectations for maintaining cleanliness and safe surroundings. A review of all resident-accessible areas was initiated to identify similar concerns. The facility's sanitation and maintenance procedures were reviewed for expectations related to cleanliness and timely repairs.	08/26/2025

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F0921 SS = F	Continued from page 120 Findings include: Walls: During observation of R15 on 6/29/25 at 10:24 a.m., R15 in resident room on second floor sitting in hospital gown with brown substance streaked on the floor. During observation and interview with R31 on 6/29/25 at 10:35 a.m., R31 stated she was disappointed in her facility stay in part due to the "environment is dirty" pointing to ceiling in her room with yellowing stain on it and a gash in the wall with brown drip stains down the wall. During observation and interview with R12 on 6/29/25 at 10:52 a.m., R12 lying in bed which was horizontally against the wall. Wall had numerous black marks along it with a yellow-colored stained area that extended on the wall for approximately half the length of his bed. R12 stated he was unhappy with the condition of the walls and would "like it addressed". R12 stated "this whole place is f***ed up" and that the facility had done nothing about it. During interview with R24 on 6/29/25 at 1:48 p.m., R24 stated "cleanliness of the place [sic] run down" R24 stated "this place is a pit". During observation and interview on the second-floor secured memory care unit in the dining room on 6/30/25 at 2:07 p.m., a baseboard in east corner of room had broken wallboard above it. Portions of the baseboard was not attached to wall due to the hole in the area. The area was approximately 18 inches long. Blue laminate edging was missing from portion of nursing desk facing the hallway. Portion was 8 inches that spanned the corner of the nursing station desk. Knee wall attached to nursing station and wall across from the nursing station had numerous scrapes and missing pain including peeling. In the dining room above chair rail in corner of it there was white corner piece that did not match color of remaining wall. The corners that came together were pulling apart showing half an inches of empty space for eighteen inches. Area also had beige staining around it. Both dining room wall frames had peeling, stained, and chipped paint on both sides. Nursing assistant (NA)-A was seated at a dining room table with resident who was in a wheelchair. Two other	F0921	Continued from page 120 Staff in maintenance, housekeeping, and dietary departments received reeducation on August 8, 2025, regarding cleaning routines and reporting procedures for sanitation or repair concerns. Ongoing monitoring began August 4, 2025, with weekly inspections for 8 weeks, then monthly for 2 months. Issues noted will be tracked and discussed in QAPI meetings to guide further action as needed. Routine maintenance tasks are scheduled to be addressed at regular intervals consistent with the facility’s preventive maintenance plan. Larger repairs requiring vendors or additional resources will be reviewed and planned collectively during QAPI meetings. Oversight will be provided by the Maintenance Director and Administrator.	

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F0921 SS = F	Continued from page 121 residents were in the room at the time. NA-A stated expectation of staff to report any maintenance issues to the MT-D. NA-A stated she would tell the nurse who would then fill out a work order on the computer or verbally tell MT-D of any concerns. NA-A looked around and stated, "[It] looks like [sic] needs to be repainted. Not looking good." During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:19 p.m., TMA-A stated, "need to be fixed or done painting or repairing." TMA-A stated expectation of staff to notify maintenance of work order request for MD-T to address concerns with "painting and repairing". TMA-A observed hole in the wall in dining room above the baseboard and stated, "Oh wow. Needs to be repaired." During observation and interview with director of nursing (DON) on 6/30/25 at 2:34 p.m., on the second-floor secured memory care unit pointing to the walls, baseboards, and door frames of resident rooms and also the two entrances to the dining room. DON stated, "Needs repair. The door frames need to be repaired and replaced." DON stated, "I would not like that at my home. DON stated expectation of staff to fill out a work order and submit it electronically or notify MD-T verbally. DON stated she had worked at facility for over two years and did not see any wall repairs or replacing of baseboards or painting of door frames during that time. During observation and interview with MD-T on 6/30/25 at 3:02 p.m., MD-T observed 2nd floor resident door frames, memory care security doors, baseboards, chipped, broken wallboards and stained ceiling tiles and walls and stated, "It is not homelike. I would not like it in my home. We need to replace all of the baseboards and repaint the walls. The doors are really chipped and need to be repainted." MT-D stated expectation of staff to submit work orders or notify him of repair needs verbally. "I have been working on them but was not aware of some of the issues. There is a lot." During observation on 6/30/25 at 5:08 p.m., in the 3rd floor dining room, two residents were eating supper at dining room table while television was on. Baseboards of dining room were beige in color with black markings all along them horizontally. Three rooms at end of hall	F0921		

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F0921 SS = F	Continued from page 122 had black markings along the walls, door frames to the dining room were chipped with stains and missing paint. All resident room door frames were chipped and missing paint. Walls with chair rails had wallpaper peeling or marked with nail holes visibly covered with white wallboard repair, sanded to reveal the nail heads resulting in white repair marks but nothing finished. Painted walls had visible nail holes which were never painted over to match. Section of cracked broken wallboard was visible outside two resident rooms ranging thirty inches horizontally above the baseboard. Broken wallboard that appears to be punched in running two feet above the baseboard outside a resident room. During observation and interview with MD-T on 7/1/25 at 8:24 a.m., on third floor outside resident room there was a horizontal broken portion of wall board above the baseboard which measured thirty inches. A small black winged insect was observed to fly in and out of the crack. MD-T stated, "yeah that looks like it needs to be repaired or replaced". During interview with R7 on 7/1/25 at 8:26 a.m., R7 stated his third-floor resident room, "I hate the way the walls and doors look here. It is junky and gross. Looks like they don't care about how it all looks (pointing out into the hallway)." During review of documents titled completed and active Work Orders with dates "May. 1, 2025 -Jul. 1, 2025" failed to identify maintenance concerns regarding condition of walls, floors, and door frames. During interview with facility's administrator on 7/1/25 at 10:31 a.m., the administrator stated he was aware of "these concerns. But there is no formalized plan written down or discussed to address these issues." The administrator stated condition of walls, floors and door frames "are not appealing". FANS: During observation on second floor on 6/30/25 at 2:01 p.m., a large circular floor fan was operating blowing air towards the elevator and nursing station from the lounge room. It had visible dust on the front and back shrouds while operating. Staff and residents were working and ambulating and wheeling selves past the fan.	F0921		

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F0921 SS = F	Continued from page 123 During observation on second floor secured memory care unit on 6/30/25 at 2:15 p.m., a circular fan operating from on the top of the counter of the nursing station. Visible dust and dark matter were noted on the front and back shroud of fan along with the blades of the fan. A female resident was seated next to the fan and another male resident was being transported in a wheelchair past the blowing fan by a staff member. During interview with trained medication aide (TMA)-A on 6/30/25 at 2:19 p.m., TMA-A pointed to the operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "I put it there". TMA-A stated the fan had been "on all day" and "it does need to be cleaned. The cover on the front and back are filthy. ..This is a lot of dirt blowing around." During observation and interview with director of nursing (DON) on 6/30/25 at 2:42 p.m., DON looked at the circular fan operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "It is an issue with infection control. Blowing dirty air throughout the unit. Needs to be cleaned." During observation and interview with maintenance director (MT)-D on 7/1/25 at 8:50 a.m., MT-D was wiping the shroud of a large circular floor fan in the lounge of second floor main area. MD stated, "I need to wipe it to get the dust out of it on the inside and outside of the fan." MD-T stated facility had no "specific" cleaning schedule for facility used fans. "I just do it quarterly". During observation and interview with dietary manager (D-M) on 7/1/25 at 10:10 a.m., a large circular portable fan was circulating air towards the dishwashing area of kitchen. The area had a large stainless-steel counter along one wall that contained used meal trays, utensils and kitchen pots and pans. The counter curved in the corner of the room to meet the dishwasher unit and clean dishes exited. The fan blew air from dirty portion of the counter to the clean portion where the dishes exited. D-M stated, "The dirty dishes are rinsed here (pointing to the beginning of the counter) and then they are rinsed and moved down the counter towards the dishwashing machine". D-M	F0921		

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F0921 SS = F	Continued from page 124 pointed to the circular portable fan and stated, "It should be getting wiped down. Does not look like it has been wiped because there is dust on the front cover while it is blowing towards the dishwashing area". During observation and interview on first floor hallway outside dining room on 7/1/25 at 11:08 a.m., a large circular floor fan was circulating air from the resident hallway towards the dining room. Visible dust was observed on the shroud. At 11:11 a.m., registered nurse health care consultant (HC) observed fan and stated, "needs to be wiped down. There is dust blowing across the hall onto residents and staff making it an infection control issue. We notice the dusty fans here yesterday and this fan was not cleaned or wiped down." During observation and interview on 7/1/25 at 8:33 a.m., MT-D wiping visible dust from shroud of large circular floor fan outside elevator on third floor. MT-D stated the fan had been in use for "weeks" blowing air towards the nursing station, elevator and resident rooms. During interview with administrator and regional director (MD) on 7/1/25 at 2:24 p.m., MD stated, "All fans should be cleaned". Facility policy on homelike environment was requested and not received. Dishmachine During initial tour of the kitchen on 6/29/25 at 8:17 a.m., several orangish blackish substances were observed on top of the dish machine. Dietary aide (DA)-D stated dishes which came through the dish machine were clean. DA-D stated staff washed the outside of the dish machine every one to two days. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated staff wiped the dish machine every day, and they were unsure of the orangish blackish substances on top of the dish machine. During interview on 7/1/25 at 2:57 p.m., the culinary district manager (CDM) stated the sediment on top of the dish machine came from the hood above the dish	F0921		

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F0921 SS = F	Continued from page 125 machine, and staff did their best to ensure the top of the dish machine was clean. CDM stated Ecolab did not assist with the hood or custom pieces, so the facility was trying to find a company who could fix the hood above. During interview on 7/2/25 at 2:24 p.m., the administrator stated maintenance was contacting vendors to install or replace the hood vent above the dish machine. The administrator stated Ecolab did not work on the hood above the dish machine and parts online or in a store would not fit. During interview on 7/2/25 at 2:42 p.m., the maintenance director (MT)-D stated hot steam rose from the dish machine fan and vent area and made the metal from the hood above rust and fall. MT-D stated they were aware of the issue for at least a few months, focused on higher priority facility needs, and were not aware how severe the rust fell from the hood. MT-D stated they discussed putting plastic over the dish machine when the machine was not running to scrape the hood above. The facility Warewashing policy dated 12/2024, did not indicate when to clean the dish machine. The Healthcare Services Group task descriptions for cooks and aides, indicated when staff were to complete their scheduled cleaning assignment.	F0921		
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure adequate pest control measures were in place to eliminate small black flies from the building. This had the potential to affect all 51 residents of the facility. Findings include: During observation and interview with R8 on 6/29/25 at	F0925	It is the policy of The Terrace at Crystal to maintain effective pest control measures to provide a clean, safe, and sanitary environment for all residents, staff, and visitors. A comprehensive pest control inspection was conducted throughout the building, and treatments were applied as needed to eliminate all pests. The facility has long maintained a partnership with Ecolab, a licensed and nationally recognized pest control service, which conducts routine inspections and treatments to prevent and manage pest activity throughout the building. In addition, the facility has also implemented supplemental strategies, such as placing apple cider vinegar traps in targeted areas and installing fly-attracting light devices in multiple locations throughout the facility. These combined	08/26/2025

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F0925 SS = F	Continued from page 126 10:27 a.m., in second floor resident room, several small black flies were observed flying around the room during interview. R8 stated the facility “is full” of small black flies and they are “all over the f***ing building”. R8 stated the flies “been issue for a while…last few months I guess”. R8 stated he was disappointed with facility’s lack of action to address the flies. R8 stated he was “not sure what’s being done about it”. During observation and interview with R31 on 6/29/25 at 10:35 a.m., in third floor resident room R31 stated she “occasionally sees fruit flies” both in her room and out in hallway and dining room. During observation and interview with R36 on 6/29/25 at 10:43 a.m., in third floor resident room, R36 stated facility “gets bugs in here” and was not pleased with it. During observation in second floor dining room on 6/29/25 at 12:17 p.m., a dietary aide was serving food on meal tray to a table with R22 seated in a geriatric chair. Visible little black flies were flying above the table were observed. During interview with nursing assistant (NA)-E on 6/29/25 at 1:19 p.m., NA-E stated she had noticed flies on the second floor. NA-E stated expectation of staff to notify management of flies and “Bring someone in to spray the place”. During interview with culinary aide (DA)-A on 6/29/25 at 1:31 p.m., DA-A stated she had seen “a lot more fruit flies now consistently [for] two or three weeks.” DA-A stated she did not hear any meetings or information from management regarding fruit flies. During interview with R24 on 6/29/25 at 1:48 p.m., in second floor resident room, R24 stated she had “seen some fruit flies” in the past and that her sister had mentioned it to her also when visiting. During interview with maintenance director (MT)-D on 6/30/25 at 11:14 a.m., MT-D stated he was aware of the small black flies’ “issue” in the facility through verbal reports by staff and residents and stated the pest management company “comes out once a month”. MT-D stated the monthly reports filled out by the pest service specialist (PS)-S were missing so he was unable to provide surveyor written reports. MT-D stated he knew nothing about what specific services PS-S provided to address the fly issue.	F0925	Continued from page 126 interventions have proven highly effective, resulting in a significant and measurable reduction in the presence of small black flies and fruit flies. Facility staff have been instructed to monitor fly activity daily, and any concerns are logged and reported to the Maintenance Director for immediate review and coordination with Ecolab for follow-up as needed. Staff received retraining on environmental sanitation practices that help prevent pest infestations, including proper waste management and sealing of entry points. The Maintenance Director will conduct weekly environmental rounds to look for any signs of pest activity and review reports from the monthly pest control service visits until any issues are resolved. Any findings will be documented and reviewed during QAPI meetings to ensure sustained compliance and prompt action when necessary. The Maintenance Director and Administrator are responsible for oversight and ensuring continued adherence to pest control protocols.	

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F0925 SS = F	Continued from page 127 During observation on 6/30/25 at 2:05 p.m., in the second-floor shower room a small black fly was buzzing around. During interview with nursing assistant (NA)-A on 6/30/25 at 2:15 p.m., NA-A stated she could see and was aware of small black flies in the facility. NA-A stated she noticed black flies when the weather started to get warmer. “Looks like something needs to be done to get rid of them. They are everywhere.” NA-A stated expectation of staff to notify the “nurse” so a report could be completed and sent to MT-D. Also, all staff had ability to email or verbally communicate to MT-D about maintenance concerns, including pests. During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:22 p.m., TMA-A stated she was aware of the small black fly issues in the building from residents and other staff including her own observations. TMA-A stated MD-T was made aware by her via verbal means. TMA-A stated, “[facility] need to do something better”. During interview with director of nursing (DON) on 6/30/25 at 2:49 p.m., DON stated she was aware of the small black fly issues. “I have seen it and reported to [MT-D] within this month.” DON stated MT-D placed “some traps out” on resident units and it “still [sic]an issue”. During interview with MT-D on 6/30/25 at 3:02 p.m., MT-D stated expectation of staff to communicate facility maintenance needs including pest concerns through electronic Work Orders which can be done through the computer. MT-D stated he is also made aware of issues including pests through verbal communication also. During interview with PS-S on 7/1/25 at 9:55 a.m., PS-S stated he had been at facility in May and June of 2025 for the monthly pest control visits. “[Facility] don’t have a logbook there.” PS-S stated, “the main issue is that I noticed small flies in the kitchen [sic].” PS-S stated he spoke to administrator and “just met [MT-D] over the phone the other day.” During tour with PS-S on 7/1/25 at 1:51 p.m., PS-S stated the facility contract with the pest control company provided, “no service for the smaller flies that are going around here.” During interview with dietary manager (D)-M on 7/1/25 at 10:10 a.m., D-M stated she was aware of the flies in the kitchen area and swatted a black fly as she exited the kitchen.	F0925		

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F0925 SS = F	Continued from page 128 During review of customer service report invoice with service date of 6/11/25, the “Target Pest” column identifies “Flies-Large”. During review of the facility’s Pest Elimination Services Agreement dated 8/30/2022, the contracted services include “Outside in Large Fly Program” with frequency of “Monthly-6 Month Program”. During review of documents titled Work Orders with dates “May. 1, 2025 -Jul. 1, 2025” failed to identify concerns with pests or small black flies. During review of Grievance Tracking logs from January 2025 to June 2025, no mention of pests for “Types of Concern”. During interview with administrator and regional director (RD) on 7/1/25 at 10:25 a.m., the administrator stated he was informed of the black flies “over a month ago”. The administrator stated MT-D bought over the counter “apple things” to trap flies and “agree, [it is] still an ongoing issue”. RD stated he was not aware the monthly pest control services and service agreement failed to address small black flies. “Should be done.” Facility policy titled Pest Control, revised May 2008 identified, “Our facility shall maintain an effective pest control program.”	F0925		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Terrace at Crystal is a Special Focus Facility (SFF). On 6/29/25 - 7/2/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		08/26/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/02/2025**

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20000	Continued from page 1 In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H52897974C (MN109554) H52897971C (MN108609) H52897972C (MN113814) H52897967C (MN106359) H52897968C (MN107818) H52897973C (MN108474) AND The following complaints were reviewed: H52897969C (MN107183) with licensing orders at 0900 and 0960 H52897970C (MN107861) with licensing orders at 0960 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically.	20000		

Minnesota State Department of Health

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20000	Continued from page 2 Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	20265	Corrected.	08/26/2025

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20265	Continued from page 3 E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promptly notify the provider consistently of high blood sugars for 1 of 1 residents (R36) of reviewed for notification of change. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). Section N-Medications indicated R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). During an interview on 6/29/25 at 10:45 a.m., R36 stated she had diabetes and had been told she was a "pretty fragile diabetic." R36 stated her blood sugars went up and down and sometimes she required insulin and sometimes she did not. R36's care plan, printed 7/2/25, included R36 had diabetes mellitus with the following interventions: monitor for signs and symptoms of hyperglycemia (high blood sugar); monitor for signs and symptoms of hypoglycemia (low blood sugar); obtain blood sugars per MD order; resident has an order for Dexcom (a continuous glucose monitoring system that is wearable that provides continual real-time blood sugar level reading without the need for frequent fingerstick), sensor to change every 10 days; diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. R36's June 2025 Medication Administration Record (MAR), printed 7/2/25, included the following orders: - Insulin NPH (Neutral Protamine Hagedorn- Human -Isophane) (an intermediate-acting insulin that helps manage blood sugar level in individuals with diabetes) Subcutaneous Suspension 100 unit/milliliter(ml) - Inject 11 units subcutaneously in the evening related to diabetes with a start date of 5/31/25. The record identified it was given all days except 6/14, 6/17, 6/18, and 6/17 which were marked with a "2" indicating "drug refused". The date 6/1 was marked with a "3"	20265		

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20265	Continued from page 4 indicating "absent from home with meds." - Insulin NPH Subcutaneous Suspension 100 unit/ml - Inject 7 units subcutaneously in the morning related to diabetes with a start date of 6/1/25. The record indicated it was administered all days. - Novolog (rapid acting insulin used to control blood sugar) Injection Solution 100 unit/ml - Inject as per sliding scale: if blood sugar is 151 - 225 = 1 unit; 226 - 300 = 2 units; 301 - 375 = 3 units; 376 - 450 = 4 units; 451+ = 5 units, subcutaneously with meals related to diabetes at mealtime only (give even if you skip meal) - Do not give correction dose if blood sugar is less than 150. Check blood glucose at bedtime and do not give correction insulin if blood glucose is less than 200. Start date 5/31/25. - Glucagon Nasal Powder 3 milligram(mg)/dose (dry nasal spray that helps raise blood sugar level in an emergency) 1 spray in nostril as needed for low blood sugar- unsupervised self-administration -In the event of unconscious hypoglycemia or hypoglycemic seizure. May repeat dose if no response after 15 minutes with a start date of 5/18/25. The record identified it was documented every day as "U-SA" which indicated unsupervised self-administration. - Glucose Oral Tablet Chewable (tablet used to quickly raise your blood sugar when it is low) 4 grams (gm), Give 1 tablet by mouth every 6 hours as needed with a start date of 4/16/25. The record indicated it was given on 6/1/25 at 10:32 p.m. and marked as effective and administered on 7/3/25 at 1:34 p.m. and marked as effective. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 2:49 a.m. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time	20265		

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20265	Continued from page 5 administration on 6/1/25 at 3:31 a.m. - Dexcom CGM G6 - Use to obtain glucose level three times daily before meals and at hs (bedtime) for diabetes with a start date of 6/14/24. - Emergency department to evaluate and treat blood glucose level of 833 and patient is symptomatic. One time only for diabetes with a start date of 6/1/25. Record indicated it was documented with a “9" which indicated "other/progress note" on 6/1/25 at 2:48 a.m. - Encourage patient to drink ice water and extra movement to help lower sugar. One time only for diabetes with a start date of 6/1/25 and was completed on 6/1/25 at 10:36 a.m. R36's orders lacked specific parameters on when to notify the provider regarding blood sugars. R36's Blood Sugar Summary Report, from 5/31/25 to 6/30/25, included the following blood sugar readings in milligrams per deciliter (mg/dL): 6/29/25 at 5:00 p.m. was 443 mg/dL 6/28/25 at 1:39 p.m., was 449 mg/dL 6/28/25 at 9:30 a.m., was 500 mg/dL 6/28/25 at 8:54 a.m., was 500 mg/dL 6/27/25 at 12:25 a.m., was 444 mg/dL 6/27/25 at 12:22 p.m., was 444 mg/dL 6/27/25 at 11:46 a.m., was 444 mg/dL 6/27/25 at 8:42 a.m., was 500 mg/dL 6/27/25 at 8:41 a.m., was 500 mg/dL 6/27/25 at 8:40 a.m., was 500 mg/dL 6/26/25 at 8:30 a.m., was 492 mg/dL 6/24/25 at 9:58 a.m., was 600 mg/dL 6/24/25 at 9:19 a.m., was 600 mg/dL 6/23/25 at 3:30 p.m., was 38 mg/dL 6/22/25 at 9:48 a.m., was 529 mg/dL	20265		

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20265	Continued from page 6 6/22/25 at 9:40 a.m., was 529 mg/dL 6/21/25 at 9:14 a.m., was 451 mg/dL 6/20/25 at 9:02 a.m., was 413 mg/dL 6/19/ 25 at 9:05 a.m., was 507 mg/dL 6/18/25 at 9:56 a.m., was 422 mg/dL 6/17/25 at 9:26 a.m., was 473 mg/dL 6/17/25 at 9:01 a.m., was 473 mg/dL 6/16/25 at 8:15 a.m., was 592 mg/dL 6/14/25 at 8:29 a.m., was 600 mg/dL 6/12/25 at 8:44 a.m., was 588 mg/dL 6/9/ 25 at 4:38 p.m., was 485 mg/dL 6/9/25 at 2:22 p.m., was 543 mg/dL 6/9/25 at 2:08 p.m., was 543 mg/dL 6/9/25 at 10:11 a.m., was 551mg/dL 6/9/25 at 8:48 a.m., was 55 mg/dL 6/7/25 at 2:56 p.m., was 441 mg/dL 6/7/25 at 11:13 a.m., was 501 mg/dL 6/7/25 at 11:13 a.m., was 441 mg/dL 6/4/25 at 9:46 a.m., was 424 mg/dL 6/4/25 at 9:37 a.m., was 424 mg/dL 6/1/25 at 8:15 a.m., was 546 mg/dL 5/31/25 at 10:19 p.m., was 401 mg/dL R36's progress notes reviewed from 5/31/25 to 6/30/25 and identified the following: -6/1/25 at 7:16 a.m.: resident blood sugar is 546 without any symptoms. -6/1/25 at 11:41 p.m.: Residents blood sugar was 84 upon returning to facility at 9:30 p.m., and at 10p.m. it was 41, 2 glucose tablets along with pudding, apple juice given, and blood sugar went up to 47. Resident	20265		

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20265	Continued from page 7 ate a cup of oranges and blood sugar went up to 95. -6/24/25: Resident's blood sugar was 600 at 9am so scheduled insulin and sliding scale insulin were given. Rechecked blood sugar at 11am. Message was left for provider. R36's progress notes lacked any additional updates to provider regarding R36's documented high and low blood sugars despite having 20 days of high blood sugars (some days multiple times a day) and 4 days of low blood sugars. Standing Orders for Skilled Nursing Facilities, printed 7/2/25, included the following information on page 3: -If type 1 diabetes, notify the provider if any blood glucose results are less than 70 or over 400 and/or change in condition. -Hypoglycemia - blood glucose less than 70: "If patient is symptomatic, conscious, and able to swallow or has a feeding tube: -Administer 6 oz. fruit juice, milk, other high carbohydrate beverage (e.g., Ensure, Boost), or glucose tables or gel orally or via feeding tube. -Repeat BG [blood glucose] after 15 minutes; if <70 [less than 70], repeat above intervention. -If after 2 attempts to treat and BG is still <70, notify provider." During an interview on 7/1/25 at 9:35 a.m., trained medication aid (TMA)-A stated they took blood sugars and reported the findings to the nurse on the floor. TMA-A stated some glucometers would not read the blood sugar if it was too high or low and they would get the nurse if that happened. TMA-A stated they did not notify providers of information as they reported everything to the nurse on the floor. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and had worked with her often. LPN-A stated if a blood sugar was over "300", staff were to notify the provider. LPN-A stated they would document provider notification in a progress note. LPN-A stated R36 was "all over with her blood sugars."	20265		

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20265	Continued from page 8 During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated they were familiar with R36. LPN-E stated it would vary per resident on when to notify the provider for high or low blood sugars as some residents had parameters on when to notify. LPN-E verified R36 did not have any parameters on when to notify the provider. LPN-E stated the expectation would be that after the provider was notified, it would be documented in a progress note. LPN-E reviewed R36's electronic medical record (EMR) and verified the provider was notified a few times on 6/1/25 regarding R36's high blood sugars and again on 6/24. LPN-E verified there were no other documented notifications in R36's EMR. LPN-E stated she would expect the provider to be notified if the blood sugar was over 451 as that was what insulin orders stopped at. LPN-E reviewed R36's blood sugars and verified she had many blood sugars over 400 in the month of June. During an interview on 7/2/25 at 11:38 a.m., director of nursing (DON) stated the expectation would be the nurses would follow the house standing orders if a doctor did not write specific parameters regarding when to be notified of high and/or low blood sugars. DON stated they expected the provider to be notified if a resident's blood sugar was less than 70 or greater than 400 and expected it to be documented in a progress note. DON stated the provider should have been notified regarding R36 and her blood sugars after review. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated they were familiar with R36. NP-A stated they would expect to be notified if R36's blood sugar was over 450 or below 70. NP-A stated if a resident's blood sugar was over 450, an order would be given to help decrease the blood sugar. NP-A stated when they were notified on 6/1/25 regarding R36's blood sugar being 833, orders for insulin were given to lower her blood sugar along with sending her to the emergency room to be evaluated. NP-A stated the facility communicated with the provider group through "the portal." NP-A reviewed the portal and stated they were notified only a couple of times in June regarding R36's blood sugar being high. A facility policy titled Change in a Resident's Condition or Status, dated 2/2021, indicated "Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status."SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures	20265		

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20265	Continued from page 9 related to notification of change in resident health status and who to notify. The Director of Nursing (or designee) should conduct measurable audits on residents health records to verify that change in health status is being completed and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20265		
20380	Policies Concerning Residents; Telephones CFR(s): MN Rule 4658.0200 Subp. 2 Subp. 2. Telephones. A nursing home must provide at least one non-coin-operated telephone which is accessible to residents at all times in case of emergency. A resident must have access to a telephone at a convenient location within the building for personal use. A nursing home may charge the resident for actual long distance charges that the resident incurs. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure there was reasonable access to private phone use for 1 of 1 residents (R153) reviewed who utilized the facility phone. Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's profile dated 6/23/25, indicated R153 resided on the third floor. During an observation on 7/1/25 at 1:03 p.m., R153 was observed sitting in a wheelchair in front of a long desk with multiple staff members surrounding it, including trained medication aide (TMA)-B and licensed practical nurse (LPN)-A. The long desk at the nursing station was observed at the middle of two parallel hallways on the third floor with resident's rooms and in front of an elevator. R153 was observed talking on a corded phone and asking someone to "get me out of here".	20380	Corrected.	08/26/2025

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20380	Continued from page 10 During an interview at 7/1/25 at 1:12 p.m., R153 stated that he did not have his own phone so had asked the facility staff if there was one he could use. R153 stated the "only phone" offered to him was the phone at the nursing station. R153 stated he asked staff to bring the phone to his room, but they said they couldn't, so he had argued with them about it as he didn't want to talk with his wife in front of all the staff members. R153 stated he felt like he did not have enough privacy when he had to make his phone calls at the nurse's station. During an interview on 7/1/25 at 1:14 p.m. with TMA-B and LPN-A, LPN-A stated most residents had their own phone to use but if they did not, they offered them the phone at the nurse's station. TMA-B confirmed that they had neither a cordless phone nor a private area for residents to use the phone if they wanted. During an interview on 7/1/25 at 1:16 p.m., LPN-E, the third-floor nurse manager, stated the only phone that they had to offer residents on the third floor was a phone that could be utilized at the nurse's station and a more private option was not available. During an interview at 7/2/25 at 10:04 a.m., the administrator stated if a resident was able to pay for it, facility staff would install a phone in a resident's room, otherwise residents were able to use the phone at the nursing stations. The facility's Resident Use of Telephones policy dated 3/17, indicated designated telephones were available for residents to make and receive "private" telephone calls. The policy indicated telephones will be in areas that offer privacy and accommodate wheelchair bound residents. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rights for privacy when using the telephone are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	20380		

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20380 20540	Comprehensive Resident Assessment CFR(s): MN Rule 4658.0400 Subp. 1 & 2 Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set	20380 20540	Corrected.	08/26/2025

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20540	Continued from page 12 (MDS) was completed in a thorough manner to ensure all areas of resident performance and activities preference were evaluated for 1 of 4 residents (R24) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose of providing guidance with how to complete the Resident Assessment Instrument (RAI), and it outlined an admission MDS was considered a comprehensive assessment. The manual listed a section labeled, "SECTION F: Preferences For Customary Routine and Activities," along with directions to complete the section. The directions outlined, "The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities." The manual directed to interact with the resident or, if needed, complete the staff examination if the resident is unable to respond. On 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated they were unsure if R24 would participate even, however, expressed they had never been asked or consulted on R24's activity preferences, either. R24's admission MDS, dated 5/5/25, identified R24 admitted to the care center on 4/28/25 from the acute care hospital and had multiple medical conditions including heart failure, dementia, and a history of stroke/transient ischemic attack (TIA). The MDS section labeled, "Section F - Preferences for Customary Routine and Activities," provided spacing to record answers with gathered data including an Interview for Daily Preferences (F0400) and Interview for Activity Preferences (F0500). However, the entire section of the MDS (F0300 to F0800) was either left blank or marked, "Not Assessed." R24's medical record was reviewed and lacked evidence R24 had been evaluated for their routine and/or activity preferences during the assessment reference date (ARD) period (See F679).	20540		

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20540	Continued from page 13 On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas "dashed" with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was "not acceptable." RN-O reviewed R24's medical record and verified the section of the MDS had been dashed and explained staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and "gives us [staff] an opportunity to see if the resident is progressing or declining." A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, "Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI]." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on MDS completion; then educate staff involved with the RAI process and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	20540		
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 residents (R50) reviewed for hospitalization. Findings include:	20550	Corrected.	08/26/2025

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20550	Continued from page 14 R50's Discharge-return not anticipated Minimum Data Set (MDS) dated 4/13/25 identified discharge from facility was planned and R50 discharged to "Short-Term General Hospital (acute hospital, IPPS)." During record review, R50's nursing progress noted dated 4/13/25 identified "Resident discharged from the facility to home with all her medication and instruction with her family members at 3:30 p.m." During interview with licensed practical nurse (LPN)-A on 6/30/25 at 5:01 p.m., LPN-A stated she recalled R50 and stated, "She went home it was planned". During interview with R50 on 6/30/25 at 6:00 p.m., R50 stated, "Yes I was there and discharged home." During interview with registered nurse and MDS facility liaison (RN)-MDS on 7/1/25 at 10:36 a.m., RN-MDS reviewed R50's electronic medical record (EMR) and stated R50 discharged home on 4/13/25. Further review of R50's Discharge-return not anticipated MDS dated 4/13/25, RN-MDS stated the MDS was coded incorrectly, "it is not accurate". RN-MDS stated expectation for MDS to be coded accurately was "it concerns payment sources". During interview with MDS clinician (MDS) on 7/1/25 at 12:13 p.m., MDS reviewed R50's 4/13/25 Discharge-return not anticipated MDS and confirmed, "we have [R50] dc'd [discharged] to hospital". MDS stated that "it looks like it was coded incorrectly" and "incorrectly coding will affect quality measures for the facility and impacts payment and reimbursement". Facility policy titled Certifying Accuracy of the Resident Assessment, revised 2019 state "The information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit	20550		

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20550	Continued from page 15 other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 2 residents (R37) reviewed for diet preferences/allergies. Findings include: R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood, and the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated the facility was aware of his food allergy. R37 stated he did not eat it, but it happened again just a few days ago and he had followed up with staff. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication	20555	Corrected.	08/26/2025

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20555	Continued from page 16 of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: - Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2-gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our meal	20555		

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20555	Continued from page 17 tracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents' preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions." R37's allergy list, printed 7/2/25, lacked indication of allergy to shellfish, seafood or fish. R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants used the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R37 and worked with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic too. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated residents' food allergies, and their food preferences should be listed on their care	20555		

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20555	Continued from page 18 plan. DON verified R37's food allergies and food preferences were not listed and should be on the care plan. A facility policy titled Care Plan, Comprehensive Person-Centered, reviewed 6/23, "assessment of residents are ongoing, and care plan are revised as information about the residents and the residents' conditions change." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are used and followed in order to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide routine care conferences to allow for resident participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 2 residents (R41) reviewed for care conferences. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24,	20570	Corrected.	08/26/2025

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20570	Continued from page 19 indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's electronic medical record (EMR) indicated R41 had one care conference since being admitted to the care facility. A progress note, dated 10/24/24, indicated R41 "had her care conference today at 1:00pm. Pt [patient], SW [social worker], and Nurse Manager were in attendance." During an interview on 6/29/25 at 3:07 p.m., R41 stated she had "been to maybe one" care conference since being admitted to the facility and had concerns about her care. During an interview on 7/1/25 at 8:17 a.m., licensed social worker (LSW)-A stated the resident care conferences and care plan review should be held "roughly" every three months and generally coordinate with the MDS cycle. LSW-A stated she had not held a care conference for R41 as R41 had "not been agreeable", however stated the interdisciplinary team should still meet quarterly to discuss the residents' care, even if the resident did not want to participate. LSW-A stated timely and routine care conferences were important to ensure there were no resident changes the team may have missed. During an interview on 7/2/25 at 12:06 p.m., the director of nursing stated it was expected that care conferences were held quarterly, even if the resident did not want to participate. A facility policy titled Care Plans, Comprehensive Person-Centered, revised 6/2023, indicated the interdisciplinary team would review and update the care plan at least quarterly, in conjunction with the required MDS assessment. The facility could review policies and procedures related to timely care conference and subsequent care plan revision. Social Services (or designee) should conduct measurable audits on residents' care conferences to ensure they are being conducted timely. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20570		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial	20830	Corrected.	08/26/2025

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20830	Continued from page 20 care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and develop interventions as needed to reduce the risk of accidents or injury for 2 of 2 residents (R38, R41) reviewed with a history of substance abuse and suspected current use. In addition, the facility failed to implement interventions for 1 of 1 resident (R35) reviewed for falls. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's diagnoses list, dated 7/13/24, indicated R41 had several medical diagnoses including psychoactive substance dependence. R41's Associated Clinic of Psychology (ACP), dated 5/20/25, indicated facility staff informed the ACP practitioner of concerns of suspected substance use, which was also listed as a barrier to care on the ACP visit note. R41's electronic medical record (EMR) lacked any documented interventions, assessments, or monitoring protocols related to suspected substance use. Furthermore, there were no care plan elements or guidance in place outlining staff responsibilities or actions to take if substance use was suspected. The absence of such documentation and intervention planning presents a potential risk to R41's health and safety, as well as to the safety and well-being of other residents and staff in the facility. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she had not seen R41	20830		

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20830	Continued from page 21 using drugs but had suspected it on more than one occasion. TMA-B stated when she suspected R41 of substance use, R41 would be doubled over in her chair with glassy eyes, pinpoint pupils and slurred speech. TMA-B stated, "you can tell she is on something" confirming she has reported the concern to the nurse manager more than once but "nothing is getting done." TMA-B stated something needed to be done because "anything could happen". During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and licensed practical nurse (LPN)-E stated she was aware R41 had a history of substance use and stated staff have reported smelling "burning" coming from R41's room at times. LPN-E confirmed there was no care planned interventions for suspected substance abuse, but should be, stating it would be expected that staff check on R41 every 15 minutes if they suspected she was using substances. R38's significant change Minimum Data Set (MDS) dated 6/23/25, indicated R38 had intact cognition with no delusions, hallucinations, or rejection of care behaviors. The MDS indicated R38 was independent with chair/bed-to-chair transfers and could wheel 150 feet in a wheelchair independently. The MDS indicated R38 was diagnosed with heart failure, kidney disease, diabetes, anxiety, and depression. R38's hospital note dated 1/4/25, indicated R38 was brought to the emergency department due to "abnormal movements". The note indicated R38 had reported to hospital staff that he had "smoked crack cocaine" two days prior. R38's care plan dated 1/6/25, included a care plan titled "substance use disorder" and indicated R38 had tardive dyskinesia (involuntary muscle movements) related to "cocaine" use, with the sole intervention being that the resident will be offered chemical use counseling as appropriate. During an interview on 7/1/25 at 9:50 a.m., R38 stated he had used methamphetamine (meth) once, but he didn't like it so did not plan to use it again. R38 stated he had smoked crack cocaine in the past but could not recall the last time this had occurred and claimed he had never smoked crack while residing at the facility. R38 stated he was trying to get himself "completely healthy" so he wasn't using anymore and only gets "98 bucks" a month, so he couldn't buy crack now even if he wanted to. R38 confirmed he had been offered chemical	20830		

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20830	Continued from page 22 use counseling, but did not want the services. During an interview on 6/29/25 at 8:58 a.m., R153 stated R38 "does crack" at night. R153 stated he hears the "click, click, click, of the lighter" but has not seen R153 use crack cocaine. R153 stated he hadn't told staff about it, but "they should know". On 6/30/25 at 1:33 p.m., R153 stated that in the last week, R38 had asked him for money to buy "crack". R153 stated R38 would barricade the door with a dresser when he was "smoking crack," and R38 told him he would hurt him if he put his call light on while he was smoking. R38 stated the last time this happened was on either Friday (6/27/25) or Saturday (6/28/25) night. During an interview on 6/29/25 at 12:55 p.m., licensed practical nurse (LPN)-B confirmed she was the nurse in charge of R38's care this shift. LPN-B stated that facility staff had suspected that R38 was using illicit drugs, but she had never observed signs or symptoms of this herself. When asked what monitoring was in place regarding R38's suspected illicit substance use, LPN-B stated they "probably should" but did not currently have any monitoring in place or a plan for if illicit substance use was suspected. During an interview on 6/30/25 at 1:57 p.m. with the administrator and director of nursing (DON), the administrator stated they had not been notified of any allegations of R153's using crack cocaine, and the DON confirmed she had also not been aware of these allegations and had not seen any symptoms of intoxication or been notified of anyone finding any drug paraphernalia, and was unsure if further assessments had been completed regarding R38's illicit substance use. During an interview on 7/2/25 at 10:01 a.m., the DON stated if a resident had a known history of illicit substance use, she would expect this to be care planned and assessed for, as well as implementing monitoring for signs or symptoms of substance abuse as well as collaborating with the provider for any additional orders if needed. The DON stated this monitoring would be outlined in either the care plan or orders. R38's medical record was reviewed, and it did not indicate that monitoring for illicit substance use was in place or that a comprehensive assessment of R38's substance abuse disorder had been completed. The facility's Substance Abuse Policy dated 6/29/25, indicated if a resident had a substance abuse disorder or displayed the potential for a substance abuse disorder, the facility would assess the residents to	20830		

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20830	Continued from page 23 determine substance abuse disorder "triggers", therapies/support available, and the resident's willingness to participate in substance use disorder services. The policy indicated that facility staff would assess for substance abuse disorders and triggers upon admission, readmission, and quarterly. The policy indicated that, based on assessment outcomes, an individual care plan would be developed and provide approaches for reducing triggers for substance use. The policy indicated it was "essential" to monitor if a resident who was suspected of illegal drug use was a danger to themselves, others, and /or staff. R35 Falls R35's annual assessment dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of osteoporosis, asthma, Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required staff assistance with most activities of daily living. R35's care plan printed 6/29/25, indicated R35 was independent to turn and reposition in bed and transferred with staff supervision. R35 was at risk for fall related to Alzheimer's disease and safety awareness. The care plan indicated R35's last fall was 5/20/24. The care plan's fall interventions included: -Anticipate and meet the resident's needs dated 1/29/24. -Be sure call light within reach and encourage resident to use it for assistance as needed dated 5/16/24. -Physical therapy to evaluate dated 5/20/24. -Physical therapy to evaluate and treat as ordered or PRN (as needed) dated 10/16/24. -Obtain order for physical therapy to evaluate and treat for 12/16/24 fall dated 12/18/24. -Keep walker next to bed for fall on 12/1/24 dated 1/28/25. R35's Resident Fall Risk assessment dated 6/25/25, indicated R35 was at "high risk" for falls related to intermittent confusion, history of one to two fall in the past three months, ambulatory and incontinent, took one or two of the medications indicated in the assessment currently and/or within the last seven days, and had one or two of the indicated predisposing diseases.	20830		

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20830	Continued from page 24 R35's progress notes indicated: -On 6/13/25 at 6:30 p.m., R35 was found on the floor next to the nursing station. R35 had her shoes on and stated she tried to stand up and twisted her leg and sat on the floor. R35's vital signs were noted, and R35 stated she did not have pain. R35 was able to move her upper and lower extremities without pain. R35 was helped to wheelchair with Hoyer lift and two nursing assistants. Family member (FM)-R, nurse manager, and provider were called. Neurological checks were started. -On 6/16/25 at 9:52 a.m., an interdisciplinary note indicated R35 was demented and forgot good body mechanics during movements. Physical therapy was requested to strengthen her mobility. R35's Un-witnessed Fall risk management assessment dated 6/13/25, indicated an incident description and immediate action taken which repeated information from the progress note dated 6/13/25. The assessment indicated no predisposing environmental factors, physiological factors including confusion and fear of falling, and situational factors of ambulating without assistance and using a walker. R35's electronic health record did not indicate therapy involvement after her fall. During interview on 06/29/25 at 10:56 a.m., FM-R stated R35 fell about a couple weeks ago, and R35 had no pain and did not need to be sent to the hospital. FM-R stated they did not know about any new intervention the facility implemented, and the facility continued with the current fall interventions. During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated staff stayed with residents who they found on the floor and called the nurse. NA-A stated the nurse assessed the resident and determined if 911 needed to be called or if staff could move residents using a Hoyer lift. NA-A stated fall interventions were noted in residents care plans and staff read the care plans every day. NA-A stated R35 was "not really" a fall risk but always made sure R35 had her walker and reminded R35 to lift her feet. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses were called when a resident had an unwitnessed or witnessed fall. RN-A stated nurses took residents' vital signs, performed neurological checks, checked for injuries and range of motion. Nurses determined if the resident was safe to	20830		

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20830	Continued from page 25 move or if 911 was needed. RN-A stated nurses notified the family, manager, and provider. A risk management assessment was completed of each fall to describe the situation and what interventions were implemented. RN-A stated R35 was a fall risk and stayed close to staff for monitoring. RN-A stated fall interventions prevented R35 from future falls. RN-A stated nurses obtained therapy orders if therapy was a fall intervention, so therapy could work on strengthening with residents. RN-A thought R35 was being seen by therapy. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapies most recent encounter with R35 was in September of 2024 for speech therapy. DOR stated she was at a meeting where therapy was discussed after her last fall but did not see any orders come through to start therapy with R35. DOR stated therapy orders from the provider came through nursing or the health unit coordinator and they usually received a therapy order within a couple days after discussed, and indicated R35's fall risk management was signed on 6/17/25. During interview on 7/2/25 at 11:38 a.m., licensed practical nurse (LPN)-B reviewed R35's risk management assessment related to R35's fall on 6/13/25. LPN-B stated an immediate intervention should have been implemented and verified R35 had no current therapy orders. LPN-B stated nurses were able to obtain therapy orders within 24 hours unless the order was needed over the weekend. LPN-B stated fall interventions were important to prevent falls, and physical therapy would help strengthen R35. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to implement immediate fall interventions, review and discuss falls, and update the care plan. The DON stated staff were able to get therapy orders timely to give to the therapy department. The DON stated implementation of fall interventions were important to prevent residents from repeated falls. The facility Falls - Clinical Protocol dated November 2022, directed the staff and physician to assess residents at risk for falls and residents who have fallen to identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The facility Falls and Fall Risk, Managing policy dated November 2022, directed staff to implement a resident-centered fall prevention plan to reduce the	20830		

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20830	Continued from page 26 specific risk factor(s) of falls for each resident at risk or with a history of falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff and monitor to ensure all residents were assessed for safety related to illicit substance use. The DON could educate all staff on these systems. The DON or designee could report the findings to the Quality Assurance Committee and complete audits to ensure compliance. The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 resident (R23) reviewed for limited range of motion (ROM). Findings include:	20895	Corrected.	08/26/2025

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20895	Continued from page 27 R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). The MDS indicated R23 was not on a restorative nursing program during the look-back period (LBP). R23's care plan printed 6/30/25, indicated R23 required extensive assistance of two staff to turn and reposition in bed, extensive assistance of one staff to transfer between surfaces, encourage resident to participate to the fullest extent possible with each interaction, and physical and occupational therapy to evaluate and treat as per provider orders. A functional maintenance program directed nursing to assist patient with applying AFO (ankle-foot orthosis) foot brace to right foot and then ambulate 100 feet with CGA (contact guard assist) and quad cane (walking aid with a base which has four legs or prongs). The care plan identified R23 refused to walk and refused to wear the AFO brace with date of 1/4/25. R23's ROM and Mobility assessment dated 5/6/25, indicated had an impairment on onside of both upper and lower extremity and was not steady and only able to stabilize with staff assistance to move from a seated to standing position. The assessment indicated walking, moving on and off a toilet seat, and surface-to-surface transfer did not occur. R23 used a wheelchair. The assessment indicated direct care staff believed R23 was capable of increased independence in at least some ADLs and did not include interventions/exercises to ensure R23 maintained his ROM if needed. R23's physician order dated 11/16/21, included nurse to ensure resident wore AFO brace to his right foot when out of bed every shift with start date of 11/16/21. R23's Treatment Administration Record (TAR) dated June 2025, directed nurses to ensure R23 was wearing his AFO brace to right foot when out of bed every shift. All three shifts were marked as completed every day except for three morning shifts. R23's progress notes dated 12/13/25 to 7/1/25, indicated one refusal to wear AFO brace.	20895		

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20895	Continued from page 28 R23's medical record did not indicate interventions/exercises for R23's right upper extremity. During observation and interview on 6/29/25 at 9:14 a.m., R23's right arm was in a sling and right-hand fingers were curled towards his palm. R23's right foot was on the wheelchair pedal and left foot was on the ground. R23 did not have a leg brace on. R23 stated staff did not complete exercises with him. During observation on 7/1/25 at 7:42 a.m., R23 was dressed and in his wheelchair. R23 had a sling on and no brace on his legs. During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his room in his wheelchair. R23 stated yes when asked if staff completed exercises with him today. R23 did not have a brace on his legs. When asked about the leg brace, R23 used his left foot to propel in his wheelchair to his closet and opened the closet. A leg brace was not found in his closet. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated they were unaware of any boot or brace for R23. NA-K stated he used to have a brace for his leg and was unsure if nursing stopped the brace. NA-K stated they completed range of motion with R23 but did not document the range of motion they completed. NA-K stated approximately four days ago they opened R23's right hand to clean it. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R23's care sheet, which indicated R23 did not walk and "AFO [right] foot when out of bed which is refused by resident". LPN-A stated staff should notify them if R23 refused the AFO brace, so LPN-A could write a progress note and let the provider or therapy know if needed. LPN-A observed R23's right hand and stated nursing could recommend therapy for R23. During interview on 7/1/25 at 12:30 p.m., NA-J stated R23's hand condition was unchanged since previous and had never seen a brace for his legs. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapy had not been recently involved with R23's right upper extremity or AFO brace. DOR expected to be notified of a change in AFO brace, and occupational therapy addressed concerns with residents' hand mobility. DOR stated R23 had MA (medical assistance) pending for insurance coverage, and the business office was involved with setting R23	20895		

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20895	Continued from page 29 up with a guardian since R23 was nonverbal. DOR reviewed R23's therapy file which included: -R23's Functional Maintenance/Restorative Nursing Program form undated (copy provided had bottom part cut off), indicated treatment recommendations to assist R23 with right foot AFO brace and walk patient 100 feet using a quad cane daily and six days per week. The goal of the recommendation was to reduce effects of debility, prevent deconditioning, and reduce risk of fall. -R23's Rehabilitation Screen dated 1/17/22, indicated R23 needed short distance ambulation with right AFO boot to reduce nursing dependency. -A physician order dated 8/24/22, directed physical therapy to evaluate and/or treat for strengthening with ambulation. -A physician order dated 1/14/24, indicated for a right AFO brace and a face-to-face for power wheelchair. -A physician order dated 1/22/24, directed physical therapy and/or occupational therapy to evaluate and treat R23 related to nerve pain and weakness in upper and lower right side. The order indicated R23 felt his upper and lower right side had a change from his baseline. No further information was provided. During interview on 7/2/25 at 10:38 a.m., LPN-E stated R23's AFO brace was important for R23's foot to help with support since R23 had a stroke. LPN-E stated the AFO brace was not in R23's room anymore, so staff were checking with therapy. LPN-E stated they were unsure how long R23's right-hand fingers had been curled and expected staff to notify nursing and therapy. During observation and interview on 7/1/25 at 11:38 a.m., LPN-A was slowly able to open R23's right-hand fingers and observe R23's palm. No skin breakdown was noted. LPN-A stated therapy should work with R23 to improve his finger mobility. During interview on 7/2/25 at 1:58 p.m., the director of nursing stated limited hand range of motion should be addressed by therapy and nursing should update the care plan and orders as indicated. The DON expected staff to follow-up immediately if a brace was found to be unavailable. The DON expected staff to prevent contractures.	20895		

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20895	Continued from page 30 The facility Range of Motion Exercises policy dated October 2010, directed staff to verify if there was a physician's order for the exercise to perform and contact the provider to obtain treatment orders if there were no orders for the exercise. The policy directed staff to document the date and time the exercise was performed, the name and title of who performed the procedure, type of ROM exercise, whether the exercise was active or passive, how long the exercise was conducted, any problems or complaints made by the resident during the exercise, and reason why and intervention taken if the resident refused the treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, interview, and record review the facility failed to identify, implement, monitor and modify interventions to provide timely treatment and services to heal and to prevent further worsening of	20900	Corrected.	08/26/2025

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20900	Continued from page 31 wounds. This failure resulted in harm for R254 when his bilateral heel pressure ulcers were not identified and addressed by facility until they progressed to stage three. Findings include: According to the national pressure injury advisory panel (NPIAP), pressure injury is defined as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. In addition, the evolution of a deep tissue pressure injury (DTI) develops from an exerted pressure about 48 hours before visible signs of purple or maroon skin. Then, about 24 hours later, the epidermis (layer of skin) lifts and reveals a dark wound bed. A stage three pressure ulcer/injury is defined as a full thickness loss of skin. R254's admissions Minimum Data Set (MDS) dated 7/17/24, and quarterly MDS dated 10/1/24, identified risk for developing pressure ulcers, had no pressure ulcers, no unhealed pressure ulcers, no unstageable pressure ulcer/injuries, and no deep tissue injuries. In addition, R254 had intact cognition, no impairment of upper and lower extremities, and was independent with self-care and mobility. R254's significant change in status (SCSA) MDS dated 11/22/24, identified two stage three pressure ulcers, with none of them present upon his admission to facility. In addition, R254 had severe cognitive impairment and was dependent on staff for toileting, bathing, personal hygiene. Also, R254 required assistance with mobility including sit to lying and lying to sitting on side of the bed. R254's admission MDS care area assessments (CAA) dated 7/17/24, identified "Potential" risk factors for pressure ulcers. Section of form to identify "Supporting Documentation. Provide the basis/reason for items being checked, including the location & date & source" was left blank. R254's CAA for the 11/22/24, SCSA MDS identified "Actual" problem for Pressure Ulcer/Injury and, "Skin breakdown with risk for further breakdown and impaired healing related to terminal condition." The Care Plan Considerations identified current pressure ulcer would be addressed in the care plan with overall objective to "Slow or minimize decline." R254's medical diagnoses include diabetes, rheumatoid arthritis, depression, hypertension, and congestive heart failure (CHF).	20900		

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20900	Continued from page 32 The Braden Scale for Predicting Pressure Ulcer Risk is an evidence-based assessment tool in health care used for predicting a patients' risk of developing pressure ulcers. It allows health care professional to implement preventive measures effectively. Scores of less than 9 indicate "Severe Risk", scores of 10-12 indicate" High Risk", scores of 13-14 indicate "Moderate Risk", and scores of 15-18 indicate a "Mild Risk". R254's Braden assessment scores (scale to assess patients' risk of developing pressure injuries) were: 7/11/24 score of 18, 9/27/24 score of 15, 10/6/24 score of 15, 11/7/24 score of 17, 11/14/24 score of 15, and 11/22/24 score of 16. R254's care plan with focus on Skin identified "resident have actual wounds to both heels and potential for impairment to skin integrity fragile skin." Date initiated was 8/15/24. CP Interventions identified "Reposition Frequently" and "Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations" was initiated 1/5/25-four days before R254 expired. R254's provider progress notes (PN) dated 7/15/24, 7/16/24, 7/17/24, 8/21/24, 8/23/24 identified "No rash, or lesions" under Examination section of form. Provider PN dated 9/6/24 identified, "No breakdown in hands or heels" and to "monitor for acute skin care breakdown". R254's hospital discharge summary (DC) dated 9/23/24, identified hospitalization from 9/13/24 to 9/23/24 for urinary retention and urinary tract infection. DC summary identified, "no rashes, ulcerations on exposed skin surfaces". Upon admission to hospital R254 had bruising to coccyx which was identified 9/14/24, with no other skin issues identified. During review of PN dated 9/25/24 identified R254 readmitted to facility from hospitalization. PN failed to indicate any assessment or issues with skin integrity. PN dated 10/2/24 at 5:23 p.m., identified R254 "felt like[sic] had an [sic] heart attack, and	20900		

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20900	Continued from page 33 would like to go to the hospital for checkup." Orders were received to send to hospital. PN dated 10/3/24 at 11:07 p.m., stated R254 returned from "hospital at 3:15 p.m." and failed to indicate any assessment or issues with skin integrity. R254's hospital DC summary dated 10/3/24, identified R254 hospitalized 10/2/24 to 10/3/24 for report of chest pain. During hospitalization on 10/2/24 a "Pressure Injury: Suspected Deep Tissue Injury" to left and right heels were first observed on 10/2/24 at 10:58 p.m., and both wounds were identified has being present "Prior to Admission". R254's weekly bath audits (BA) dated 10/7/24, 10/14/24, 10/21/24, 10/28/24, 11/4/24, 11/11/24, 11/17/24, 12/3/24, identified, "no new alterations in skin". BAs were marked as, "weekly wound assessment initiated and completed." R254's podiatry consultation noted dated 10/22/24, identified "ulcer heels" and "monitor pressure". R254 was admitted to hospice services on 11/14/24, with terminal diagnosis of congestive heart failure. R254's hospice admission note identified, "bilateral stage 3 pressure injuries on heels". R254's provider orders (PO) dated 11/22/24, initiated PO for left and right heel ulcers. The PO for left heel identified, "left Heel wound order: cleanse with vashe (wound cleanser), skin prep to area, santyl (topical medication used to clean and remove dead tissue) to wound bed and apply mepilex (a foam dressing) to area, change daily". PO for right heel identified, "Right heel wound orders: cleanse with vashe, paint heel with betadine, cover with gauze 4x4 and wrap with kerlix, change daily". During review of R254's EMR, the documentation of R254's left and right heel ulcers by infection control preventionist and facility wound nurse (IP) began on 11/12/24 by using the Skin and Wound Evaluation assessments. Measurements of wounds include: Left heel: 11/12/24: 1.5 centimeters (cm) long x 1.7 cm wide x 1.2cm deep. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. Notation of, "This is a new wound." Right heel:	20900		

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20900	Continued from page 34 11/12/24: 5.5cm x 3.6cm x 2.2cm. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. R254's provider PN dated 12/10/24, identified "Chief Complaint: f/u wound rounds." PN stated pressure ulcers of left and right heel were "unstageable." Left heel measurements were: 11/12/24: 1.73 cm x 1.27 cm, 11/15/24: 2.2cm x 1.3 cm, 11/22/24: 2.8cm x 2.6cm, 12/10/24: 3.5 cm x 4.4cm. Right heel measurements were: 11/12/24: 4.47cm x 3.0cm, 11/22/24: 4.7cm x 6.6cm, 12/10/24: 4.0cm x 6.2 cm. During review of R254's Skin and Wound Evaluation assessment for 12/27/24, the left heel wound measurements were 2.1cm x 2.3cm x 1.2cm deep and the right heel measurements were 8.7cm x 4.4cm x 2.7cm deep. During interview with wound care provider (WP) on 7/1/25 at 8:15 a.m., WP stated facility wide wound care rounds were performed with infection control preventionist (IP) twice per week. WP stated IP developed a list of residents who needed to be seen each time. WP stated facility nurses "will tell [IP] of new wounds" and IP assessed and obtained new wound care orders. IP then added these residents to his bi-weekly wound care rounds for monitoring and managing of wounds. During interview with director of nursing (DON) on 7/2/25 at 7:37 a.m., DON stated she was familiar with R254 because DON was the nurse manager on the unit where R254 lived on during the entire time of his facility stay. DON reviewed 10/3/25 hospital DC summary and agreed the documentation identified bilateral heel DTI's. DON reviewed R254's electronic medical record (EMR) and stated she was unable to determine if R254's DTIs were identified at the facility prior to R254's hospitalization on 10/2/24. DON stated expectation of	20900		

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20900	Continued from page 35 staff members who identify impaired skin issues to "report ASAP to nurse, the nurse should assess and update the provider and document [sic] it in progress note". DON stated, first note of impaired skin issues with R254 was on 11/14/24, with the PO for wound care orders to both heels. DON stated R254's CP "should have been updated and was not". DON stated first indication of wound care for R254 was placed in CP on 8/15/24, but not acted on until 11/14/24, when the IP obtained the PO. DON stated importance of identifying and acting on impaired skin integrity "is to ensure appropriate interventions are initiated immediately". DON stated she was unable to determine when R254's DTIs occurred by looking at his EMR. During interview with LPN-B on 7/2/25 at 11:46 p.m., LPN-B stated expectation of staff to assess and "check [residents] skin upon hospital return" including feet and coccyx. LPN-B stated any new or developing skin issues should be addressed right away and provider should be contacted, orders received and notify the IP. In addition, a PN should be put in the EMR. LPN-B stated expectation of "all skin" to be checked weekly with the bath and documented in the "weekly bath audit". During interview with LPN-A on 7/2/25 at 11:57 a.m., LPN-A stated expectation of staff to assess and "check skin" and to document in the EMR under the PN about skin condition. If there was a new skin injury, then staff were expected to "chart it and notify the wound team". LPN-A stated CP interventions for skin care were changed and updated by the IP "when they review [the wounds]". During interview with LPN-B on 7/2/25 at 12:53 p.m., LPN-B stated a "body audit should be done for all [residents] readmitting" to facility. LPN-B reviewed R254's EMR and stated, "no there is nothing there.". LPN-B stated she remembered R254 during his facility stay and stated "I remember seeing them [bilateral pressure ulcers to heels] two months before [R254] passed. Me and [IP] were doing something for [R254] and noticed it while changing his socks. I remember seeing it for the first time saying, 'oh my God'. I did not document anything. That is [IP]'s job. IP is the wound nurse and should have done it," and continued, "No, I do not see it was done". During interview with medical director (MD) on 7/2/25 at 8:58 a.m., MD reviewed R254's EMR and physician notes and stated, "I expect the facility to have assessed [R254's] heels prior to [sic] admission to the hospital in October [10/2/24]." MD stated R254's EMR	20900		

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20900	Continued from page 36 lacked orders, progress notes, and other documentation to support identifying R254's bilateral heel PU's until they progressed to stage three. MD stated, "[it was] most likely avoidable." During interview with IP on 7/2/25 at 8:28 a.m., IP stated he was familiar with R254 during his facility stay. IP reviewed R254's EMR and stated, "[11/12/24] is when we first identified [R254's] heel ulcers." IP stated he did not obtain PO for R254 until 11/14/24, and IP failed to document in the PN. IP stated expectation of staff to "notify me ASAP" when there is a new or worsening skin issue, "then, I will assess and get orders from the [provider] and put the resident on 'weekly wound rounds'". IP stated, "we missed it and should have taken steps earlier to address [R254's] wound to his heels." IP reviewed R254's hospital DC summary dated 10/3/24, and stated, "it shows there was identified DTI's to both heels at the time. We [Facility] did not identify any concerns until 11/12/24". IP stated R254's bilateral heel wounds, "should have been addressed by us before 10/2/24 [when R254] was admitted to the hospital". IP stated wound care rounds involve IP "putting names on paper for people who I look at for wound rounds and then do the rounds with the provider" and document in the EMR. IP stated the Braden documentation was used by the facility to determine pressure injury risk. During interview with hospice vice president of clinical operations (VP)-M on 7/2/24 at 11:23 a.m., VP-M reviewed R254's admission paperwork to hospice services on 11/19/24 and stated R254 had "two wounds on admission. Stage three right and left heel pressure ulcers." During interview with IP on 7/2/25 at 11:44 a.m., IP stated expectation of the nurse at facility to perform a skin integrity assessment every time a patient came back from hospital and write a PN in the EMR. IP reviewed R254's EMR and stated it failed to show a skin assessment was done and PN failed to identify any issues with skin integrity when R254 returned to the facility on 10/3/24. During interview with regional director (RD), administrator, and DON on 7/2/25 at 12:11 p.m., RD stated R254 "could have gotten it [DTI's] from the hospital or transport". Also, RD stated, "[facility] identified our documentation was not up to par" and that R254 "had a history of refusing care" despite no interventions to address any refusals. During interview and review of IP Wound Rounds notes	20900		

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20900	Continued from page 37 (WRN) dated 7/1/24 to 9/17/24, and 12/3/24 to 1/3/25, with IP on 7/2/25 at 11:44 a.m., IP stated he was unable to find the WRN's for dates between 9/17/24 to 12/3/24. WRN for 8/20/24 identified a listing titled "Pressure Ulcer" with three resident names including R254 and no other information. IP reviewed his notes and EMR and was unable to determine rationale for listing R254 with PU on 8/20/24. WRN for 8/27/24 identified R254 being seen for "Rash-Ointment to be ordered." WRN dated 12/3/24, 12/6/24, 12/17/24, 12/20/24, 12/27/24, 1/3/25 identified R254 as being seen. During interview with hospice team leader (H)-TL on 7/7/25 at 9:48 a.m., H-TL identified R254's hospice nurse manager no longer works for facility and reviewed R254's hospice admission paperwork. H-TL stated R254 had two stage three PU's to his heels on admission to hospice services on 11/19/24 and stated, "facilities can just 'let them go' and not do a good job of preventing or lessening the progression of pressure ulcers" in residents who are on hospice. HT-L confirmed R254 passed away at the facility on 1/9/25. Facility policy titled Prevention of Pressure Injuries, revised April 2020 identified "Inspect the skin on a daily basis" and "Inspect pressure pointes (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.)". Facility policy titled Pressure Injury Risk Assessment, revised March 2020 identified purpose "to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs)". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		

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20900 20915	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 A Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene cares for 1 of 1 resident (R23) reviewed who needed assistance with fingernail care. Findings include: R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). The MDS indicated R23 needed substantial/maximal assistance with person hygiene which included combing hair, shaving, washing/drying face and hands, etc.. R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). R23's care plan printed 6/30/25, directed staff to check nail length and trim and clean on bath day and as	20900 20915	Corrected.	08/26/2025

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20915	Continued from page 39 necessary and to report any changes to the nurse. The care plan indicated R23 required extensive assist of one staff for personal hygiene. R23's Treatment Administration Record (TAR) dated June 2025, directed staff to complete a weekly skin review and/or bath, and nursing staff to open a skin review assessment and complete. The order directed staff to chart all refusals in the evening every Wednesday. The order had a start date of 7/12/23 and discontinued date of 6/27/25. R23's Weekly Bath Audit dated 6/25/25, indicated R23 received a bed bath, did not have any new skin alterations, and was not resistive to or refused bathing. The audit did not reference nail care. R23's Point of Care (POC; an app which allows care staff to document ADLs) documentation, indicated R23 refused bathing on 6/25/25. R23's recent progress notes indicated R23 was seen by podiatry for foot care on 6/17/25. R23's progress notes did not indicate fingernail care or refusals of fingernail care. During observation and interview on 6/29/25 at 9:11 a.m., R23's nails were multiple millimeters (mm) in length with dark debris underneath them. R23 stated staff assisted him with nail care, and he would like his nails cut. During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his wheelchair and dressed. R23's nails were in the same condition as the previous observation. R23 reiterated he wanted his nails cut and cleaned. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated R23 refused to have his nails cut at times and told the nurse when he refused. NA-K stated they would cut his nails after lunch. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A stated residents nails were trimmed on bath days and refusals should be	20915		

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20915	Continued from page 40 documented. LPN-A verified the condition of R23's nails and stated his nails needed to be trimmed. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected nail care to be completed with weekly showers and as needed to prevent infection and maintain resident dignity. The facility policy Care of Fingernails/Toenails dated February 2018, indicated nail care included daily cleaning and regular trimming, and proper nail care aided in the prevention of skin problems around the nail bed and from accidental scratching and injury to residents' skin. The policy directed staff to document the reason why and intervention taken if a resident refused nail care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents requiring assistance from facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently. The results of those audits should be taken to QAPI to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20915		
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 3 of 3 residents (R12, R8, R153) who complained about cold food at meals. This had potential to affect a total of 25 residents identified to reside on the unit where the meals were served and sample tray tested. Findings include: R12's quarterly Minimum Data Set (MDS), dated 1/18/25, identified R12 demonstrated no delusional thinking.	20960	Corrected.	08/26/2025

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20960	Continued from page 41 However, the section to record R12's cognition was dashed with, "Not Assessed [See F638]." On 6/29/25 at 10:53 a.m., R12 was interviewed about his quality of life at the care center. R12 complained about the food and described it as "garbage," and "nasty." R12 stated the meals were often served cold and he wanted warm food to eat. R8's quarterly MDS, dated 6/20/25, identified R8 demonstrated no delusional thinking. On 6/29/25 at 10:23 a.m., R8 was interviewed and expressed aloud, "The food sucks." R8 explained the kitchen rarely seemed to have meat products but rather just carb-filled food items which he disliked due to having diabetes. R8 explained the food was often served cold adding this occurred, "Most of the time." R8 stated "most of the time" the meals delivered via room tray were often served cold and the aides rarely would heat it up even if asked adding, "The aides don't do [expletive] here." R8 reiterated his displeasure with the meal service and stated, "This place just sucks." R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25, but a cognitive assessment had not yet been completed. During an interview on 6/29/25 at 8:50 a.m., R153 stated the food was "garbage," tasted like "dog food," and was always "freezing cold" when it should be hot. On 6/29/25, the following observations and interviews occurred: -At 11:52 a.m., cook (CK)-A stated they already temped the food for lunch. CK-A stated the temped the pork loin which was above 170 degrees Fahrenheit and did not need to temp the cabbage, potatoes, or other items. CK-A was unsure of where to write down the food temperatures. Dietary aide (DA)-C stated the food carts were already brought upstairs for service. DA-A was still in the kitchen collecting serving items with food in pans and covered on their cart. -At 12:03 p.m., DA-A stated they went to the second floor as soon as possible to turn on the steam table and ensure serving items were stocked. DA-A started to scoop food onto plates and serve to residents in the dining area. DA-A was not observed to temp the food before service. -At 12:42 p.m., some room trays were set up and plated on the cart and others were not. DA-A was not in the dining area. -At 12:47 p.m., DA-A returned to the dining area with a	20960		

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20960	Continued from page 42 sandwich. -At 12:55 p.m., DA-A stated they plated up the last room tray. A test tray was requested, plated, and placed on the cart. Some room trays were already brought to rooms and other rooms trays were still on the cart. -At 12:59 p.m., there were still room trays on the cart and DA-A went to the kitchen on the first floor to bring up a resident's alternative meal option. -At 1:02 p.m., DA-A plated a meal for a new resident. -At 1:05 p.m., the test tray was taken for another resident. -At 1:09 p.m., DA-A stated the last tray on the cart could be used as a test tray instead of the initial one which was taken for a resident. The director of nursing (DON) sampled the pork loin, potatoes, and cabbage. The DON stated the pork loin and cabbage could be a "little warmer". During interview on 6/29/25 at 1:31 p.m., DA-A stated they heard about complaints of cold food. DA-A stated they asked others about temping food once on the steam trays and were told they did not need to temp the food. During interview on 7/1/25 at 2:20 p.m., CK-C stated they temped all the food to ensure the food was hot or cold and had a temperature log they filled in. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to temp and track all food and temp again after placed in the steam tables. CD stated temping food was important to ensure food was cooked appropriately and prevent food poisoning. During follow-up interview on 7/2/25 at 10:22 a.m., CD reviewed the temperature log and verified the pork loin and cabbage were not items listed as temped on 6/29/25 for lunch. CD expected food to be served at appropriate temperatures to avoid bacteria growth, and residents liked hot food. The facility Food: Quality and Palatability policy dated 2/2023, indicated food would be palatable, attractive, and served at a safe and appetizing temperature. The facility Time and Temperature Control and Recording policy undated, directed staff to record final cooking temperatures on the Cooking Temperature Log and check	20960		

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20960	Continued from page 43 good temperatures when food was placed in steam table or hot holding unit and at least every two hours thereafter. SUGGESTED METHOD OF CORRECTION: The director of nutrition services, or designee, could review applicable policies and procedures to ensure timely serving of prepared food items to ensure palatability; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	20960		
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food allergens and/or preferences were followed for 3 of 4 residents (R258, R35, and R37) reviewed for food allergens/preferences. Findings include: R258 R258's quarterly minimum data set (MDS), dated 6/25/25, indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. R258's face sheet, printed 7/2/25, indicated R258 had several allergies including cornstarch, gluten, and soybean Oil. R258's care plan, dated 6/19/25, indicated "resident [R258] has reported food intolerances that cause abdominal pain (corn starch, dairy (butter, American Cheese & Hard Cheeses ok), egg whites (ok if cooked into things), gluten, soy, soybean oil." The care plan contained an intervention, dated 2/10/25, that directed staff to not serve "corn starch, dairy (butter,	20965	Corrected.	08/26/2025

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20965	Continued from page 44 American Cheese & Hard Cheeses are ok per Debra), egg white (ok if cooked into something), gluten, soy, or soybean oil" unless requested. R258's meal ticket, used by the kitchen staff to communicate allergies, preference, and diet type, also indicated R258's allergy/preference to not have foods cooked in soybean oil. During observation and interview on 6/29/25 at 10:14 a.m., R258 was in her room, lying in bed with her breakfast tray on the overbed table. On the tray were what appeared to be two, untouched fried eggs. R258 stated the food at the facility was "a joke" and that she had allergies that were still served to her, including gluten and soybean oil. R258 stated the eggs were "the worst" and always cooked in soybean oil and "sometimes you lift them [the eggs] up and they are just greasy with oil." R258 stated if she eats things cooked in soybean oil it causes her to have extreme upset stomach and that if she didn't buy her own food, she "would not get enough to eat." R258 confirmed the dietary manager was aware. During an interview on 6/29/25 at 3:08 p.m., cook (CK)-A stated they use an Arrezzio 90/10 Vegetable and Olive Pomace Oil Blend. The oil blend contains 90% soybean oil and 10% olive oil. During observation on 07/01/25 at 8:51 a.m., an Arrezzio oil container was sitting next to cracked eggs in the kitchen. During an interview on 7/1/25 at 2:20 p.m., (CK)-C stated they used the Arrezzio oil for cooking and did not know of any residents who needed a different kind of oil. CK-C stated they used the oil for frying eggs, deep frying foods, and chicken breasts. CK-C stated they used butter for frying eggs at times, to grease pans, and to make cookies. During interview on 7/2/25 at 7:23 a.m., CK-B stated they used the Arrezzio oil for food like eggs unless a resident specifically stated they wanted their eggs fried with butter. CK-B stated there were two residents who requested butter instead of oil for cooking but one of those residents passed away and the other resident did not reside in the facility anymore. CK-B stated	20965		

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20965	Continued from page 45 they were not aware of any current residents for whom they should avoid cooking with the oil. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated they knew of one resident, R258, who could not have soybean oil and expected staff to cook her meat and steam eggs without the soybean oil. R35 R35's annual Minimum Data Set (MDS) dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. The care plan indicated eggs caused R35 to have an upset stomach unless the eggs were cooked into food. The care plan indicated R35's preference to avoid strawberries and nuts, and R35 liked fish patties with tartar sauce, chicken, turkey porkchops, and applesauce. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. During observation and interview on 7/1/25 at 8:32 a.m., R35 sat at a dining room table and ate breakfast. Dietary aide (DA)-E stated R35's plate had pureed biscuit, pureed scrambled eggs, and oatmeal. The meal ticket next to R35 indicated "Allergies: *Strawberry Allergen*, Egg Yolk, Treenuts, Soy/Soybean Oil, *Peanut Allergen*". The meal ticket indicated "No eggs at breakfast" under the listed allergies and "NO EGGS" under the listed breakfast items. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's allergies but would reference the meal ticket. NA-A stated they would change a resident's plate if they noticed a resident was not served the correct meal. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets	20965		

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20965	Continued from page 46 listed diet texture, allergies, and preferences. During interview on 7/2/25 at 10:22 a.m., the culinary director (CD) expected staff to follow residents' meal tickets and should not plate items listed as an allergy for a resident since staff may not know if the food item was an allergy or preference. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to not serve food listed as an allergy to residents for safety reasons. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. R37 R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care and was independent with eating after set-up assistance. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood. R37 stated the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated he did not eat it, but it happened again just a few days ago. R37 stated he had followed up with the social worker when this happened as it continued to happen. R37's allergy list, printed 7/2/25, lacked identification of allergy to shellfish, seafood, or fish. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: -Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up	20965		

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20965	Continued from page 47 - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions."	20965		

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20965	Continued from page 48 R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." Grievance log for June 2025 indicated a grievance was filed by R37 on 6/24/25 regarding food concerns. On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants use the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they are familiar with R37 and work with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic to. CDM stated that he encouraged residents and staff to fill out grievances as this was a great way to track concerns. CDM reported R37 should not receive any sort of seafood or fish products as it was documented that he has an allergy to seafood, shellfish and fish. During an interview on 7/02/25 at 8:06 a.m., licensed social worker (LSW)-A stated she had met with R37 on 6/24/25 regarding concerns with R37's supper on 6/24/25. LSW-A stated R37 was served shrimp for dinner and verified R37 had an allergy to shellfish and should	20965		

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20965	Continued from page 49 not have been served shrimp due to his allergy. LSW-A stated she had seen his dinner plate, reviewed his meal ticket, and he had not received the food that was on the meal ticket. LSW-A stated she filled out a grievance form regarding this and notified the administrator and director of nursing. LSW-A stated the grievance form was given to the dietary manager to address. LSW-A stated dinner was purchased for R37 on 6/24/25 as the kitchen was closed when R37 had come to talk to her about the meal that was given to him. During an interview on 7/02/25 at 8:20 a.m., culinary director (CD) stated she had received a grievance regarding R37 receiving a shrimp dinner on 6/24/25, which he should not have received. CD stated she followed up with R37 and staff involved. CD stated staff are to follow the meal tickets and verified in this instance they did not. R37 was to get the alternative meal, due to shellfish allergy, and R37 was served shrimp. CD stated she has provided education to dietary staff regarding the importance of following meal tickets upon receiving the grievance form. CD stated R37 has an allergy to shellfish, seafood and fish and when asked what type of allergy stated, "probably his throat swells up, probably would need an epi-pen or something." CD verified the allergy was listed on the meal ticket. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated that residents' food allergies should be listed under resident's allergies. DON verified R37's food allergies were not listed in his allergy list. The facility Food Allergies and Intolerances policy dated August 2017, directed staff to ensure residents with food intolerances and allergies were offered appropriate substitutions for foods they cannot eat. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident. The facility Dining and Food Preferences policy dated 10/2022, indicated individual tray assembly tickets identified all food items appropriate for the resident based on diet order, allergies & intolerances, and preferences. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods given, offered, or consumed by residents reflect the nutritional needs and prevent potential food allergies	20965		

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20965	Continued from page 50 of residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food allergies. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are appropriate. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20965		
21015	Dietary Staff Requirements- Sanitary conditi CFR(s): MN Rule 4658.0610 Subp. 7 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to ensure opened dairy products (i.e., milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. These findings had potential to affect all 51 residents within the care center. Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, "How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?]," dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on	21015	Corrected.	08/26/2025

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21015	Continued from page 51 the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, "06-19-25 [10 days prior]." The milk container had a commercial stamp along the collar which outlined a 'best by' date of, "06/29/25." DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used "three days" after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, "I don't know." On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, "06-25-25 [five days prior]." DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been "rubbed off" by them just before they brought the cart up. DA-B stated the black writing read "6/9" before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, "I'm not sure." DA-B verified the milk was intended to be used for the supper meal service that evening. Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed.	21015		

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21015	Continued from page 52 They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to "the number of diseases that come with it [using milk beyond that range]," adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart. On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, "Refrigerator Temperature Log," which was dated, "June 2025." The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, "06-24-25." However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, "I don't check this." DA-A verified the milk was beyond the 'best by' date and was not dated when	21015		

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21015	Continued from page 53 opened, and they expressed there was enough milk in the container to serve "seven or eight" people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was "a resident fridge" used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated "the kitchen, not us" was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, "05/23/25," and "Gravy." The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, "I think it's gravy." NA-D verified the condition of the food product and dates on the tinfoil. One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, "Yea," when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, "Obviously no one was doing it." LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked "disgusting." LPN-B stated many of the food items in	21015		

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21015	Continued from page 54 the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, "So things like that [surveyor findings] don't happen." On 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more "daily oversight" of tasks like that to ensure they get done. CDM explained there was a "monthly routine" to check the unit refrigerators for food dates and expirations but added, "Some people can be forgetful." CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, "Especially with the vulnerable base we have." On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, "The nursing staff will discard perishable foods on or before the 'use by' date," adding further, "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor ...)."	21015		

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21015	Continued from page 55 INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished	21015		

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21015	Continued from page 56 up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and "use by" date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop, review, and/or revise policies and procedures to ensure proper hair protection worn for facial hair, ensure proper methods of drying and stacking dishware utilized, and ensure dry baking and frozen food stored to reduce contamination. The dietary manager or designee could educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21015 21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to ensure opened dairy products (i.e., milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. These findings had potential to affect all 51 residents within the care center. Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, "How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?]," dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, "06-19-25 [10 days prior]." The milk container had a commercial stamp along the collar which outlined a 'best by' date of, "06/29/25." DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from	21015 21100	Corrected.	08/26/2025

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21100	Continued from page 58 the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used "three days" after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, "I don't know." On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, "06-25-25 [five days prior]." DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been "rubbed off" by them just before they brought the cart up. DA-B stated the black writing read "6/9" before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, "I'm not sure." DA-B verified the milk was intended to be used for the supper meal service that evening. Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to "the number of diseases that come with it [using milk beyond that range]," adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart.	21100		

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21100	Continued from page 59 On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, "Refrigerator Temperature Log," which was dated, "June 2025." The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, "06-24-25." However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, "I don't check this." DA-A verified the milk was beyond the 'best by' date and was not dated when opened, and they expressed there was enough milk in the container to serve "seven or eight" people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was "a resident fridge" used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated "the kitchen, not us" was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the	21100		

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21100	Continued from page 60 refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, "05/23/25," and "Gravy." The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, "I think it's gravy." NA-D verified the condition of the food product and dates on the tinfoil. One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, "Yea," when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, "Obviously no one was doing it." LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked "disgusting." LPN-B stated many of the food items in the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, "So things like that [surveyor findings] don't happen." On 6/30/25 at 5:04 p.m., the contracted group (dietary)	21100		

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21100	Continued from page 61 district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more "daily oversight" of tasks like that to ensure they get done. CDM explained there was a "monthly routine" to check the unit refrigerators for food dates and expirations but added, "Some people can be forgetful." CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, "Especially with the vulnerable base we have." On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, "The nursing staff will discard perishable foods on or before the 'use by' date," adding further, "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor ...)." INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack	21100		

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21100	Continued from page 62 and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to	21100		

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21100	Continued from page 63 prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and "use by" date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents	21385	Corrected.	08/26/2025

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21385	Continued from page 64 and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure current infection control standards of practice were followed when performing resident personal care for 1 of 4 residents (R153) observed for personal care. Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's Medical Diagnosis list dated 6/23/25, indicated R153 was diagnosed with diabetes, a stroke, and heart disease. R153's care plan dated 6/30/25, indicated R153 required the assistance of one to two staff members for bed mobility and dressing, and the assistance of two staff members for toileting and transferring. During an observation on 7/1/25 at 8:27 a.m., R153 was observed lying in bed. Nursing assistant (NA)-I and NA-J were observed assisting R153 with personal care. NA-I, with gloved hands, was observed to assist R153 with perineal care while R153 was lying on his back. NA-J was observed to assist the resident in rolling towards her, while NA-I completed perineal care on the backside. NA-I was observed, still with gloved hands, to assist the resident to apply a new pad and put on shorts. Then both aides assisted R153 to sit on the edge of the bed. NA-J was observed to position a motorized stand aide while NA-I, with gloved hands, assisted the resident to position his hand and feet on the machine. NA-J was observed to complete hand hygiene and then leave the room. NA-I with gloved hands, assisted R153 to position himself in the wheelchair and readjust his glasses. NA-I took off his gloves, gathered the trash, and left the room. NA-I was not observed to complete hand hygiene during this observation or to change gloves. During an interview on 7/1/25 at 8:50 a.m., NA-I stated he had completed hand hygiene and applied gloves before entering R153's room, taken off his gloves before	21385		

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21385	Continued from page 65 leaving the room, and then, after he had thrown away the trash, he completed hand hygiene. NA-I confirmed he had otherwise not completed hand hygiene while completing R153's care. NA-I stated he was taught to complete hand hygiene before and after care but had not been told that he also needed to complete hand hygiene during care. During an interview on 7/2/25 at 9:58 a.m., the director of nursing (DON) stated staff were expected to complete hand hygiene before applying gloves, when changing gloves, after glove use, and after a task like perineal care to prevent "cross-contamination". The facility Handwashing/Hand Hygiene policy dated 8/19, indicated staff were to complete hand hygiene before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, and after removing gloves. SUGGESTED METHOD OF CORRECTION: The DON or infection control officer could develop could educate staff on the infection control program along with random audits of staff cares to ensure proper techniques are implemented. The infection control program could be integrated with the quality assurance program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426	It is Terrace at Crystal's policy to establish and maintain a comprehensive tuberculosis (TB) infection control program according to the most current CDC guidelines, including a TB infection control plan that covers all residents, employees, contractors, students, and volunteers. TB symptom screenings were completed for R21, R24, R47, and R49, and results were documented in the electronic medical record. NA-B completed the second step of the two-step Mantoux TST within the required timeframe, with results documented. LPN-C completed the required TB symptom screening, with results documented in the employee file. Licensed Practical Nurse (LPN) D completed the required IGRA blood test and TB symptom screening, with results documented in the employee file.	08/26/2025

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21426	Continued from page 66 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure that required tuberculosis (TB) testing was completed for 3 of 5 staff members (NA-B, LPN-C, LPN-D) and 4 of 5 residents (R21, R24, R47, R49) reviewed for TB screening. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of an assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for infection with mycobacterium tuberculosis. In addition to aforementioned tests, a chest x-ray, and/or medical examination by a medical practitioner was to be completed to rule out active disease. The MDH Regulations for Tuberculosis Control in Minnesota Health Care Settings dated 7/2013, indicated "a baseline TB screening is required for all health care workers. The baseline TB screening consists in three components: 1. Assessing for current symptoms of active TB disease 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step Mantoux Tuberculin Skin Test (TST) or singe interferon gamma release assay (IGRA) blood test. An employee may begin working with patients after a negative TB symptoms screen (i.e., no symptoms of active TB disease) and negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." RESIDENT R21's annual Minimum Data Set (MDS) dated 4/18/25, indicated R21 was admitted to the facility on 6/11/22,	21426	Continued from page 66 A facility-wide audit of all resident and staff TB screenings was conducted to ensure all required screenings and tests were completed and documented. Any missing screenings were completed immediately. The policies titled “Screening Residents for Tuberculosis” and “Employee Screening for Tuberculosis” were reviewed. The Infection Control Nurse and/or designee will maintain a TB Screening Tracking Log to monitor timely completion for all residents and staff. DON or designee will conduct audits of all new admissions/reentries and new hires to ensure TB screenings and testing are completed prior to resident contact. Audits will be completed 1x per week for 8 weeks, then monthly for 4 months, or until sustained compliance is verified. Results of audits will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs. DON and/or Infection Control Nurse are responsible for compliance.	

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21426	Continued from page 67 with a reentry date on 9/15/24. R24's admission Minimum Data Set (MDS) dated 5/5/25, indicated R24 was admitted to the facility on 4/28/25. R47's quarterly Minimum Data Set (MDS) dated 5/8/25, indicated R47 was admitted to the facility on 1/29/25. R49's admission Minimum Data Set (MDS) dated 6/4/25, indicated R49 was admitted to the facility on 5/29/25. R21, R24, R47 and R49's medical records were reviewed on 7/22/25 at 11:22 a.m., and no TB symptom screenings (a tool used to determine if active TB infection could be present) were identified. STAFF Nursing assistant (NA)-B's TB screening tool signed on 6/4/25, indicated a TST was administered on 6/4/25 and read on 6/6/25 at zero millimeters. The form had a spot labeled "test #2" which was left blank. The form indicated a "2nd step" would be administered within one to three weeks. The form had a spot labeled "date of hire" which read 6/4/25. During an interview on 6/30/25 at 4:06 p.m., the infection preventionist (IP) stated LPN-D always had a positive skin test and knew a blood test was required and had completed the test a few months ago, and stated LPN-D was asked to email the document. The IP confirmed a screening tool had not been completed, and they did not receive confirmation that a IGRA blood test was completed. LPN-D was hired on 3/19/25. Licensed practical nurse (LPN)-C was hired on 3/19/25 and completed a IGRA blood test, also known as a Quantiferon-TB Gold, that was drawn on 5/12/25 and reported on 5/14/25 with a negative test result. The IP confirmed a screening tool was not completed for LPN-C. During an interview on 7/1/25 at 2:27 p.m., the IP stated TB screenings for residents were done electronically through the electronic medical record (EMR) and titled Resident Tuberculosis Screener. The IP confirmed R21, R24, R47, R49 did not have a screening on file. The IP confirmed NA-B did not have a second	21426		

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21426	Continued from page 68 TST, LPN-C did not have a screening on file, and LPN-D never sent over test results and did not have a screening on file. During an interview on 7/2/25 at 8:34 a.m., the director of nursing (DON) stated the IP is responsible for all TB screening and testing at the facility. The expectation is that all staff and residents were screened and tested. This was important so that the residents were not put at risk and to follow all state regulations. The DON confirmed if a step 1 TST was completed, a step 2 TST must also be completed within one to three weeks. The DON also confirmed NA-B was on the schedule and worked as a nursing assistant without a second test. The DON confirmed both LPN-C and LPN-D were on the schedule and worked in the facility but was not aware that screenings or test were not completed. DON was also not aware R21, R24, R47 and R49's were not screened for TB, and stated it was important to screen all residents so that the community was not exposed. A policy, Screening Residents for Tuberculosis revised 8/19, identified "This facility shall screen all residents for tuberculosis infection and disease (TB)". A policy, Employee Screening for Tuberculosis dated 3/21, identified "all employees are screened for latent tuberculosis (LTBI) and active tuberculosis (TB) disease using skin test (TST) or in or interferon gamma release assay (IGRA) and symptoms screening prior to beginning employment". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor residents and employee TB screenings to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one-(21) days.	21426		
21435	Activity and Recreation Program; General CFR(s): MN Rule 4658.0900 Subp. 1 Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed	21435	Corrected.	08/26/2025

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21435	Continued from page 69 to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 1 of 2 residents (R24) reviewed for activities. Findings include: R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. However, the section to record R24's activity preferences and routines was left blank or marked, "Not Assessed [See F636]." On 6/29/25 at 10:46 a.m., R24 was observed lying in bed while in her room on the locked unit. R24's television was turned on and positioned along the opposite wall of her bed. R24 was interviewed and expressed aloud, "I don't know," when asked how long they'd lived at the center. R24 was dressed in a hospital-type gown and her hair appeared with a light, greasy-looking shine. R24 was asked about what, if any, activities the floor staff involve her with and she abruptly responded, "Would you leave me alone?!" Following, on 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G explained they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated R24 had been outside "maybe once" since admitting from their recall and expressed the staff may be offering them to her and she's declining them but was unsure. FM-G stated R24 had a television in her room which she needed help to operate and expressed they were unsure if staff knew that or not adding, "I don't know they realize that." FM-G stated R24 enjoyed mystery and "murder shows" on the television. Further, FM-G reiterated they were unsure if R24 would participate in activities even, however, stated nobody from the care center had ever talked with them about her likes or dislikes for activities since she admitted.	21435		

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21435	Continued from page 70 R24's medical record was reviewed and lacked evidence R24 had been comprehensively assessed for what, if any, individual or group-based activities she would like to attend; nor did the record have evidence of any other activities (i.e., 1:1) being provided. R24's care plan, printed 7/1/25, identified all R24's current or potential concerns the facility had identified and implemented interventions to address. The care plan was reviewed and lacked any recorded focus statements, goals, or interventions for leisure and/or activities despite R24 admitting to the care center months prior. Further, the entire electronic medical record (EMR) lacked any completed tasks or progress note(s) in the system to demonstrate R24 had been provided any activities since she admitted to the care center. On 6/30/25 at 1:33 p.m., R24 was again observed lying in bed while in her room. R24's television was turned on and a day-time drama television show was on. R24 was asked about the show or if she enjoyed it, however, R24 just mumbled a response which was not discernable. R24 was asked if she was able to use the remote or needed help and just stared at the surveyor with no audible response. When interviewed on 6/30/25 at 1:36 p.m., nursing assistant (NA)-A stated they had worked with R24 prior, and expressed R24 needed help with nearly all her cares. NA-A stated R24 would rarely get up from bed and expressed it "all depends" on her mood and what she'd allow each day. NA-A stated R24 would get up to the wheelchair maybe "three to four times [week]" and then added, "She really likes to be in her room." NA-A stated they were aware of some activities happening "at the back there" on the unit, however, had only seen her at a few they could recall. NA-A stated R24 liked her "criminal shows" and would try to keep those on the television for her. NA-A stated they knew R24 enjoyed 'criminal shows' as "I work with her a lot of times," adding nobody from the care center activities' staff had ever told them which channels or shows to play for R24 adding, "I just found out on my own." NA-A verified R24 would, at times, not speak to staff and would remain silent adding R24 needed to "be in a good mood" to converse. When questioned how other staff, including pool staff, would know which shows or channels R24 enjoyed NA-A responded aloud, "That's hard." NA-A stated the staff used a "care guide" which had all residents listed on it and reviewed this with the surveyor. R24's name was listed, however, the guide lacked any information on which channels, shows, or activities R24 enjoyed or wanted. NA-A verified the guide lacked this information and expressed aloud,	21435		

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21435	Continued from page 71 "It's not there." NA-A stated having it listed on the care guide would help others adding, "Everybody works different with these people." When interviewed on 6/30/25 at 1:45 p.m., trained medication aide (TMA)-A stated they had worked with R24 prior and described her as needing "a lot of help" with cares. TMA-A explained R24 could be "real mean" sometimes and "not too often" would get up from bed. TMA-A stated physical therapy (PT) was working with her and even for them, R24 would still "not too often" get up from bed. TMA-A stated they had never seen R24 attend any activities prior and was unsure what, if any, in-room activities the staff were doing for her adding, "I haven't seen it." TMA-A stated R24 could "tell you what she wants" if she needed the television adjusted but then expressed R24 would not usually speak to people she didn't like or didn't know adding the aides often rotate amongst the units "all the time." TMA-A stated the activities personnel would know more about R24. On 6/30/25 at 1:51 p.m., the activities assistant (AA)-A was interviewed, and explained they worked on the memory care unit. AA-A stated a previous activities supervisor used to do the comprehensive assessments for residents, however, lately it had been them doing it. AA-A stated activities' likes and dislikes were tracked using a paper flow sheet on each floor and then entered into the system under the "assessments" tab. AA-A stated the activities director (AD) did the care plans adding, "We don't do that." AA-A stated the AD would likely have more information on the assessment and care planning of activities. AA-A explained they were aware of R24 and expressed aloud, "She don't come out their room." AA-A stated they do a "coffee and chat" quick with her everyday but R24 often didn't verbally respond to her. AA-A stated they "check on her" a few times every day they felt. AA-A explained they used to track activities within the EMR, however, a previous management staff told them to stop doing so as "State [MDH] can't see it," which is where the paper flow sheets came from. AA-A stated this had been the process since "like two administrators ago" from their recall. AA-A stated R24 was "not a normal person to talk to" but felt she enjoyed "the old, old shows" and "like gray and white shows" from her recall. Later, on 6/30/25 at 2:01 p.m., the AD and AA-A were interviewed and the paper flow sheets, as completed by AA-A, were provided for review. These identified a paper with rows and columns which had multiple resident room numbers on the side and spacing to record across the paper for each day of the week. These identified:	21435		

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21435	Continued from page 72 May 26 to May 31; R24's name and room number were identified. The flow sheet recorded a 1:1 was held four times, however, it didn't record any date(s) or length of time or what activities (i.e., nail care, reading news) were completed during it. June 2 to June 6; R24's name and room number were identified. The flow sheet recorded a 1:1 was held six times, once each day from Monday to Saturday, respectively. However, again, the sheet didn't record any length of time or what activities were completed during it. June 9 to June 14; R24's name and room number were identified. The flow sheet recorded a 1:1 was held five times, once each day from Monday to Wednesday, and on Friday and Saturday. The flow sheet recorded a single entry on Thursday which read, "Unv." However, again, the sheet didn't record any length of time or what activities were completed during the 1:1 sessions or an explanation for what 'unv' meant. July 12 (i.e., "7/12"); R24's name and room number were identified. R24 was not listed on the flow sheet and no activities were recorded for her. AA-A explained the 1:1's recorded on the flow sheet for R24 were the 'coffee and chat' sessions they had explained. AA-A acknowledged the charting on the flow sheet showed only once but reiterated they stopped in the room a "couple times a day" to check on her. AD explained the AA staff help complete the comprehensive assessments for each resident upon admission which were then entered into the EMR adding that should be done "as soon as they come in." From those assessments, then the care plan gets developed in the EMR. AD reviewed R24's medical record and verified it lacked any completed assessments for activities and the care plan lacked information or interventions for activities adding, "It's not in there." AD stated they felt it was completed and possibly just not entered adding, "I know we did it." AD stated the lack of assessment and care plan made it appear "like they [staff] didn't talk to her at all." AA-A stated they had search for a paper copy of the completed assessment, however, were unable to locate it adding aloud, "Maybe we missed one." However, both AD and AA-A verified residents' should be assessed and care planned for their activities preferences adding such was important, "So we know what they like and like to do." AA-A stated they would go and assess R24 now since this was identified. A facility provided Activity Programs policy, dated	21435		

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21435	Continued from page 73 3/2025, identified activities would be offered based on the comprehensive assessment and preferences of each resident. The policy outlined activities were scheduled seven (7) days a week and residents would be given opportunity to contribute to the planning, conducting and critiquing of them. The policy directed, "All activities are documented in the resident's medical record." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on activities assessment and care planning; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	21435		
21540	Unnecessary Drug Usage; Monitoring CFR(s): MN Rule 4658.1315 Subp. 2 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident was free from unnecessary medication by failing to attempt to decrease a resident's nicotine patch (a known psychotropic medication) despite the consulting pharmacist's and Centers for Disease Control and Prevention's recommendations for 1 of 5 residents (R7) reviewed for unnecessary medications.	21540	Corrected.	08/26/2025

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21540	Continued from page 74 Findings include: R7's quarterly Minimum Data Set (MDS), dated 4/26/25, indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications. R7'S electronic medical record (EMR) contained an order, dated 3/8/24, for a Nicotine Transdermal Patch 24 Hour 21 milligrams (MG) per 24 hours (Nicotine) - Apply one patch transdermal (on the skin) every 24 hours for nicotine dependence in remission. R7's most recent smoking review, dated 5/6/25, indicated that R7 was currently smoking and intended to continue to smoke. R7 was also on the facility provided list of residents who smoke. R7's care plan, dated 5/12/25, indicated R7 was a "current smoker, trying to quit, resident received Nicotine Patch each morning will sometimes refuse it." R7's monthly medication regiment reviews (MRR), dated 2/21/25, 3/24/25, 4/24/25, and 5/23/25 all indicated a pharmacist recommendation to decrease R7's nicotine patch and to discontinue it if resident was still choosing to smoke. The consultant pharmacist (CP)-A gave a rationale of nicotine being a psychotropic medication intended to help a person quit smoking by reducing nicotine dependence and manage withdrawal symptoms. CP-A further indicated the CDC advises nicotine patch doses should be lowered overtime (8-12 weeks) with a goal of stopping use of the nicotine patch completely. On the MRR dated 5/23/24, the provider had checked "agree". A handwritten note on the MRR from LPN-E, dated 5/29/25, indicated "resident [R7] refused to have patch decreased, stated that the patch keeps him from smoking, the he has not smoked in long time. Provider updated." During an interview on 6/30/25 at 5:41 p.m., trained medication aide (TMA)-C stated R7 was currently still smoking. During an interview on 6/30/25 at 5:47 p.m., trained medication aide (TMA)-D stated R7 was currently still smoking. During an interview on 7/1/25 at 8:06 a.m., R7 stated he has not smoked "in a couple of months."	21540		

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21540	Continued from page 75 During an interview on 7/1/25 at 9:36 a.m., TMA-B stated she had worked at the facility for a few years, and stated R7 "smoked heavily" and would still go outside to smoke daily. During an interview on 7/1/25 at 1:46 p.m., CP-A stated she had issued the recommendation to decrease R7's nicotine patch and had received a response in June from her May recommendation that the provider had agreed to decrease the dose but R7 had refused. The CP stated the intent of a nicotine patch was to assist a resident to quit smoking and was safer than smoking however, staff or R7 would not know how effective the patch was in helping R7 quit if it was not reduced, stating ideally it would be nice to reduce the dose, and ideally R7 would not be on the patch forever. CP-A further stated there were alternatives to the nicotine patch that R7 could try such as nicotine gum or lozenges to attempt to decrease R7's nicotine patch. CP-A further stated the patch should be discontinued if R7 was still smoking. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated R7 had told her he was not smoking however R7 was outside a lot, so she was unsure if R7 was still smoking or not. LPN-E stated they had tried to discontinue or reduce R7's nicotine patch but he refused and had been on the patch for a "long time" and "demanded it." LPN-E stated she had sent the provider messages that R7 was still on the nicotine patch but did not know what the provider's response was. A facility policy titled Tapering Medications and Gradual Dose Reduction, revised 4/2007, indicated attempted tapering of psychopharmacological medications shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. The facility could review policies and procedures related to unnecessary medications and tapering or psychotropic medications when advised. The Director of Nursing (or designee) should conduct measurable audits on residents using psychotropic medications to ensure they are necessary and at a necessary dose. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21540		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C	21545	Corrected.	08/26/2025

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21545	Continued from page 76 A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors when a narcotic pain medication was not administered as ordered for 1 of 5 (R10) residents reviewed for unnecessary medications.	21545		

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21545	Continued from page 77 Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25 and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25 and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given 6/1/25 through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25 and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered. -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to	21545		

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21545	Continued from page 78 be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone. -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain noted.	21545		

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21545	Continued from page 79 R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still don't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated nursing staff had used oxycodone from the emergency supply until they ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed, when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would have missed fewer doses of the medication or not missed any doses at all. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the	21545		

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21545	Continued from page 80 issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures for medication administration, and the policy for medication errors. The DON or designee could develop a system to educate staff and monitoring system to ensure pain medications were correctly administered . The DON or designee could monitor and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complications for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25, and discontinued on	21550	Corrected.	08/26/2025

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21550	Continued from page 81 6/23/25. The order was documented as given on 6/1/25 through 6/18/25, and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25, and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given 6/1/25, through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25, and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered. -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone. -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated	21550		

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21550	Continued from page 82 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress note dated 6/20/25 at 4:19 p.m., indicated R10's provider had been contacted to request a new prescription for her 2.5 mg order of oxycodone. R10's progress note dated 6/30/25 at 9:56 a.m., indicated a call was placed to the provider to get a new prescription for her oxycodone. R10's progress note dated 6/30/25 at 11:58 a.m., indicated that a voicemail was received from the provider indicating a new prescription [did not indicate what medication] was sent to the pharmacy. R10's progress notes were reviewed dated 6/1/25 through 6/30/25, and did not indicate any further requests for oxycodone were made. R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain documented. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone	21550		

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21550	Continued from page 83 once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still didn't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated she had trouble getting a new prescription from the provider, and when she did, sometime last week, she thought the pharmacy had not accepted it due to the way the dosage was written. LPN-E stated nursing staff had used oxycodone from the emergency supply until the facility ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E confirmed she had reviewed R10's medical record and the first time she saw that a new prescription for the oxycodone had been requested from the provider was on 6/20/25, although the medication ran out on 6/19/25, and she did not see that the medication was requested from the pharmacy until 6/27/25. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would	21550		

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21550	Continued from page 84 have missed fewer doses of the medication or not missed any doses at all. During an interview on 7/1/25 at 12:38 p.m., the dispensing pharmacist (DP) stated she had reviewed their records for R10 and did not see any requests for oxycodone to be dispensed until 6/28/25, including the week before 6/19/25. The DP stated they had sent a new card of medication yesterday (6/30/25), but she would have expected a request from the facility before the medication was needed as it took time to prepare the medication. During an interview on 7/2/25 at 10:00 a.m., the director of nursing (DON) stated she expected nursing staff to reorder the medication from the pharmacy when the medication card only has the far-right column left in the package, or about 8 doses. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		
21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed inhaled	21620	Corrected.	08/26/2025

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21620	Continued from page 85 medications were stored in their correct packaging to prevent potential administration error for 1 of 5 residents (R3); and failed to ensure prescribed oral medications were labeled with minimum identifiers to ensure correct administration (i.e., right patient, right medication) for 1 of 5 residents (R3) observed to received medication during the survey. Findings include: INCORRECT STORAGE: R3's Medication Administration Record (MAR), dated 7/2025, identified R3's current physician ordered medications, directions for their use, and staff spaces to record their administration or refusal. The MAR included an order for Mometasone (a steroid medication) 50 micrograms (MCG) with directions to administer 2 sprays in each nostril once daily for a respiratory infection. The MAR listed a start date for this medication as, "06/13/2025," and scheduled administration time of 8:00 a.m. On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3. LPN-B removed various oral medications from the cart while comparing them to R3's MAR which was displayed on a laptop computer on the cart. LPN-B stated R3 had a steroid inhaler (Mometasone) scheduled to be given and then removed a clear bag with a pharmacy label attached which had R3's name listed and read, "Nasal Decong Spr [spray] 0.05%," which had directions, "2 DROP IN BOTH NOSTRILS EVERY 12 HOURS AS NEEDED FOR CONGESTION." LPN-B continued to search the upper row of the medication cart before finding another clear bag with a pharmacy label attached which had R3's name listed and read, "Mometasone [steroid medication; used for asthma] Spr 50 MCG [micrograms]," with directions listed reading, "INSTILL 2 SPRAYS IN EACH NOSTRIL ONCE DAILY." However, this bag was empty with no medication or inhaler inside. LPN-B reviewed R3's MAR and verified the Mometasone was scheduled to be given; however, the inhaler wasn't in the bag. LPN-B searched the drawer and then reviewed the nasal decongestant bag. LPN-B opened the bag and expressed the Mometasone inhaler had been placed in the wrong bag. The steroid medication was placed in the nasal decongestant bag and not the correct one. LPN-B stated they were unsure how long the medication had been stored like that and, when questioned how medications could end up stored in the wrong pharmacy labeled containers, responded aloud, "Carelessness." LPN-B stated the medications should be stored in their correct pharmacy packaging so "there's	21620		

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21620	Continued from page 86 no confusion." LPN-B verified trained medication aide (TMA) staff worked on the medication carts within the building, and they reiterated correct storage of the medication was necessary to reduce the risk of residents getting the wrong medications. When interviewed on 7/1/25 at 9:42 a.m., the director of nursing (DON) stated nasal medications typically come in a "little zippy bag" from the pharmacy and should be kept in them. DON stated the correct medication should be kept inside the correct bag from the pharmacy to help ensure "accurate administration" and so staff were "giving what they're supposed to be giving." DON acknowledged medications stored in the wrong bags could lead to a medication error as the two medications (i.e., nasal decongestant / Mometasone) were different medications for different purposes. On 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A was interviewed via telephone, and they explained Mometasone was a "longer acting" medication and meant more for "ongoing therapy" versus a nasal decongestant medication. CP-A stated inhalers typically arrived to the care center in a plastic bag from the pharmacy and were usually kept inside the same bags once in the medication carts. CP-A stated staff should use one inhaler at a time to ensure they're placed back into the correct bags when done. CP-A stated having the correct inhaler stored in the correct bag helped "the double checking" when doing medication administration to ensure the right medication was being given at the right time. A facility provided Medication Storage In The Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements and, " ... Medications are kept in these containers." The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." MEDICATION NOT LABELED: R3's Order Summary Report, signed 5/15/25, identified R3's physician orders along with their administration instructions. This included an order which read, "Nicotine Polacrilex Mouth/Throat Gum ... Give 4 mg [milligrams] by mouth every 1 hours as needed for withdrawal symptoms." The order had a start date recorded, "04/11/2025." On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B	21620		

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21620	Continued from page 87 preparing medications at a mobile cart for R3 who was seated in their doorway. R3 stated they wanted their nicotine gum and LPN-B expressed they would get it. LPN-B opened the medication cart and removed a white-colored package which was labeled, "Rubgy [brand name] Nicotine Gum ... Stop Smoking Aid 4 mg," and provided it to the surveyor for review. The package was commercial and there were no pharmacy labels attached to it; nor was there any written identifier(s) to demonstrate whom the medication was for (i.e., R3). LPN-B verified the package was opened with several doses removed, and it lacked any pharmacy labeling expressing aloud, "I'm not sure why her name isn't on it." LPN-B verified the medication was not considered a "stock med" and expressed they were unsure when it had been filled or sent by the pharmacy since it wasn't labeled. LPN-B stated they believed it to be R3's supply though but verified all medications, including nicotine gum, should be labeled from the pharmacy. This was important "so we know whose it is and they [residents] get the right meds." LPN-B then removed one piece of the nicotine gum and provided it to R3. Following, at 8:27 a.m., registered nurse unit manager (RN)-A approached the mobile medication cart and LPN-B asked them aloud, "Do you know why this [gum] wouldn't be labeled from the pharmacy?" RN-A stated all medications come with a pharmacy label which should remain on the box or package. RN-A stated if staff locate a medication which doesn't have a label, then the pharmacy should be contacted for instructions on how to correct it. RN-A verified nicotine gum was considered a medication and should be labeled from the pharmacy as "we want to make sure we're giving the right medication with the right patient" adding the label helps staff to ensure the medication inside the package is correct. Later, on 7/1/25 at 8:58 a.m., RN-A stated they had just contacted the dispensing pharmacy who verified the nicotine gum should be labeled adding, "Normally, yes [should be]." RN-A stated the pharmacy was unsure why the medication was not labeled, and they were going to send a "new package" out to correct the issue. RN-A stated they told the pharmacy to investigate the situation "on their end." On 7/1/25 at 9:42 a.m., the director of nursing (DON) was interviewed. DON verified nicotine gum was considered a medication since it was listed on the MAR, and they expressed the medication should come with a pharmacy label. DON stated if staff discovered a medication that was not labeled, then they should contact the pharmacy and "get the right label on it." DON stated having medications labeled with correct	21620		

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21620	Continued from page 88 information was important as it was "an identifier" to help staff know they're giving the right medication to the right person. When interviewed on 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A verified nicotine gum would be considered a medication and typically would be labeled from the pharmacy with patient name and directions for administration. CP-A explained some nicotine gum brands come wrapped in a plastic film which sometimes has the label attached and, upon being removed, the label gets destroyed at the same time. CP-A verified the medicated gum should be labeled with, at minimum, the patient's name so staff know whose it was. CP-A stated if staff found a medication without a label, then they could contact the pharmacy who could help them resolve it. Further, CP-A stated it was important to ensure medications were labeled with basic information to help "make sure it's getting to the right patient" and help reduce the risk of error. A facility provided Medication Storage in the Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements. The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." An additional facility provided Medication Ordering and Receiving from Pharmacy policy, dated 5/2022, identified medications would be labeled in accordance with facility requirements and state and/or federal law. The policy outlined labels were to be permanently affixed to the outside of the prescription container and if the label didn't fit directly onto the product then it could be affixed to the outside container adding, " ... the resident's name, at least, must be maintained directly on the actual product container." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on pharmacy labeling and actions to address un-labeled items; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	21620		
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment,	21665	Corrected.	08/26/2025

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21665	Continued from page 89 allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair which had the potential to affect all 51 residents, staff, and visitors of the facility. Findings include: Walls: During observation of R15 on 6/29/25 at 10:24 a.m., R15 in resident room on second floor sitting in hospital gown with brown substance streaked on the floor. During observation and interview with R31 on 6/29/25 at 10:35 a.m., R31 stated she was disappointed in her facility stay in part due to the "environment is dirty" pointing to ceiling in her room with yellowing stain on it and a gash in the wall with brown drip stains down the wall. During observation and interview with R12 on 6/29/25 at 10:52 a.m., R12 lying in bed which was horizontally against the wall. Wall had numerous black marks along it with a yellow-colored stained area that extended on the wall for approximately half the length of his bed. R12 stated he was unhappy with the condition of the walls and would "like it addressed". R12 stated "this whole place is f***ed up" and that the facility had done nothing about it. During interview with R24 on 6/29/25 at 1:48 p.m., R24 stated "cleanliness of the place [sic] run down" R24 stated "this place is a pit". During observation and interview on the second-floor secured memory care unit in the dining room on 6/30/25 at 2:07 p.m., a baseboard in east corner of room had broken wallboard above it. Portions of the baseboard was not attached to wall due to the hole in the area. The area was approximately 18 inches long. Blue laminate edging was missing from portion of nursing desk facing the hallway. Portion was 8 inches that spanned the corner of the nursing station desk. Knee	21665		

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21665	Continued from page 90 wall attached to nursing station and wall across from the nursing station had numerous scrapes and missing pain including peeling. In the dining room above chair rail in corner of it there was white corner piece that did not match color of remaining wall. The corners that came together were pulling apart showing half an inches of empty space for eighteen inches. Area also had beige staining around it. Both dining room wall frames had peeling, stained, and chipped paint on both sides. Nursing assistant (NA)-A was seated at a dining room table with resident who was in a wheelchair. Two other residents were in the room at the time. NA-A stated expectation of staff to report any maintenance issues to the MT-D. NA-A stated she would tell the nurse who would then fill out a work order on the computer or verbally tell MT-D of any concerns. NA-A looked around and stated, "[It] looks like [sic] needs to be repainted. Not looking good." During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:19 p.m., TMA-A stated, "need to be fixed or done painting or repairing." TMA-A stated expectation of staff to notify maintenance of work order request for MD-T to address concerns with "painting and repairing". TMA-A observed hole in the wall in dining room above the baseboard and stated, "Oh wow. Needs to be repaired." During observation and interview with director of nursing (DON) on 6/30/25 at 2:34 p.m., on the second-floor secured memory care unit pointing to the walls, baseboards, and door frames of resident rooms and also the two entrances to the dining room. DON stated, "Needs repair. The door frames need to be repaired and replaced." DON stated, "I would not like that at my home. DON stated expectation of staff to fill out a work order and submit it electronically or notify MD-T verbally. DON stated she had worked at facility for over two years and did not see any wall repairs or replacing of baseboards or painting of door frames during that time. During observation and interview with MD-T on 6/30/25 at 3:02 p.m., MD-T observed 2nd floor resident door frames, memory care security doors, baseboards, chipped, broken wallboards and stained ceiling tiles and walls and stated, "It is not homelike. I would not like it in my home. We need to replace all of the baseboards and repaint the walls. The doors are really chipped and need to be repainted." MT-D stated	21665		

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21665	Continued from page 91 expectation of staff to submit work orders or notify him of repair needs verbally. "I have been working on them but was not aware of some of the issues. There is a lot." During observation on 6/30/25 at 5:08 p.m., in the 3rd floor dining room, two residents were eating supper at dining room table while television was on. Baseboards of dining room were beige in color with black markings all along them horizontally. Three rooms at end of hall had black markings along the walls, door frames to the dining room were chipped with stains and missing paint. All resident room door frames were chipped and missing paint. Walls with chair rails had wallpaper peeling or marked with nail holes visibly covered with white wallboard repair, sanded to reveal the nail heads resulting in white repair marks but nothing finished. Painted walls had visible nail holes which were never painted over to match. Section of cracked broken wallboard was visible outside two resident rooms ranging thirty inches horizontally above the baseboard. Broken wallboard that appears to be punched in running two feet above the baseboard outside a resident room. During observation and interview with MD-T on 7/1/25 at 8:24 a.m., on third floor outside resident room there was a horizontal broken portion of wall board above the baseboard which measured thirty inches. A small black winged insect was observed to fly in and out of the crack. MD-T stated, "yeah that looks like it needs to be repaired or replaced". During interview with R7 on 7/1/25 at 8:26 a.m., R7 stated his third-floor resident room, "I hate the way the walls and doors look here. It is junky and gross. Looks like they don't care about how it all looks (pointing out into the hallway)." During review of documents titled completed and active Work Orders with dates "May. 1, 2025 -Jul. 1, 2025" failed to identify maintenance concerns regarding condition of walls, floors, and door frames. During interview with facility's administrator on 7/1/25 at 10:31 a.m., the administrator stated he was aware of "these concerns. But there is no formalized plan written down or discussed to address these issues." The administrator stated condition of walls, floors and door frames "are not appealing".	21665		

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21665	Continued from page 92 FANS: During observation on second floor on 6/30/25 at 2:01 p.m., a large circular floor fan was operating blowing air towards the elevator and nursing station from the lounge room. It had visible dust on the front and back shrouds while operating. Staff and residents were working and ambulating and wheeling selves past the fan. During observation on second floor secured memory care unit on 6/30/25 at 2:15 p.m., a circular fan operating from on the top of the counter of the nursing station. Visible dust and dark matter were noted on the front and back shroud of fan along with the blades of the fan. A female resident was seated next to the fan and another male resident was being transported in a wheelchair past the blowing fan by a staff member. During interview with trained medication aide (TMA)-A on 6/30/25 at 2:19 p.m., TMA-A pointed to the operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "I put it there". TMA-A stated the fan had been "on all day" and "it does need to be cleaned. The cover on the front and back are filthy. ..This is a lot of dirt blowing around." During observation and interview with director of nursing (DON) on 6/30/25 at 2:42 p.m., DON looked at the circular fan operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "It is an issue with infection control. Blowing dirty air throughout the unit. Needs to be cleaned." During observation and interview with maintenance director (MT)-D on 7/1/25 at 8:50 a.m., MT-D was wiping the shroud of a large circular floor fan in the lounge of second floor main area. MD stated, "I need to wipe it to get the dust out of it on the inside and outside of the fan." MD-T stated facility had no "specific" cleaning schedule for facility used fans. "I just do it quarterly". During observation and interview with dietary manager (D-M) on 7/1/25 at 10:10 a.m., a large circular	21665		

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21665	Continued from page 93 portable fan was circulating air towards the dishwashing area of kitchen. The area had a large stainless-steel counter along one wall that contained used meal trays, utensils and kitchen pots and pans. The counter curved in the corner of the room to meet the dishwasher unit and clean dishes exited. The fan blew air from dirty portion of the counter to the clean portion where the dishes exited. D-M stated, "The dirty dishes are rinsed here (pointing to the beginning of the counter) and then they are rinsed and moved down the counter towards the dishwashing machine". D-M pointed to the circular portable fan and stated, "It should be getting wiped down. Does not look like it has been wiped because there is dust on the front cover while it is blowing towards the dishwashing area". During observation and interview on first floor hallway outside dining room on 7/1/25 at 11:08 a.m., a large circular floor fan was circulating air from the resident hallway towards the dining room. Visible dust was observed on the shroud. At 11:11 a.m., registered nurse health care consultant (HC) observed fan and stated, "needs to be wiped down. There is dust blowing across the hall onto residents and staff making it an infection control issue. We notice the dusty fans here yesterday and this fan was not cleaned or wiped down." During observation and interview on 7/1/25 at 8:33 a.m., MT-D wiping visible dust from shroud of large circular floor fan outside elevator on third floor. MT-D stated the fan had been in use for "weeks" blowing air towards the nursing station, elevator and resident rooms. During interview with administrator and regional director (MD) on 7/1/25 at 2:24 p.m., MD stated, "All fans should be cleaned". Facility policy on homelike environment was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.	21665		

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21665	Continued from page 94 TIME PERIOD FOR CORRECTION: 21 days	21665		
21730	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 11 Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure adequate pest control measures were in place to eliminate small black flies from the building. This had the potential to affect all 51 residents of the facility. Findings include: During observation and interview with R8 on 6/29/25 at 10:27 a.m., in second floor resident room, several small black flies were observed flying around the room during interview. R8 stated the facility “is full” of small black flies and they are “all over the f***ing building”. R8 stated the flies “been issue for a while…last few months I guess”. R8 stated he was disappointed with facility’s lack of action to address the flies. R8 stated he was “not sure what’s being done about it”. During observation and interview with R31 on 6/29/25 at 10:35 a.m., in third floor resident room R31 stated she “occasionally sees fruit flies” both in her room and out in hallway and dining room. During observation and interview with R36 on 6/29/25 at 10:43 a.m., in third floor resident room, R36 stated facility “gets bugs in here” and was not pleased with it. During observation in second floor dining room on 6/29/25 at 12:17 p.m., a dietary aide was serving food on meal tray to a table with R22 seated in a geriatric chair. Visible little black flies were flying above the table were observed. During interview with nursing assistant (NA)-E on 6/29/25 at 1:19 p.m., NA-E stated she had noticed flies	21730	Corrected.	08/26/2025

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21730	Continued from page 95 on the second floor. NA-E stated expectation of staff to notify management of flies and “Bring someone in to spray the place”. During interview with culinary aide (DA)-A on 6/29/25 at 1:31 p.m., DA-A stated she had seen “a lot more fruit flies now consistently [for] two or three weeks.” DA-A stated she did not hear any meetings or information from management regarding fruit flies. During interview with R24 on 6/29/25 at 1:48 p.m., in second floor resident room, R24 stated she had “seen some fruit flies” in the past and that her sister had mentioned it to her also when visiting. During interview with maintenance director (MT)-D on 6/30/25 at 11:14 a.m., MT-D stated he was aware of the small black flies’ “issue” in the facility through verbal reports by staff and residents and stated the pest management company “comes out once a month”. MT-D stated the monthly reports filled out by the pest service specialist (PS)-S were missing so he was unable to provide surveyor written reports. MT-D stated he knew nothing about what specific services PS-S provided to address the fly issue. During observation on 6/30/25 at 2:05 p.m., in the second-floor shower room a small black fly was buzzing around. During interview with nursing assistant (NA)-A on 6/30/25 at 2:15 p.m., NA-A stated she could see and was aware of small black flies in the facility. NA-A stated she noticed black flies when the weather started to get warmer. “Looks like something needs to be done to get rid of them. They are everywhere.” NA-A stated expectation of staff to notify the “nurse” so a report could be completed and sent to MT-D. Also, all staff had ability to email or verbally communicate to MT-D about maintenance concerns, including pests. During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:22 p.m., TMA-A stated she was aware of the small black fly issues in the building from residents and other staff including her own observations. TMA-A stated MD-T was made aware by her via verbal means. TMA-A stated, “[facility] need to do something better”. During interview with director of nursing (DON) on 6/30/25 at 2:49 p.m., DON stated she was aware of the small black fly issues. “I have seen it and reported to [MT-D] within this month.” DON stated MT-D placed “some	21730		

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21730	Continued from page 96 traps out" on resident units and it "still [sic]an issue". During interview with MT-D on 6/30/25 at 3:02 p.m., MT-D stated expectation of staff to communicate facility maintenance needs including pest concerns through electronic Work Orders which can be done through the computer. MT-D stated he is also made aware of issues including pests through verbal communication also. During interview with PS-S on 7/1/25 at 9:55 a.m., PS-S stated he had been at facility in May and June of 2025 for the monthly pest control visits. "[Facility] don't have a logbook there." PS-S stated, "the main issue is that I noticed small flies in the kitchen [sic]." PS-S stated he spoke to administrator and "just met [MT-D] over the phone the other day." During tour with PS-S on 7/1/25 at 1:51 p.m., PS-S stated the facility contract with the pest control company provided, "no service for the smaller flies that are going around here." During interview with dietary manager (D)-M on 7/1/25 at 10:10 a.m., D-M stated she was aware of the flies in the kitchen area and swatted a black fly as she exited the kitchen. During review of customer service report invoice with service date of 6/11/25, the "Target Pest" column identifies "Flies-Large". During review of the facility's Pest Elimination Services Agreement dated 8/30/2022, the contracted services include "Outside in Large Fly Program" with frequency of "Monthly-6 Month Program". During review of documents titled Work Orders with dates "May. 1, 2025 -Jul. 1, 2025" failed to identify concerns with pests or small black flies. During review of Grievance Tracking logs from January 2025 to June 2025, no mention of pests for "Types of Concern". During interview with administrator and regional director (RD) on 7/1/25 at 10:25 a.m., the administrator stated he was informed of the black flies "over a month ago". The administrator stated MT-D bought over the counter "apple things" to trap flies and "agree, [it is] still an ongoing issue". RD stated he was not aware the monthly pest control services and service agreement failed to address small black flies. "Should be done."	21730		

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21730	Continued from page 97 Facility policy titled Pest Control, revised May 2008 identified, “Our facility shall maintain an effective pest control program.” SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative pest control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21730		
21825	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 9 Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	21825	Corrected.	08/26/2025

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21825	Continued from page 98 failed to obtain and document an informed consent, including with explanation of risk and benefits, before giving psychotropic medications for 2 of 5 residents (R24, R25) reviewed for unnecessary medication use. Findings include: R24 R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. The MDS recorded R24 as having severe cognitive impairment and consuming both antipsychotic and antidepressant medications. R24's Order Summary Report, signed 5/15/25, identified R24's current physician-ordered medications and treatments along with their respective start date(s). These included orders for duloxetine (antidepressant medication) 20 milligrams (mg) once daily, haloperidol (an antipsychotic medication) with multiple doses ordered daily, and mirtazapine (antidepressant medication) 7.5 mg every bedtime. These medications all had a start date recorded of, "04/29/2025." R24's Medication Administration Record (MAR), dated 6/2025, identified R24's medications along with staff initials to demonstrate their respective administration. The orders for duloxetine, haloperidol, and mirtazapine were listed and each of these medications were recorded as administered for the entire month period. On 7/1/25 at 12:28 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they were R24's financial guardian and were very involved in her (R24) care decisions, too. FM-G stated R24 had been on the antidepressant medication since she was hospitalized a few months prior due to being "very combative" with staff members there. FM-G stated there had been no discussion from the care center about the duloxetine or mirtazapine medications thus far to their recall and then abruptly asked the surveyor aloud, "What are the side effects?!" R24's medical record was reviewed and lacked evidence a signed or verbal consent for use of the medication was obtained prior to them being provided. Further, the record lacked evidence the risks or expected benefits of the medication regimen had been reviewed or discussed with R24 or their responsible family member prior to initiation of the medications.	21825		

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21825	Continued from page 99 When interviewed on 7/1/25 at 12:41 p.m., licensed practical nurse (LPN)-B explained the "admitting nurse" was the person who typically obtained consent for psychotropic medications from the resident or family upon admission. LPN-B stated this was done with "a form we have them sign" about the medications, and there should be a separate one for each psychotropic ordered. The forms were then scanned into the electronic medical record (EMR). LPN-B reviewed R24's medical record, including hard chart and EMR, and expressed they were unable to locate any consents for the mirtazapine or duloxetine adding, "We're missing those two." LPN-B stated R24 had family members who were involved with her care and mentioned FM-G by name as the person who helped R24 sign paperwork and make decisions. LPN-B verified they were unable to locate evidence of a signed, informed consent being obtained for the two psychotropic medications adding they'd looked "everywhere that I would know to look [for them]." LPN-B stated mirtazapine and duloxetine both should have had a signed consent due to their potential side effects adding, "Those medications just have to have consent." When interviewed on 7/1/25 at 12:56 p.m., social worker (SW)-A stated nursing was responsible to get medication consents. SW-A added, "Nursing will do that." On 7/1/25 at 3:43 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R24's medical record for the consents. DON stated the admitting nurse should obtain all required consents and document them on paper before getting them scanned into the medical record. DON verified they were unable to locate any signed consents for R24's duloxetine or mirtazapine adding, "I didn't [find them]." DON added, "Something didn't get done." DON stated they would start education with the nurses to ensure consents were obtained moving forward adding obtaining consent was important so the patient "understands the risk and benefits [of the medication]." DON added, "It's part of the state regs [regulations]." R25 R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R25's diagnoses included aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medication.	21825		

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21825	Continued from page 100 R25's Medication Administration Record dated June 2025, indicated R25 received risperidone (an antipsychotic medication) 1 milligram by mouth at bedtime for severe, recurrent major depressive disorder with psychotic symptoms with a start date of 6/10/25. R25's medical record lacked evidence of an informed consent for risperidone. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated the admitting nurse obtained psychotropic medication consents for new admissions. RN-A stated if there was a change in psychotropic medication there was usually an associated clinic of psychology (ACP) provider involved who spoke with the resident or resident representative about the change in dosage first. If the ACP provider did not involve the responsible party, then nursing would obtain the consent for the psychotropic medication. During interview on 7/2/25 at 11:20 a.m., the director of nursing (DON) stated nursing obtained the consent for risperidone today, since they did not find a risperidone consent form in R25's medical record. During follow-up interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to obtain consents for psychotropic medications. The DON stated it was important to ensure the resident or responsible part were aware of the risks and benefits of the medication before administration. The facility Antipsychotic Medication Use policy dated December 2016, directed the attending physician and other staff to gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy did not specifically address informed consent to educate a resident or responsible party on the side effect/risks and benefits of antipsychotic medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on informed consent and the process to obtain such with psychotropic medications; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	21825		
21880	Patients & Residents of HC Fac.Bill of Rights	21880	Corrected.	08/26/2025

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21880	Continued from page 101 CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to appropriately follow up on continued and repeated voiced grievances of provided food for a diabetic diet for 1 of 2 residents (R31) reviewed for grievances who gained 35% of their weight since being admitted to the care facility. Findings include: R31's annual Minimal Data Set (MDS), dated 4/26/25, R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood	21880		

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21880	Continued from page 102 pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes. R31's weights, listed in the electronic medical record (EMR), indicated R31 weighed 165 pounds at admission to the care center and their most recent weight was listed as 231 pounds, a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet. R31's EMR lacked any progress notes from dietary or nutritional services and lacked any mention of R31's food concerns despite repeated vocal complaints. The facility's grievance log for the past six months was reviewed and also lacked any mention of R31's voiced complaints about the food she was receiving. During an interview on 6/29/25 at 10:35 a.m., R31 stated she had to buy her own fridge and food to ensure she had foods to eat that would work within her diabetic diet, stating she should be on a diabetic diet but feels the facility does not follow it. R31 stated she had told multiple people about her food concerns but had not worked with the dietician at the care facility. During an interview on 7/1/25 at 10:48 a.m., licensed practical nurse (LPN)-B stated the food at the facility had been an issue for "over a year" stating they don't offer R31"diabetic options" such as sugar free items or syrup. LPN-B confirmed R31 had voiced her complaints plenty of times and R31 would often say, "they know I'm on a diabetic diet and give me all these carbs". LPN-B further stated many times R31 would make the decision not to eat the food that was served to her. LPN-B stated dietary was aware of the complaints. During an interview on 7/1/25 at 11:58 a.m., the certified dietary (district) manager (CDM) stated if a resident had an order for a diabetic diet, then the system would automatically push starch items to half portions or substitute out that item for a different item. The CDM stated they had started education with diabetic residents to help them understand that they might still see carbs on their plate even if they were on a diabetic diet and to help the residents "understand where we [the facility] are coming from regarding diabetic diets." The CDM stated R31 was on a consistent carbohydrate diet, not a renal diet, which would include more carbs than a renal diet. The CDM further stated R31 was a vocal person so the assumption was that everyone had heard her concerns, however,	21880		

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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, Minnesota, 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
21880	Continued from page 103 "sometimes word doesn't travel as well as we would like - we are working to have better communication between the floor staff and us". During an interview on 7/1/25 at 12:49 p.m., LPN-A stated R31 complained about the facility food all the time and voiced complaints about not getting food consistent with a diabetic diet. LPN-A stated she let the nurse manager know about R31's complaints but had not noticed any changes. During an interview on 7/2/25 at 8:57 a.m., the third-floor nurse manager, LPN-E, stated she had heard complaints from R31 about how terrible the food was but did not recall any complaints specific to her diabetic diet. During an interview on 7/2/25 at 10:15 a.m., licensed social worker (LSW)-A, who was the grievance officer at the facility, stated she would have expected to hear about repeated concerns relating to food or receiving proper diets, confirming she did not have any formal grievances for R31. A facility policy titled Grievances/Complaints - Staff Responsibility, revised 10/2017, indicated should a staff member overhear or be the recipient of a complaint voiced by a resident concerning care in the facility, including food, the staff member is encouraged to help, or guide, the resident to file a written complaint with the facility. The facility could review policies and procedures related to grievances. The Administrator (or designee) should conduct measurable audits on grievances to ensure resident concerns are being documented and addressed. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21880		

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E0000	Initial Comments The Terrace at Crystal is a Special Focus Facility (SFF). On 6/29/25 - 7/2/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/26/2025
F0000	INITIAL COMMENTS The Terrace at Crystal is a Special Focus Facility (SFF). On 6/29/25 - 7/2/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H52897974C (MN109554) H52897971C (MN108609) H52897972C (MN113814) H52897967C (MN106359) H52897968C (MN107818) H52897973C (MN108474) AND	F0000		08/26/2025

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 reverse for further 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.

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

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F0000	Continued from page 1 The following complaints were reviewed: H52897969C (MN107183) with a deficiency issued at F686 and F804 H52897970C (MN107861) with a deficiency issued at F804 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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.	F0000		
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550	It is Terrace at Crystal's policy to provide care in an environment promoting resident quality of life, including dignity, respect, and choice. R25's & R203 dining preferences, assistance and needs were reviewed and the care plan was updated. They are both receiving dignified and appropriate dining services. All residents were interviewed about their dining preferences The "Resident Rights and Dignity" policy was reviewed and revised as necessary. All staff received education on person-centered language and dignified dining. Staff ensured all subsequent dining experiences were respectful, using appropriate person-centered language. DON and/or designees will complete audits 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Results, along with resident feedback, will be reviewed at the monthly QAPI meeting to determine further monitoring needs. DON and/or designee is responsible for compliance.	08/26/2025

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F0550 SS = E	Continued from page 2	F0550		

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is NOT MET as evidenced by:

Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R25) who was referred to as a "feeder".

Findings include:

R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R25 was dependent on staff for eating.

R203's entry tracking record indicated R203 admitted to the facility on 6/15/25.

R203's care plan printed 6/29/25, indicated R203 required setup assistance by one staff member to eat.

During meal service on 6/29/25 at 12:14 p.m., dietary aide (DA)-A plated and served food to residents in the dining area. There were approximately eight residents in the dining area, both from the memory care area and non-memory care area. DA-A went to serve R25 when nursing assistant (NA)-E stated she was a "feeder" out loud, and DA-A placed the plate on top of the steam table instead of serving to the resident.

During interview on 6/29/25 at 1:31 p.m., DA-A stated a person who was a "feeder" needed one to one support to eat. DA-A stated "feeder" was not a "humane" term for a

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F0550 SS = E	Continued from page 3 human with emotions and could hear what was said. DA-A stated the term was hurtful, belittling, and may make a resident feel "less human". During interview on 7/1/25 at 1:14 p.m., R203 stated the staff called residents "feeders" "all the time" and it probably made residents feel "bad". During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff should call residents by their name and not their situation. RN-A stated staff cannot call a resident "feeder". During interview on 7/2/25 at 1:58 p.m., the director of nursing stated staff should not refer to residents who needed assistance with eating as "feeders". The DON stated the term would not make a resident feel "good".	F0550		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, before giving psychotropic medications for 2 of 5 residents	F0552	It is Terrace at Crystal's policy to ensure residents have the right to be fully informed of their care and treatment, and to participate in or refuse care after receiving sufficient information to make an informed decision. R24 and R25 medication orders were reviewed, and all consents were signed and obtained. All residents on psychotropic medications, informed consent forms were obtained and fully completed, including documented discussions of risks and benefits with the resident or their legal representative. The policy titled "Antipsychotic Medication Use policy" and "Gradual Dose Reduction" were reviewed and revised as necessary. Licensed nursing staff received education on obtaining informed consent completely and accurately, emphasizing the necessity of documenting discussions regarding risks and benefits. Nurse managers and/or designees will complete psychotropic medication audits for each new admission for 2 months, then monthly for 2 months or until sustained compliance is verified. Audit results will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs.	08/26/2025

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F0552 SS = D	Continued from page 4 (R24, R25) reviewed for unnecessary medication use. Findings include: R24 R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. The MDS recorded R24 as having severe cognitive impairment and consuming both antipsychotic and antidepressant medications. R24's Order Summary Report, signed 5/15/25, identified R24's current physician-ordered medications and treatments along with their respective start date(s). These included orders for duloxetine (antidepressant medication) 20 milligrams (mg) once daily, haloperidol (an antipsychotic medication) with multiple doses ordered daily, and mirtazapine (antidepressant medication) 7.5 mg every bedtime. These medications all had a start date recorded of, "04/29/2025." R24's Medication Administration Record (MAR), dated 6/2025, identified R24's medications along with staff initials to demonstrate their respective administration. The orders for duloxetine, haloperidol, and mirtazapine were listed and each of these medications were recorded as administered for the entire month period. On 7/1/25 at 12:28 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they were R24's financial guardian and were very involved in her (R24) care decisions, too. FM-G stated R24 had been on the antidepressant medication since she was hospitalized a few months prior due to being "very combative" with staff members there. FM-G stated there had been no discussion from the care center about the duloxetine or mirtazapine medications thus far to their recall and then abruptly asked the surveyor aloud, "What are the side effects?!" R24's medical record was reviewed and lacked evidence a signed or verbal consent for use of the medication was obtained prior to them being provided. Further, the record lacked evidence the risks or expected benefits of the medication regimen had been reviewed or discussed with R24 or their responsible family member prior to initiation of the medications. When interviewed on 7/1/25 at 12:41 p.m., licensed practical nurse (LPN)-B explained the "admitting nurse"	F0552	Continued from page 4 DON and/or designee is responsible for compliance.	

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F0552 SS = D	Continued from page 5 was the person who typically obtained consent for psychotropic medications from the resident or family upon admission. LPN-B stated this was done with "a form we have them sign" about the medications, and there should be a separate one for each psychotropic ordered. The forms were then scanned into the electronic medical record (EMR). LPN-B reviewed R24's medical record, including hard chart and EMR, and expressed they were unable to locate any consents for the mirtazapine or duloxetine adding, "We're missing those two." LPN-B stated R24 had family members who were involved with her care and mentioned FM-G by name as the person who helped R24 sign paperwork and make decisions. LPN-B verified they were unable to locate evidence of a signed, informed consent being obtained for the two psychotropic medications adding they'd looked "everywhere that I would know to look [for them]." LPN-B stated mirtazapine and duloxetine both should have had a signed consent due to their potential side effects adding, "Those medications just have to have consent." When interviewed on 7/1/25 at 12:56 p.m., social worker (SW)-A stated nursing was responsible to get medication consents. SW-A added, "Nursing will do that." On 7/1/25 at 3:43 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R24's medical record for the consents. DON stated the admitting nurse should obtain all required consents and document them on paper before getting them scanned into the medical record. DON verified they were unable to locate any signed consents for R24's duloxetine or mirtazapine adding, "I didn't [find them]." DON added, "Something didn't get done." DON stated they would start education with the nurses to ensure consents were obtained moving forward adding obtaining consent was important so the patient "understands the risk and benefits [of the medication]." DON added, "It's part of the state regs [regulations]." R25 R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R25's diagnoses included aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medication.	F0552		

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F0552 SS = D	Continued from page 6 R25's Medication Administration Record dated June 2025, indicated R25 received risperidone (an antipsychotic medication) 1 milligram by mouth at bedtime for severe, recurrent major depressive disorder with psychotic symptoms with a start date of 6/10/25. R25's medical record lacked evidence of an informed consent for risperidone. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated the admitting nurse obtained psychotropic medication consents for new admissions. RN-A stated if there was a change in psychotropic medication there was usually an associated clinic of psychology (ACP) provider involved who spoke with the resident or resident representative about the change in dosage first. If the ACP provider did not involve the responsible party, then nursing would obtain the consent for the psychotropic medication. During interview on 7/2/25 at 11:20 a.m., the director of nursing (DON) stated nursing obtained the consent for risperidone today, since they did not find a risperidone consent form in R25's medical record. During follow-up interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to obtain consents for psychotropic medications. The DON stated it was important to ensure the resident or responsible part were aware of the risks and benefits of the medication before administration. The facility Antipsychotic Medication Use policy dated December 2016, directed the attending physician and other staff to gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy did not specifically address informed consent to educate a resident or responsible party on the side effect/risks and benefits of antipsychotic medication.	F0552		
F0576 SS = D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where	F0576	It is Terrace at Crystal's policy to ensure residents have the right to retain and use personal possessions, including adequate and appropriate storage space, and to have access to and use their personal property, which includes communication devices, in a manner that respects their privacy.	08/26/2025

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F0576 SS = D	Continued from page 7 calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure there was reasonable access to private phone use for 1 of 1 residents (R153) reviewed who utilized the facility phone. Findings include:	F0576	Continued from page 7 R153 discharged All residents who utilize personal communication devices were spoken to and educated on their right to privacy during personal conversation and the opportunity to voice their concerns. The policy titled "Resident Use of Telephones policy" was reviewed and revised as necessary. A wireless phone is now available at the nurse station that residents may take to their own room or any private area of their choice for personal conversations. Nursing, activities, and social services staff received education on the resident use of telephones policy. Nursing unit managers and/or social service director will conduct audits 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Results of audits and resident feedback will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs. Social Service Director and/or designee are responsible for compliance.	

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F0576 SS = D	Continued from page 8 R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's profile dated 6/23/25, indicated R153 resided on the third floor. During an observation on 7/1/25 at 1:03 p.m., R153 was observed sitting in a wheelchair in front of a long desk with multiple staff members surrounding it, including trained medication aide (TMA)-B and licensed practical nurse (LPN)-A. The long desk at the nursing station was observed at the middle of two parallel hallways on the third floor with resident's rooms and in front of an elevator. R153 was observed talking on a corded phone and asking someone to "get me out of here". During an interview at 7/1/25 at 1:12 p.m., R153 stated that he did not have his own phone so had asked the facility staff if there was one he could use. R153 stated the "only phone" offered to him was the phone at the nursing station. R153 stated he asked staff to bring the phone to his room, but they said they couldn't, so he had argued with them about it as he didn't want to talk with his wife in front of all the staff members. R153 stated he felt like he did not have enough privacy when he had to make his phone calls at the nurse's station. During an interview on 7/1/25 at 1:14 p.m. with TMA-B and LPN-A, LPN-A stated most residents had their own phone to use but if they did not, they offered them the phone at the nurse's station. TMA-B confirmed that they had neither a cordless phone nor a private area for residents to use the phone if they wanted. During an interview on 7/1/25 at 1:16 p.m., LPN-E, the third-floor nurse manager, stated the only phone that they had to offer residents on the third floor was a phone that could be utilized at the nurse's station and a more private option was not available. During an interview at 7/2/25 at 10:04 a.m., the administrator stated if a resident was able to pay for it, facility staff would install a phone in a resident's room, otherwise residents were able to use the phone at the nursing stations.	F0576		

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F0576 SS = D	Continued from page 9 The facility's Resident Use of Telephones policy dated 3/17, indicated designated telephones were available for residents to make and receive "private" telephone calls. The policy indicated telephones will be in areas that offer privacy and accommodate wheelchair bound residents.	F0576		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent State agency (SA) were posted in a prominent location and readily accessible at all times of the inspection reports within the campus. This had the potential to affect all 51 residents and any visitors who wanted to	F0577	It's Terrace at Crystal's policy to ensure residents, their representatives, and the public have the right to promptly access the results of the most recent survey conducted by the State or Federal government, as well as any plans of correction. The most recent survey report, along with all survey results for the past three years, including complaints, is now posted in a prominent, publicly accessible location within the facility, ensuring they are always readily viewable. The policy titled "Resident Right to Examine Survey Results" was reviewed and revised as necessary. All staff members were educated on the policy and the location of the posted survey results and how to direct residents, representatives, or visitors to this information. The Administrator or their designee will conduct audits 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Results of audits, along with any resident or visitor feedback, will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs. The Administrator and/or designee is responsible for compliance.	08/26/2025

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F0577 SS = C	Continued from page 10 review this information Findings include: The CMS CASPER Report 0003D, dated 6/24/25, identified the completed recertification surveys for the previous three years, with the most recently completed recertification survey having exited on 2/13/25. On 7/1/25 at 11:30 a.m., an informal resident council meeting was held with R8, R13, and R1. The residents were asked, as part of the meeting, if the most recent survey results were readily posted within the facility for them to review at leisure. However, none of the residents voiced they knew the location or these results, nor had the results been discussed with them during the resident council meetings. Immediately following the council meeting, on 7/1/25 around 1:45 p.m., a tour of the nursing home was completed with the administrator. Administrator stated he was responsible along with the director of nursing for keeping the survey binder up to date. The main entrance had a 3-tiered black bookshelf to the right of the front desk which contained 4 three ring binders with 2022, 2023, 2024 and 2025 on the spine of the binders. Above the bookshelf hung a laminated sign "Survey Results." Within the 2025 binder were the results from the survey exited on 4/8/25. The sign above lacked evidence that additional survey results were available upon request. Furthermore, the binder lacked results from standard abbreviated surveys (complaint) surveys which had been investigated since that last recertification survey. The administrator verified these findings during the tour. During the continued tour, on 2nd floor, there was a 3-tiered black bookshelf in the solarium on the backside of the wall, not in visible sight unless a person was in the solarium. Above the shelf was a sign "Survey Results." The bookshelf contained 3 three ring binders. The front of the three binders were marked "2022", "2023" and "2024." Within the binders were the survey results. The most recent results were from the survey with an exit date of 10/7/24 (a follow up visit from the 8/30/24 survey). In addition, the binder lacked any complaint survey results. The sign above lacked evidence that additional survey results were available upon request. The administrator verified these findings during the tour. On 3rd floor, there was a 3-tiered black bookshelf that contained 3 three ring binders with a sign above it which identified "Survey Results." The front of the	F0577		

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F0577 SS = C	Continued from page 11 three binders were marked "2022", "2023" and "2024." Within the binders were the survey results, the most recent results being from the survey with an exit date of 10/7/24 (a follow up visit from the 8/30/24 survey). In addition, the binder lacked any complaint survey results. The sign above lacked evidence that additional survey results were available upon request. The administrator verified these findings during the tour. During the tour and interview, administrator stated the survey binders were needed on each floor as some residents did not leave the floor and should have access to the results. Administrator stated the binders should include the complaint and recertification survey results. During an interview on 7/1/25 at 1:41 p.m., activities director (AD)-A stated that she helped coordinate resident council. AD-A stated they had never talked about survey results during resident council meetings since she had been helping coordinate resident council, which had been about 5 months. A facility policy titled "Resident Right to Examine Survey Results," dated 1/30/17, identified the resident has a right to examine the three most recent annual survey results and any plan of correction. Furthermore, "Information concerning the location of our facility's three most recent survey reports will be posted on the resident bulletin board and at each nurses' station."	F0577		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due	F0580	It is the policy of Terrace at Crystal to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when significant events occur (injury/decline/rooms/etc.) 1. R36, an assessment was completed, and the provider was notified after identification of repeated elevated blood sugar readings. The resident's care plan was updated, and blood glucose monitoring was reviewed. The provider provided updated parameters for notification. 2. All Diabetic residents Blood sugar readings were reviewed and those outside of designated parameters were reviewed for MD notification. New orders were implemented. Care plans were reviewed and updated accordingly. 3. The facility policy titled "Change in a Resident's Condition or Status" was reviewed and updated as necessary.	08/26/2025

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F0580 SS = D	Continued from page 12 to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promptly notify the provider consistently of high blood sugars for 1 of 1 residents (R36) of reviewed for notification of change. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). Section N-Medications indicated	F0580	Continued from page 12 4. All licensed nursing staff received education on the policy, including their roles and responsibilities in identifying and reporting changes in resident condition. 5. Audits will be completed 5x a week to ensure changes in condition are recognized and that the physician is notified in accordance with policy. Audits will be conducted for 8 weeks. 6. Results will be presented during the monthly QAPI meeting for review and determination of continued auditing or corrective actions. 7. The Director of Nursing and/or designee is responsible for compliance.	

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F0580 SS = D	Continued from page 13 R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). During an interview on 6/29/25 at 10:45 a.m., R36 stated she had diabetes and had been told she was a "pretty fragile diabetic." R36 stated her blood sugars went up and down and sometimes she required insulin and sometimes she did not. R36's care plan, printed 7/2/25, included R36 had diabetes mellitus with the following interventions: monitor for signs and symptoms of hyperglycemia (high blood sugar); monitor for signs and symptoms of hypoglycemia (low blood sugar); obtain blood sugars per MD order; resident has an order for Dexcom (a continuous glucose monitoring system that is wearable that provides continual real-time blood sugar level reading without the need for frequent fingerstick), sensor to change every 10 days; diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. R36's June 2025 Medication Administration Record (MAR), printed 7/2/25, included the following orders: - Insulin NPH (Neutral Protamine Hagedorn- Human -Isophane) (an intermediate-acting insulin that helps manage blood sugar level in individuals with diabetes) Subcutaneous Suspension 100 unit/milliliter(ml) - Inject 11 units subcutaneously in the evening related to diabetes with a start date of 5/31/25. The record identified it was given all days except 6/14, 6/17, 6/18, and 6/17 which were marked with a "2" indicating "drug refused". The date 6/1 was marked with a "3" indicating "absent from home with meds." - Insulin NPH Subcutaneous Suspension 100 unit/ml - Inject 7 units subcutaneously in the morning related to diabetes with a start date of 6/1/25. The record indicated it was administered all days. - Novolog (rapid acting insulin used to control blood sugar) Injection Solution 100 unit/ml - Inject as per sliding scale: if blood sugar is 151 - 225 = 1 unit; 226 - 300 = 2 units; 301 - 375 = 3 units;	F0580		

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F0580 SS = D	Continued from page 14 376 - 450 = 4 units; 451+ = 5 units, subcutaneously with meals related to diabetes at mealtime only (give even if you skip meal) - Do not give correction dose if blood sugar is less than 150. Check blood glucose at bedtime and do not give correction insulin if blood glucose is less than 200. Start date 5/31/25. - Glucagon Nasal Powder 3 milligram(mg)/dose (dry nasal spray that helps raise blood sugar level in an emergency) 1 spray in nostril as needed for low blood sugar- unsupervised self-administration -In the event of unconscious hypoglycemia or hypoglycemic seizure. May repeat dose if no response after 15 minutes with a start date of 5/18/25. The record identified it was documented every day as "U-SA" which indicated unsupervised self-administration. - Glucose Oral Tablet Chewable (tablet used to quickly raise your blood sugar when it is low) 4 grams (gm), Give 1 tablet by mouth every 6 hours as needed with a start date of 4/16/25. The record indicated it was given on 6/1/25 at 10:32 p.m. and marked as effective and administered on 7/3/25 at 1:34 p.m. and marked as effective. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 2:49 a.m. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 3:31 a.m. - Dexcom CGM G6 - Use to obtain glucose level three times daily before meals and at hs (bedtime) for diabetes with a start date of 6/14/24. - Emergency department to evaluate and treat blood glucose level of 833 and patient is symptomatic. One time only for diabetes with a start date of 6/1/25. Record indicated it was documented with a “9" which indicated "other/progress note" on 6/1/25 at 2:48 a.m. - Encourage patient to drink ice water and extra movement to help lower sugar. One time only for diabetes with a start date of 6/1/25 and was completed on 6/1/25 at 10:36 a.m.	F0580		

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F0580 SS = D	Continued from page 15 R36's orders lacked specific parameters on when to notify the provider regarding blood sugars. R36's Blood Sugar Summary Report, from 5/31/25 to 6/30/25, included the following blood sugar readings in milligrams per deciliter (mg/dL): 6/29/25 at 5:00 p.m. was 443 mg/dL 6/28/25 at 1:39 p.m., was 449 mg/dL 6/28/25 at 9:30 a.m., was 500 mg/dL 6/28/25 at 8:54 a.m., was 500 mg/dL 6/27/25 at 12:25 a.m., was 444 mg/dL 6/27/25 at 12:22 p.m., was 444 mg/dL 6/27/25 at 11:46 a.m., was 444 mg/dL 6/27/25 at 8:42 a.m., was 500 mg/dL 6/27/25 at 8:41 a.m., was 500 mg/dL 6/27/25 at 8:40 a.m., was 500 mg/dL 6/26/25 at 8:30 a.m., was 492 mg/dL 6/24/25 at 9:58 a.m., was 600 mg/dL 6/24/25 at 9:19 a.m., was 600 mg/dL 6/23/25 at 3:30 p.m., was 38 mg/dL 6/22/25 at 9:48 a.m., was 529 mg/dL 6/22/25 at 9:40 a.m., was 529 mg/dL 6/21/25 at 9:14 a.m., was 451 mg/dL 6/20/25 at 9:02 a.m., was 413 mg/dL 6/19/ 25 at 9:05 a.m., was 507 mg/dL 6/18/25 at 9:56 a.m., was 422 mg/dL 6/17/25 at 9:26 a.m., was 473 mg/dL 6/17/25 at 9:01 a.m., was 473 mg/dL 6/16/25 at 8:15 a.m., was 592 mg/dL 6/14/25 at 8:29 a.m., was 600 mg/dL	F0580		

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F0580 SS = D	Continued from page 16 6/12/25 at 8:44 a.m., was 588 mg/dL 6/9/ 25 at 4:38 p.m., was 485 mg/dL 6/9/25 at 2:22 p.m., was 543 mg/dL 6/9/25 at 2:08 p.m., was 543 mg/dL 6/9/25 at 10:11 a.m., was 551mg/dL 6/9/25 at 8:48 a.m., was 55 mg/dL 6/7/25 at 2:56 p.m., was 441 mg/dL 6/7/25 at 11:13 a.m., was 501 mg/dL 6/7/25 at 11:13 a.m., was 441 mg/dL 6/4/25 at 9:46 a.m., was 424 mg/dL 6/4/25 at 9:37 a.m., was 424 mg/dL 6/1/25 at 8:15 a.m., was 546 mg/dL 5/31/25 at 10:19 p.m., was 401 mg/dL R36's progress notes reviewed from 5/31/25 to 6/30/25 and identified the following: -6/1/25 at 7:16 a.m.: resident blood sugar is 546 without any symptoms. -6/1/25 at 11:41 p.m.: Residents blood sugar was 84 upon returning to facility at 9:30 p.m., and at 10p.m. it was 41, 2 glucose tablets along with pudding, apple juice given, and blood sugar went up to 47. Resident ate a cup of oranges and blood sugar went up to 95. -6/24/25: Resident's blood sugar was 600 at 9am so scheduled insulin and sliding scale insulin were given. Rechecked blood sugar at 11am. Message was left for provider. R36's progress notes lacked any additional updates to provider regarding R36's documented high and low blood sugars despite having 20 days of high blood sugars (some days multiple times a day) and 4 days of low blood sugars. Standing Orders for Skilled Nursing Facilities, printed 7/2/25, included the following information on page 3:	F0580		

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F0580 SS = D	Continued from page 17 -If type 1 diabetes, notify the provider if any blood glucose results are less than 70 or over 400 and/or change in condition. -Hypoglycemia - blood glucose less than 70: "If patient is symptomatic, conscious, and able to swallow or has a feeding tube: -Administer 6 oz. fruit juice, milk, other high carbohydrate beverage (e.g., Ensure, Boost), or glucose tables or gel orally or via feeding tube. -Repeat BG [blood glucose] after 15 minutes; if <70 [less than 70], repeat above intervention. -If after 2 attempts to treat and BG is still <70, notify provider." During an interview on 7/1/25 at 9:35 a.m., trained medication aid (TMA)-A stated they took blood sugars and reported the findings to the nurse on the floor. TMA-A stated some glucometers would not read the blood sugar if it was too high or low and they would get the nurse if that happened. TMA-A stated they did not notify providers of information as they reported everything to the nurse on the floor. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and had worked with her often. LPN-A stated if a blood sugar was over "300", staff were to notify the provider. LPN-A stated they would document provider notification in a progress note. LPN-A stated R36 was "all over with her blood sugars." During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated they were familiar with R36. LPN-E stated it would vary per resident on when to notify the provider for high or low blood sugars as some residents had parameters on when to notify. LPN-E verified R36 did not have any parameters on when to notify the provider. LPN-E stated the expectation would be that after the provider was notified, it would be documented in a progress note. LPN-E reviewed R36's electronic medical record (EMR) and verified the provider was notified a few times on 6/1/25 regarding R36's high blood sugars and again on 6/24. LPN-E verified there were no other documented notifications in R36's EMR. LPN-E stated she would expect the provider to be notified if the blood sugar was over 451 as that was what insulin orders stopped at. LPN-E reviewed R36's blood sugars and verified she	F0580		

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F0580 SS = D	Continued from page 18 had many blood sugars over 400 in the month of June. During an interview on 7/2/25 at 11:38 a.m., director of nursing (DON) stated the expectation would be the nurses would follow the house standing orders if a doctor did not write specific parameters regarding when to be notified of high and/or low blood sugars. DON stated they expected the provider to be notified if a resident's blood sugar was less than 70 or greater than 400 and expected it to be documented in a progress note. DON stated the provider should have been notified regarding R36 and her blood sugars after review. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated they were familiar with R36. NP-A stated they would expect to be notified if R36's blood sugar was over 450 or below 70. NP-A stated if a resident's blood sugar was over 450, an order would be given to help decrease the blood sugar. NP-A stated when they were notified on 6/1/25 regarding R36's blood sugar being 833, orders for insulin were given to lower her blood sugar along with sending her to the emergency room to be evaluated. NP-A stated the facility communicated with the provider group through "the portal." NP-A reviewed the portal and stated they were notified only a couple of times in June regarding R36's blood sugar being high. A facility policy titled Change in a Resident's Condition or Status, dated 2/2021, indicated "Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status."	F0580		
F0582 SS = A	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F0582		08/26/2025

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F0582 SS = A	Continued from page 19 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-Coverage (NOMNC) was provided timely to 1 of 3 residents (R3) reviewed for beneficiary notices. Findings include: R3's significant change Minimum Data Set (MDS) dated 6/18/25, indicated R3 had intact cognition.	F0582		

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F0582 SS = A	Continued from page 20 R3's SNF Beneficiary Protection Notification Review form dated 4/25/25, indicated R3's last covered day of Medicare Part A service was on 4/25/25, and the termination was provider-initiated when Part A benefit days were not exhausted. R3's NOMNC form dated 4/25/25, indicated R3's last covered day of Medicare Part A service was on 4/25/25, and the resident refused to sign the notice but was "okay with therapy ending today". The form was not signed by the resident but was signed by licensed social worker (LSW)-A and dated 4/25/25. R3's Census record dated 6/29/25, indicated a switch from her primary payer source of Medicare A to Minnesota Medicaid on 4/26/25, and then R3 remained in the facility. During an interview on 7/1/25 at 1:34 p.m., R3 stated she did not recall anyone reviewing the form mentioned above with her but was okay with her therapy services ending. During an interview on 7/1/25 at 1:48 a.m., LSW-A confirmed she oversaw reviewing NOMNCs with residents and, after reviewing R3's medical record, could not find evidence that the notice had been given to R3 at least two days before the end of Medicare Part A coverage as required. During an interview on 7/2/25 at 10:04 a.m., the administrator confirmed LSW-A oversaw beneficiary notices and deferred questions regarding this to LSW-A. The facility's NOMNC policy dated 11/1/27 indicated the NOMNC must be delivered at least two calendar days before Medicare-covered services end.	F0582		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F0585	It is Terrace at Crystal's policy to ensure that all resident grievances are acknowledged, investigated, and resolved promptly and thoroughly, and that appropriate actions are taken to address the concerns raised, especially when they involve clinical needs such as specialized diets. R31 grievances regarding their diabetic diet were	08/26/2025

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F0585 SS = D	Continued from page 21 reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	Continued from page 21 immediately reviewed. R31's weight gain and dietary preferences were reassessed. A new individualized diabetic meal plan has been created and implemented. The residents' concerns were addressed directly and documented in the grievance. All residents with physician-ordered diabetic diets were reviewed to identify any similar concerns or unresolved grievances. The facility's "Grievances/Complaints Policy" was reviewed and revised as necessary. Nursing, dietary, and social workers received education and training on, identifying verbal and written grievances, timely investigation and documentation. Audits will be conducted by the social worker and/or designee weekly for 4 weeks. 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Audit results will be reviewed during QAPI meetings to determine additional actions or system changes. The social worker is responsible for ongoing compliance and monitoring.	

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F0585 SS = D	Continued from page 22 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to appropriately follow up on continued and repeated voiced grievances of provided food for a diabetic diet for 1 of 2 residents (R31) reviewed for grievances who gained 35% of their weight since being admitted to the care facility. Findings include: R31's annual Minimal Data Set (MDS), dated 4/26/25, R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes.	F0585		

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F0585 SS = D	Continued from page 23 R31's weights, listed in the electronic medical record (EMR), indicated R31 weighed 165 pounds at admission to the care center and their most recent weight was listed as 231 pounds, a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet. R31's EMR lacked any progress notes from dietary or nutritional services and lacked any mention of R31's food concerns despite repeated vocal complaints. The facility's grievance log for the past six months was reviewed and also lacked any mention of R31's voiced complaints about the food she was receiving. During an interview on 6/29/25 at 10:35 a.m., R31 stated she had to buy her own fridge and food to ensure she had foods to eat that would work within her diabetic diet, stating she should be on a diabetic diet but feels the facility does not follow it. R31 stated she had told multiple people about her food concerns but had not worked with the dietician at the care facility. During an interview on 7/1/25 at 10:48 a.m., licensed practical nurse (LPN)-B stated the food at the facility had been an issue for "over a year" stating they don't offer R31"diabetic options" such as sugar free items or syrup. LPN-B confirmed R31 had voiced her complaints plenty of times and R31 would often say, "they know I'm on a diabetic diet and give me all these carbs". LPN-B further stated many times R31 would make the decision not to eat the food that was served to her. LPN-B stated dietary was aware of the complaints. During an interview on 7/1/25 at 11:58 a.m., the certified dietary (district) manager (CDM) stated if a resident had an order for a diabetic diet, then the system would automatically push starch items to half portions or substitute out that item for a different item. The CDM stated they had started education with diabetic residents to help them understand that they might still see carbs on their plate even if they were on a diabetic diet and to help the residents "understand where we [the facility] are coming from regarding diabetic diets." The CDM stated R31 was on a consistent carbohydrate diet, not a renal diet, which would include more carbs than a renal diet. The CDM further stated R31 was a vocal person so the assumption was that everyone had heard her concerns, however, "sometimes word doesn't travel as well as we would like - we are working to have better communication between the floor staff and us".	F0585		

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F0585 SS = D	Continued from page 24 During an interview on 7/1/25 at 12:49 p.m., LPN-A stated R31 complained about the facility food all the time and voiced complaints about not getting food consistent with a diabetic diet. LPN-A stated she let the nurse manager know about R31's complaints but had not noticed any changes. During an interview on 7/2/25 at 8:57 a.m., the third-floor nurse manager, LPN-E, stated she had heard complaints from R31 about how terrible the food was but did not recall any complaints specific to her diabetic diet. During an interview on 7/2/25 at 10:15 a.m., licensed social worker (LSW)-A, who was the grievance officer at the facility, stated she would have expected to hear about repeated concerns relating to food or receiving proper diets, confirming she did not have any formal grievances for R31. A facility policy titled Grievances/Complaints - Staff Responsibility, revised 10/2017, indicated should a staff member overhear or be the recipient of a complaint voiced by a resident concerning care in the facility, including food, the staff member is encouraged to help, or guide, the resident to file a written complaint with the facility.	F0585		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of	F0605	It is the policy of Terrace at Crystal to ensure that residents are not administered unnecessary medications and that all medications, including antipsychotics, are monitored for effectiveness and potential side effects. R7, a clinical review was completed to assess for symptoms and side effects associated with the prescribed antipsychotic medication. Orthostatic blood pressure assessment was conducted, and no acute symptoms were identified at the time of evaluation. The physician was notified, and the resident's care plan and medication monitoring parameters were updated to include orthostatic vital signs per protocol. Residents receiving antipsychotic medications have been reviewed to ensure proper documentation and monitoring for side effects, including orthostatic hypotension were/are in place. Care plans and MARs were reviewed for compliance with psychotropic medication monitoring guidelines and updated as warranted and/or necessary. The facility's policy titled "Psychotropic Medication Use" was reviewed and revised as necessary	08/26/2025

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F0605 SS = D	Continued from page 25 resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §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. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F0605	Continued from page 25 All licensed nursing staff received education on the revised policy, including, how to conduct and document orthostatic blood pressure measurements, recognizing and responding to symptoms of orthostatic hypotension as well as communicating findings to the provider and updating care plans accordingly. Staff were re-educated on side effect monitoring requirements for psychotropic medication use. Audits of 20% of residents on antipsychotic medications will be conducted weekly for 2 months, and then monthly for 2 additional months to ensure ongoing compliance with side effect monitoring requirements. Results will be reviewed during QAPI meetings for further review and determination of further auditing and monitoring need. The Director of Nursing and/or designee is responsible compliance with this plan.	

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F0605 SS = D	Continued from page 26 §483.45(e) Psychotropic Drugs. 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 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: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 5 residents (R7) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include: A National Library of Medicine (NIH) Management of	F0605		

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F0605 SS = D	Continued from page 27 Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... orthostatic hypotension should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R7's quarterly Minimum Data Set (MDS), dated 4/26/25, indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications. R7's electronic medical record (EMR) contained an order for orthostatic blood pressure once a month due to "psych" medication use. The order instructed the nursing staff to obtain a lying, sitting, and standing blood pressure five minutes apart. R7's EMR further contained on order, dated 3/8/24, for Olanzapine (an atypical antipsychotic medication) 10 milligrams (mg) by mouth at bedtime. R7's most recent fall risk screening, dated 5/6/26, indicated R7 was at high risk for falls. R7's EMR, including the medication and treatment administration records, vitals section, and progress notes, lacked evidence staff had obtained orthostatic blood pressure readings for the past 2 months that were reviewed. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated there were currently no residents on R31's floor who had orders for orthostatic blood pressures that she was aware of. TMA-B stated orders for any vital signs would pop up on their medication administration records. During an interview on 7/1/25 at 1:46 p.m., consultant pharmacist (CP)-A stated all antipsychotic medications pose a risk of causing orthostasis and residents who consumed antipsychotic medications should be monitored for orthostatic hypotension. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated if a resident needed to have orthostatic blood pressure readings it would show	F0605		

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F0605 SS = D	Continued from page 28 up, and be documented, in the residents' medication administration record. LPN-A confirmed currently no residents had any orthostatic blood pressure readings. During an interview on 7/2/25 at 8:57 a.m., third floor nurse manager and (LPN)-E stated the expectation was for orthostatic blood pressure readings to be obtained monthly if a resident was receiving an antipsychotic medication. LPN-E confirmed R7 had an order for orthostatic blood pressures to be obtained monthly, however was unable to find evidence they had been completed, confirming the information was not in R7's medication or treatment administration record or vital sign documentation, stating "he has an order so it should be on the MAR [medication administration record]". A facility policy titled Antipsychotic Medication Use, revised 12/2016, indicated nursing staff would monitored for side effects and adverse consequences of antipsychotic medication including cardiovascular effects such as orthostatic hypotension.	F0605		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F0636	It is the policy of Terrace at Crystal to complete a comprehensive and accurate Minimum Data Set (MDS) assessment for each resident, ensuring that all areas of resident performance, functional status, and preferences are thoroughly evaluated. This assessment is used to develop an individualized, person-centered care plan and ensure regulatory compliance. R24 MDS was reviewed for completeness and accuracy. Identified discrepancies in activity preferences and resident performance areas were corrected. Resident representatives were interviewed again to confirm their preferences and functional abilities. A facility-wide audit of all MDSs completed in the last 30 days will be conducted to verify accuracy and thoroughness. The policy titled “MDS Completion and Submission Timeframes policy” was reviewed and revised as necessary Education on MDS accuracy and performance, functional status, and preferences was provided for the activity director who is responsible for contributing to the MDS. Audits of MDS assessments will be conducted by the MDS coordinator and/or designee 1x per week for 2 months,	08/26/2025

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F0636 SS = D	Continued from page 29 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set	F0636	Continued from page 29 then monthly for 2 months or until sustained compliance is verified. Audit results will be reviewed during QAPI meetings to determine additional actions or system changes. The remote MDS Coordinator and their facility contact person are responsible for ensuring compliance with accurate and complete MDS assessments.	

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F0636 SS = D	Continued from page 30 (MDS) was completed in a thorough manner to ensure all areas of resident performance and activities preference were evaluated for 1 of 4 residents (R24) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose of providing guidance with how to complete the Resident Assessment Instrument (RAI), and it outlined an admission MDS was considered a comprehensive assessment. The manual listed a section labeled, "SECTION F: Preferences For Customary Routine and Activities," along with directions to complete the section. The directions outlined, "The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities." The manual directed to interact with the resident or, if needed, complete the staff examination if the resident is unable to respond. On 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated they were unsure if R24 would participate even, however, expressed they had never been asked or consulted on R24's activity preferences, either. R24's admission MDS, dated 5/5/25, identified R24 admitted to the care center on 4/28/25 from the acute care hospital and had multiple medical conditions including heart failure, dementia, and a history of stroke/transient ischemic attack (TIA). The MDS section labeled, "Section F - Preferences for Customary Routine and Activities," provided spacing to record answers with gathered data including an Interview for Daily Preferences (F0400) and Interview for Activity Preferences (F0500). However, the entire section of the MDS (F0300 to F0800) was either left blank or marked, "Not Assessed." R24's medical record was reviewed and lacked evidence R24 had been evaluated for their routine and/or activity preferences during the assessment reference date (ARD) period (See F679).	F0636		

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F0636 SS = D	Continued from page 31 On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas "dashed" with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was "not acceptable." RN-O reviewed R24's medical record and verified the section of the MDS had been dashed and explained staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and "gives us [staff] an opportunity to see if the resident is progressing or declining." A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, "Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI]."	F0636		
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the quarterly Minimum Data Set (MDS) was completed in a thorough manner to ensure areas of cognition and potential depressive symptoms were fully evaluated for 2 of 4 residents (R22, R23) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined a	F0638	It is the policy of The Terrace at Crystal to complete accurate and timely quarterly Minimum Data Set (MDS) assessments for each resident, ensuring that all areas of cognition and mood are thoroughly evaluated. These assessments are essential to developing and maintaining individualized, person-centered care plans that address the mental and emotional well-being of each resident and ensure regulatory compliance. R22 and R23, the most recent quarterly MDS assessments, were reviewed for completeness and accuracy. BIMS and PHQ-9 mood assessments were re-administered. A facility-wide audit of all quarterly MDSs completed in the past 30 days will be conducted to ensure accurate evaluation of cognitive and mood indicators. The policy titled “MDS Completion and Submission Timeframes policy” was reviewed and revised as necessary. Education was provided to the social work team regarding quarterly MDS assessments. Audits of all completed quarterly MDS assessments will be conducted 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified.	08/26/2025

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F0638 SS = D	Continued from page 32 quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident' status between comprehensive assessments " ... to ensure critical indicators of gradual change in a resident's status are monitored." The manual included a section labeled, "SECTION C: COGNITIVE PATTERNS," which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, "These items are crucial factors in many care-planning decisions;" with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, "SECTION D: MOOD," which outlined the section would be used to help address mood distress and social isolation adding, "Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity," and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R22 R22's most recent quarterly MDS, dated 4/11/25, identified R22 had multiple medical conditions including high blood pressure, renal insufficiency or failure, and dementia. The MDS listed, "Section C - Cognitive Patterns," with areas to record R22's Brief Interview for Mental Status (BIMS) and/or the Staff Assessment for Mental Status. However, nearly all of these responses were marked, "Not Assessed." In total, section(s) C0100 to C1000 were marked, "Not Assessed," or left blank. The MDS listed, "Section D - Mood," with areas to record R22's Resident Mood Interview (PHQ-9) and/or a Staff Assessment of (the) Resident Mood, and potential social isolation symptoms. However, again, nearly all of these responses were marked, "Not Assessed." In total, section(s) D0100 to D0700 were marked, "Not Assessed," or left blank. R22's medical record was reviewed and lacked evidence either of these sections or corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the assessment reference date (ARD) to help determine what, if any, complications or issues R22 was demonstrating with these respective areas. R23 R23's most recent quarterly MDS, dated 5/22/25, identified R23 had multiple medical conditions including a history of stroke and aphasia (language disorder; difficulty with words). The MDS listed,	F0638	Continued from page 32 Audit results will be reviewed during QAPI meetings to determine additional actions or system changes. The remote MDS Coordinator and/or designee are responsible for ensuring continued compliance with accurate and thorough completion of quarterly MDS assessments.	

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F0638 SS = D	Continued from page 33 "Section C - Cognitive Patterns," with areas to record R23's BIMS and/or the Staff Assessment for Mental Status. However, nearly all of these responses were marked, "Not Assessed." In total, section(s) C0100 to C1310 were marked, "Not Assessed," or left blank. The MDS listed, "Section D - Mood," with areas to record R23's Resident Mood Interview (PHQ-9) and/or a Staff Assessment of (the) Resident Mood, and potential social isolation symptoms. However, again, nearly all of these responses were marked, "Not Assessed." In total, section(s) D0100 to D0700 were marked, "Not Assessed," or left blank. R23's medical record was reviewed and lacked evidence either of these sections or corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the ARD to help determine what, if any, complications or issues R23 was demonstrating with these respective areas. On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas "dashed" with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was "not acceptable." RN-O reviewed R22's medical record and verified the sections of the MDS were dashed and reiterated staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O reviewed R23's medical record and verified the sections of the MDS were dashed and, again, reiterated "the dashing situation" had been explained to the staff at the campus. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and "gives us [staff] an opportunity to see if the resident is progressing or declining." A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, "Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI]."	F0638		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641	It is the policy of The Terrace at Crystal to ensure that each resident receives an accurate Minimum Data Set (MDS) assessment reflective of their current status at the time of completion. MDS assessments must be completed by staff qualified to assess relevant care areas and knowledgeable about the resident’s condition,	08/26/2025

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F0641 SS = D	Continued from page 34 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 residents (R50) reviewed for hospitalization. Findings include: R50's Discharge-return not anticipated Minimum Data Set (MDS) dated 4/13/25 identified discharge from facility was planned and R50 discharged to "Short-Term General Hospital (acute hospital, IPPS)." During record review, R50's nursing progress noted dated 4/13/25 identified "Resident discharged from the	F0641	Continued from page 34 needs, strengths, and areas of decline. Accurate MDS documentation ensures regulatory compliance, appropriate care planning, and continuity of care. R50 discharged A facility-wide audit of all MDS discharge assessments completed in the past 30 days will be conducted The policy titled “MDS Accuracy and Discharge Documentation” was reviewed and revised as necessary. Nursing leadership, social services, MDS, activities and dietary received education focused on coding accuracy, with emphasis on commonly miscoded areas such as Sections G, GG, I, A, and Z. MDS Coordinator will audit 1x per week for 2 months, then monthly for 2 months or until sustained compliance is verified. Audit results will be documented and reviewed during monthly QAPI meetings to evaluate trends, accuracy, and opportunities for additional training. The remote MDS Coordinator and an in-facility designee are jointly responsible for oversight and ongoing monitoring of MDS coding accuracy and compliance.	

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F0641 SS = D	Continued from page 35 facility to home with all her medication and instruction with her family members at 3:30 p.m." During interview with licensed practical nurse (LPN)-A on 6/30/25 at 5:01 p.m., LPN-A stated she recalled R50 and stated, "She went home it was planned". During interview with R50 on 6/30/25 at 6:00 p.m., R50 stated, "Yes I was there and discharged home." During interview with registered nurse and MDS facility liaison (RN)-MDS on 7/1/25 at 10:36 a.m., RN-MDS reviewed R50's electronic medical record (EMR) and stated R50 discharged home on 4/13/25. Further review of R50's Discharge-return not anticipated MDS dated 4/13/25, RN-MDS stated the MDS was coded incorrectly, "it is not accurate". RN-MDS stated expectation for MDS to be coded accurately was "it concerns payment sources". During interview with MDS clinician (MDS) on 7/1/25 at 12:13 p.m., MDS reviewed R50's 4/13/25 Discharge-return not anticipated MDS and confirmed, "we have [R50] dc'd [discharged] to hospital". MDS stated that "it looks like it was coded incorrectly" and "incorrectly coding will affect quality measures for the facility and impacts payment and reimbursement". Facility policy titled Certifying Accuracy of the Resident Assessment, revised 2019 state "The information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment".	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F0656	It is the policy of The Terrace at Crystal to develop and maintain comprehensive, individualized care plans that fully address each resident's needs, including diet preferences and allergies. Care plans are developed by the interdisciplinary team (IDT) and updated regularly to reflect resident preferences, medical needs, and changes in condition. For Resident #37, the care plan was reviewed to ensure it accurately reflected the resident's dietary preferences and allergies. The care plan was updated to include all relevant diet restrictions, allergies, and preferences.	08/26/2025

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F0656 SS = D	Continued from page 36 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 2 residents (R37) reviewed for diet preferences/allergies. Findings include: R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care. Pertinent diagnoses include type 2	F0656	Continued from page 36 All residents with documented dietary restrictions or allergies have the potential to be affected by this practice. A facility-wide audit of care plans for residents with diet restrictions and allergies completed within the past 90 days will be conducted. The policy titled “Care Plan, Comprehensive Person-Centered” was reviewed. It clearly defines procedures for accurately assessing, documenting, and incorporating dietary preferences and allergies into care plans. Education will be provided to nursing staff, dietary personnel, and interdisciplinary team members on thorough care plan development, emphasizing dietary preferences, allergy identification, and timely updates. Weekly care plan audits will be conducted to verify accurate documentation and incorporation of dietary needs and allergies for 4 weeks and monthly for 2 months. Audit results will be reviewed at monthly QAPI meetings to assess compliance and determine the need for further education. DON and dietary manager are responsible for oversight and compliance.	

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F0656 SS = D	Continued from page 37 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood, and the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated the facility was aware of his food allergy. R37 stated he did not eat it, but it happened again just a few days ago and he had followed up with staff. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: - Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences.	F0656		

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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
F0656 SS = D	Continued from page 38 R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions." R37's allergy list, printed 7/2/25, lacked indication of allergy to shellfish, seafood or fish. R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants used the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R37 and worked with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet	F0656		

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F0656 SS = D	Continued from page 39 orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic too. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated residents' food allergies and their food preferences should be listed on their care plan. DON verified R37's food allergies and food preferences were not listed and should be on the care plan. A facility policy titled Care Plan, Comprehensive Person-Centered, reviewed 6/23, "assessment of residents are ongoing, and care plan are revised as information about the residents and the residents' conditions change."	F0656		
F0657 SS = D	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	F0657	It is the policy of The Terrace at Crystal to ensure that each resident receives timely, person-centered care plan reviews and revisions, with full participation of the resident and/or their representative, and the interdisciplinary team (IDT). For Resident #41, the timing of the care conference was reviewed to support ongoing interdisciplinary collaboration and resident involvement. Care Conference was held. The care plan will be reviewed, updated as necessary, and documentation will be completed to reflect the conference. All residents are at risk for being affected by this deficient practice. A facility-wide audit will be completed to identify any residents overdue for a care conference. All identified residents will be scheduled and hold care conferences within appropriate timeframes. The care plans will be reviewed and updated to reflect current resident status, preferences, and goals of care. The policy titled “Care Plan, Comprehensive Person-Centered” was reviewed to ensure compliance with F-657. Refresher training will be provided to unit managers,	08/26/2025

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F0657 SS = D	Continued from page 40 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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide routine care conferences to allow for resident participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 2 residents (R41) reviewed for care conferences. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's electronic medical record (EMR) indicated R41 had one care conference since being admitted to the care facility. A progress note, dated 10/24/24, indicated R41 "had her care conference today at 1:00pm. Pt [patient], SW [social worker], and Nurse Manager were in attendance." During an interview on 6/29/25 at 3:07 p.m., R41 stated she had "been to maybe one" care conference since being admitted to the facility and had concerns about her care. During an interview on 7/1/25 at 8:17 a.m., licensed social worker (LSW)-A stated the resident care conferences and care plan review should be held "roughly" every three months and generally coordinate with the MDS cycle. LSW-A stated she had not held a care conference for R41 as R41 had "not been agreeable", however stated the interdisciplinary team should still meet quarterly to discuss the residents' care, even if the resident did not want to participate. LSW-A stated timely and routine care conferences were important to ensure there were no resident changes the team may have missed. During an interview on 7/2/25 at 12:06 p.m., the director of nursing stated it was expected that care conferences were held quarterly, even if the resident did not want to participate.	F0657	Continued from page 40 social services, therapy, dietary, and other IDT members on the policy and the importance of timely care conferences, proper documentation, and resident-centered care planning. Weekly audits will be conducted for newly completed care plans and care conference schedules. A sample of at least 5 residents per month will be reviewed for care conference timeliness and documentation. Results will be discussed during monthly QAPI meetings to evaluate compliance and identify opportunities for improvement. Social Worker and DON and/or designee are responsible for oversight and compliance.	

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F0657 SS = D	Continued from page 41 A facility policy titled Care Plans, Comprehensive Person-Centered, revised 6/2023, indicated the interdisciplinary team would review and update the care plan at least quarterly, in conjunction with the required MDS assessment.	F0657		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language,	F0676	It is the policy of The Terrace at Crystal to ensure that residents who are unable to carry out activities of daily living (ADLs) independently receive the necessary services to maintain good hygiene, grooming, and overall well-being, including fingernail care. Residents who require assistance must have clearly outlined care interventions in their care plan, and staff must provide timely and consistent support in accordance with the resident's assessed needs. R23, fingernail care needs were reviewed as part of routine hygiene services and provided fingernail care. The resident's care plan was reviewed and updated to include detailed instructions and scheduled intervals for nail care A facility-wide audit of residents dependent on staff for ADLs will be conducted, focusing on nail care needs and hygiene interventions. Any resident identified as needing nail care received services promptly, and their care plans were updated to reflect ongoing support needs. The facility policy titled "Care of Fingernails/Toenails Policy" was reviewed to reinforce requirements for routine fingernail care as a component of ADL services. Education will be provided to all nursing staff on performing fingernail care, recognizing signs of unmet hygiene needs, documenting care provided, and ensuring care plans accurately reflect resident support requirements. Audits of ADLS will be completed through weekly audits 1x per week for 2 months, then monthly for 2 months to verify accurate documentation and incorporation of dietary needs and allergies. Results will be reviewed during monthly QAPI meetings to assess compliance trends and determine if additional corrective actions or training are necessary. The Director of Nursing (DON) and/or designee is responsible for oversight and compliance with this plan.	08/26/2025

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F0676 SS = D	Continued from page 42 (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene cares for 1 of 1 resident (R23) reviewed who needed assistance with fingernail care. Findings include: R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). The MDS indicated R23 needed substantial/maximal assistance with person hygiene which included combing hair, shaving, washing/drying face and hands, etc.. R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). R23's care plan printed 6/30/25, directed staff to check nail length and trim and clean on bath day and as necessary and to report any changes to the nurse. The care plan indicated R23 required extensive assist of one staff for personal hygiene. R23's Treatment Administration Record (TAR) dated June 2025, directed staff to complete a weekly skin review and/or bath, and nursing staff to open a skin review assessment and complete. The order directed staff to chart all refusals in the evening every Wednesday. The order had a start date of 7/12/23 and discontinued date of 6/27/25. R23's Weekly Bath Audit dated 6/25/25, indicated R23 received a bed bath, did not have any new skin alterations, and was not resistive to or refused bathing. The audit did not reference nail care. R23's Point of Care (POC; an app which allows care staff to document ADLs) documentation, indicated R23 refused bathing on 6/25/25.	F0676		

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F0676 SS = D	Continued from page 43 R23's recent progress notes indicated R23 was seen by podiatry for foot care on 6/17/25. R23's progress notes did not indicate fingernail care or refusals of fingernail care. During observation and interview on 6/29/25 at 9:11 a.m., R23's nails were multiple millimeters (mm) in length with dark debris underneath them. R23 stated staff assisted him with nail care, and he would like his nails cut. During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his wheelchair and dressed. R23's nails were in the same condition as the previous observation. R23 reiterated he wanted his nails cut and cleaned. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated R23 refused to have his nails cut at times and told the nurse when he refused. NA-K stated they would cut his nails after lunch. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A stated residents nails were trimmed on bath days and refusals should be documented. LPN-A verified the condition of R23's nails and stated his nails needed to be trimmed. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected nail care to be completed with weekly showers and as needed to prevent infection and maintain resident dignity. The facility policy Care of Fingernails/Toenails dated February 2018, indicated nail care included daily cleaning and regular trimming, and proper nail care aided in the prevention of skin problems around the nail bed and from accidental scratching and injury to residents' skin. The policy directed staff to document the reason why and intervention taken if a resident refused nail care.	F0676		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F0679	It is the policy of The Terrace at Crystal to ensure that each resident receives a program of activities that is designed to meet their individual physical, mental, and psychosocial well-being, in accordance with	08/26/2025

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F0679 SS = D	Continued from page 44 §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: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 1 of 2 residents (R24) reviewed for activities. Findings include: R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. However, the section to record R24's activity preferences and routines was left blank or marked, "Not Assessed [See F636]." On 6/29/25 at 10:46 a.m., R24 was observed lying in bed while in her room on the locked unit. R24's television was turned on and positioned along the opposite wall of her bed. R24 was interviewed and expressed aloud, "I don't know," when asked how long they'd lived at the center. R24 was dressed in a hospital-type gown and her hair appeared with a light, greasy-looking shine. R24 was asked about what, if any, activities the floor staff involve her with and she abruptly responded, "Would you leave me alone?!" Following, on 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G explained they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated R24 had been outside "maybe once" since admitting from their recall and expressed the staff may be offering them to her and she's declining them but was unsure. FM-G stated R24 had a television in her room which she needed help to operate and expressed they were unsure if staff knew that or not adding, "I don't know they realize that." FM-G stated R24 enjoyed mystery and "murder shows" on the television. Further, FM-G reiterated they were unsure	F0679	Continued from page 44 their comprehensive assessment and personal preferences. Activity programming must be person-centered, culturally relevant, and adjusted to the resident's abilities and interests. R24 activity needs were reviewed to support quality of life through meaningful engagement. The Activity Director met with the resident to assess their interests, preferences, and functional capabilities. The updated care plan was reviewed with IDT. A facility-wide audit will be conducted of all residents' activity assessments and care plans completed within the last 90 days. Any resident whose interests or functional ability were not clearly reflected in their activities care plan will be reassessed. Care plans will be updated accordingly, and activity interventions were implemented to ensure resident-centered engagement. The policy titled "Activity Programs policy" was reviewed and revised as necessary Activities staff, IDT members, and social services will be educated on conducting comprehensive activity assessments, documenting resident interests and abilities, and developing and implementing individualized care plans that promote quality of life. Audits will be completed 1x per week for 2 months, then monthly for 2 months to verify accurate documentation and incorporation of activity interests and preferences Results will be reviewed during monthly QAPI meetings to assess compliance trends and determine if additional corrective actions or training are necessary. The Activity Director and DON are responsible for oversight and compliance with this plan.	

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F0679 SS = D	Continued from page 45 if R24 would participate in activities even, however, stated nobody from the care center had ever talked with them about her likes or dislikes for activities since she admitted. R24's medical record was reviewed and lacked evidence R24 had been comprehensively assessed for what, if any, individual or group-based activities she would like to attend; nor did the record have evidence of any other activities (i.e., 1:1) being provided. R24's care plan, printed 7/1/25, identified all R24's current or potential concerns the facility had identified and implemented interventions to address. The care plan was reviewed and lacked any recorded focus statements, goals, or interventions for leisure and/or activities despite R24 admitting to the care center months prior. Further, the entire electronic medical record (EMR) lacked any completed tasks or progress note(s) in the system to demonstrate R24 had been provided any activities since she admitted to the care center. On 6/30/25 at 1:33 p.m., R24 was again observed lying in bed while in her room. R24's television was turned on and a day-time drama television show was on. R24 was asked about the show or if she enjoyed it, however, R24 just mumbled a response which was not discernable. R24 was asked if she was able to use the remote or needed help and just stared at the surveyor with no audible response. When interviewed on 6/30/25 at 1:36 p.m., nursing assistant (NA)-A stated they had worked with R24 prior, and expressed R24 needed help with nearly all her cares. NA-A stated R24 would rarely get up from bed and expressed it "all depends" on her mood and what she'd allow each day. NA-A stated R24 would get up to the wheelchair maybe "three to four times [week]" and then added, "She really likes to be in her room." NA-A stated they were aware of some activities happening "at the back there" on the unit, however, had only seen her at a few they could recall. NA-A stated R24 liked her "criminal shows" and would try to keep those on the television for her. NA-A stated they knew R24 enjoyed 'criminal shows' as "I work with her a lot of times," adding nobody from the care center activities' staff had ever told them which channels or shows to play for R24 adding, "I just found out on my own." NA-A verified R24 would, at times, not speak to staff and would remain silent adding R24 needed to "be in a good mood" to converse. When questioned how other staff, including pool staff, would know which shows or channels R24 enjoyed NA-A responded aloud, "That's hard." NA-A stated the staff used a "care guide" which had all residents listed on it and reviewed this with the	F0679		

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F0679 SS = D	Continued from page 46 surveyor. R24's name was listed, however, the guide lacked any information on which channels, shows, or activities R24 enjoyed or wanted. NA-A verified the guide lacked this information and expressed aloud, "It's not there." NA-A stated having it listed on the care guide would help others adding, "Everybody works different with these people." When interviewed on 6/30/25 at 1:45 p.m., trained medication aide (TMA)-A stated they had worked with R24 prior and described her as needing "a lot of help" with cares. TMA-A explained R24 could be "real mean" sometimes and "not too often" would get up from bed. TMA-A stated physical therapy (PT) was working with her and even for them, R24 would still "not too often" get up from bed. TMA-A stated they had never seen R24 attend any activities prior and was unsure what, if any, in-room activities the staff were doing for her adding, "I haven't seen it." TMA-A stated R24 could "tell you what she wants" if she needed the television adjusted but then expressed R24 would not usually speak to people she didn't like or didn't know adding the aides often rotate amongst the units "all the time." TMA-A stated the activities personnel would know more about R24. On 6/30/25 at 1:51 p.m., the activities assistant (AA)-A was interviewed, and explained they worked on the memory care unit. AA-A stated a previous activities supervisor used to do the comprehensive assessments for residents, however, lately it had been them doing it. AA-A stated activities' likes and dislikes were tracked using a paper flow sheet on each floor and then entered into the system under the "assessments" tab. AA-A stated the activities director (AD) did the care plans adding, "We don't do that." AA-A stated the AD would likely have more information on the assessment and care planning of activities. AA-A explained they were aware of R24 and expressed aloud, "She don't come out their room." AA-A stated they do a "coffee and chat" quick with her everyday but R24 often didn't verbally respond to her. AA-A stated they "check on her" a few times every day they felt. AA-A explained they used to track activities within the EMR, however, a previous management staff told them to stop doing so as "State [MDH] can't see it," which is where the paper flow sheets came from. AA-A stated this had been the process since "like two administrators ago" from their recall. AA-A stated R24 was "not a normal person to talk to" but felt she enjoyed "the old, old shows" and "like gray and white shows" from her recall. Later, on 6/30/25 at 2:01 p.m., the AD and AA-A were interviewed and the paper flow sheets, as completed by	F0679		

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F0679 SS = D	Continued from page 47 AA-A, were provided for review. These identified a paper with rows and columns which had multiple resident room numbers on the side and spacing to record across the paper for each day of the week. These identified: May 26 to May 31; R24's name and room number were identified. The flow sheet recorded a 1:1 was held four times, however, it didn't record any date(s) or length of time or what activities (i.e., nail care, reading news) were completed during it. June 2 to June 6; R24's name and room number were identified. The flow sheet recorded a 1:1 was held six times, once each day from Monday to Saturday, respectively. However, again, the sheet didn't record any length of time or what activities were completed during it. June 9 to June 14; R24's name and room number were identified. The flow sheet recorded a 1:1 was held five times, once each day from Monday to Wednesday, and on Friday and Saturday. The flow sheet recorded a single entry on Thursday which read, "Unv." However, again, the sheet didn't record any length of time or what activities were completed during the 1:1 sessions or an explanation for what 'unv' meant. July 12 (i.e., "7/12"); R24's name and room number were identified. R24 was not listed on the flow sheet and no activities were recorded for her. AA-A explained the 1:1's recorded on the flow sheet for R24 were the 'coffee and chat' sessions they had explained. AA-A acknowledged the charting on the flow sheet showed only once but reiterated they stopped in the room a "couple times a day" to check on her. AD explained the AA staff help complete the comprehensive assessments for each resident upon admission which were then entered into the EMR adding that should be done "as soon as they come in." From those assessments, then the care plan gets developed in the EMR. AD reviewed R24's medical record and verified it lacked any completed assessments for activities and the care plan lacked information or interventions for activities adding, "It's not in there." AD stated they felt it was completed and possibly just not entered adding, "I know we did it." AD stated the lack of assessment and care plan made it appear "like they [staff] didn't talk to her at all." AA-A stated they had search for a paper copy of the completed assessment, however, were unable to locate it adding aloud, "Maybe we missed one." However, both AD and AA-A verified residents' should be assessed and care planned for their activities preferences adding such was important, "So we know what	F0679		

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F0679 SS = D	Continued from page 48 they like and like to do." AA-A stated they would go and assess R24 now since this was identified. A facility provided Activity Programs policy, dated 3/2025, identified activities would be offered based on the comprehensive assessment and preferences of each resident. The policy outlined activities were scheduled seven (7) days a week and residents would be given opportunity to contribute to the planning, conducting and critiquing of them. The policy directed, "All activities are documented in the resident's medical record."	F0679		
F0684 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: Based on observation, interview, and document review, the facility failed to ensure proper wheelchair positioning for eating was maintained to promote comfort for 1 of 1 resident (R22); and failed to ensure medical devices for edema management were consistently applied to reduce peripheral swelling for 1 of 2 residents (R258) reviewed for edema care. Findings include: R22 R22's quarterly Minimum Data Set (MDS), dated 4/11/25, identified R22 had dementia but demonstrated no delusional thinking, however, the section to record R22's cognition was dashed as, "Not Assessed [see F638]." On 6/29/25 at 8:48 a.m., R22 was observed seated in the Broda-style wheelchair while in the dining room on the locked unit. R22 was positioned next to the table with his meal served on the table. R22's wheelchair back was in a reclined position at approximately 50 degrees and R22 was observed leaning forward approximately 12 to 14 inches from the wheelchair back to eat his meal. The	F0684	It is the policy of The Terrace at Crystal to ensure that residents receive the necessary care and services to maintain or improve their highest practicable physical, mental, and psychosocial well-being, in accordance with their comprehensive assessments and individual care plans. This includes proper positioning during meals to promote comfort and safety, and consistent application of prescribed medical devices to manage clinical conditions such as edema. R22 wheelchair positioning during meals was reviewed to ensure safe and comfortable dining. The resident’s seating and dining position was evaluated by nursing and therapy staff. R258 use of prescribed medical devices for peripheral edema management was reviewed to support consistent and effective care. The resident’s care plan was updated. Residents requiring specialized seating or therapeutic devices care plans were reviewed and updated as needed to ensure appropriate positioning and consistent use of medical devices. The facility prepared a policy titled “Resident Wheelchair Positioning Policy and Therapeutic Devices Use Policy”. Education will be provided to nursing staff, therapy, and restorative aids on proper wheelchair positioning for mealtimes and the clinical importance of consistent medical device application for edema control and the importance of edema management and the documentation of device use Ongoing monitoring will be conducted through weekly audits 1x per week for 2 months, then monthly for 2 months to verify quality of care	08/26/2025

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F0684 SS = D	Continued from page 49 seat of the wheelchair was approximately 12 to 14 inches from the ground and the table height was elevated, placing the meal plate at R22's chest level while he consumed the meal. Later, at 8:55 a.m., R22 continued to eat the meal from his plate in the same position, with several areas of spilled food on the table and R22's lap visible. There was no obvious attempt to correct R22's position during the observed meal service. R22's Physician Order, dated 12/12/24, outlined R22 was on hospice care and directed to continue consuming a regular diet with thin liquids, using a lipped plate for all meals, and, "Ensure pt [patient] is at proper positioning for all PO [oral] intake." R22's care plan, printed 7/1/25, identified all R22's current and potential problems along with interventions to address them. The care plan outlined R22 was dependent on staff for mobility using a Broda chair and listed an intervention which read, "Resident will have comfortable body alignment while in their chair." This intervention had an initiation date recorded, "01/06/2025." The plan continued and outlined R22 as being independent with eating after meal tray set-up, and listed R22 as having potential for inadequate oral intake due to dementia and being on hospice care. The plan directed, "Assist at meals as needed." On 6/30/25 at 5:24 p.m., the supper meal service on the locked unit was observed. R22 was pushed up to the table while seated in his Broda chair by nursing assistant (NA)-C and left there. R22's Broda chair was, again, in a reclined position and R22's buttock while seated in the chair was only 12-14 inches up from the ground. The table remained at the same height as prior with the table edge being even with R22's upper chest while he was seated in the Broda chair. NA-C returned to the table after a few moments and placed a lipped plate on the table in front of R22 before leaving the table again. R22 then, again, leaned forward nearly 12 to 14 inches or more from the reclined Broda chair and began eating his meal using the provided utensils. After several minutes, R22 was observed eating his meal and the Broda chair remained in a reclined position with R22 having to lean forward while eating to reach the cups and meal items. R22 then dropped his utensil on the ground with an audible noise to which NA-H responded to him from nearby, "Did you drop anything?" NA-H then retrieved the utensil and placed in onto the table, however, made no attempt to reposition R22 or improve his posture despite him leaning forward from the Broda chair-back to eat over 12 inches.	F0684	Continued from page 49 Results will be reviewed during monthly QAPI meetings to evaluate trends, staff adherence, and identify needs for additional training. The Rehab Director and DON and/or designee are responsible for the implementation, oversight, and continued compliance with this corrective action plan.	

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F0684 SS = D	Continued from page 50 Following, at 5:31 p.m., NA-H was interviewed and verified they had worked with R22 prior. NA-H explained R22 typically ate meals at the table in the dining room while seated in his Broda chair and, when asked to look at R22's posture, walked over and adjusted the back of the Broda chair to a more upright position which brought R22 to a more elevated position from which to eat his meal; however, the plate still was elevated and now appeared to be level with R22's mid-chest height. NA-H stated they keep the Broda chair in a reclined position "so he can't fall" from it. NA-H stated they had never seen or attempted to use any other tables, such as a bedside table, to provide a better posture for R22 to consume his meals. NA-H stated they were unsure why the Broda chair was left in the reclined position when R22 was provided his meal but reiterated the Broda chair-back should be raised to a vertical position while he's eating adding, "That's how he eat [sic]." When interviewed on 6/30/25 at 5:39 p.m., trained medication aide (TMA)-A stated they had worked with R22 and observed him seated at the table in the dining room. TMA-A acknowledged the seat of the wheelchair being approximately 12 inches or so from the ground and R22's plate being positioned mid-chest level despite the chair-back being raised forward. TMA-A stated the table could likely be adjusted and expressed they were unsure who, if anyone, evaluates a resident' eating posture or position adding, "I don't know that." TMA-A stated R22 had used the Broda chair for awhile and expressed they had never seen any other type of table used for him at meals to see if the positioning improved. TMA-A stated, at minimum, R22's Broda chair-back should be raised forward though at meals "so he can sit up while he's eating." TMA-A added, "How can you really enjoy your food [sitting back]?" R22's medical record was reviewed and lacked evidence R22 had been comprehensively evaluated or assessed for what, if any, alternatives or interventions were needed for his posture while seated in the Broda chair at meals despite him having to lean significantly forward from that chair to consume his meals. On 6/30/25 at 5:44 p.m., registered nurse unit manger (RN)-A stated the speech therapist would typically evaluate someone for eating posture or positioning, if needed. RN-A stated they had never seen R22 use a bedside table or anything else to provide a better posture with eating adding, "I've not observed that." RN-A stated they had not noticed R22's eating position while at the table prior and expressed no one of the floor staff had mentioned to them, either. RN-A	F0684		

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F0684 SS = D	Continued from page 51 verified R22's Broda chair-back should be moved forward for meals so he's not eating at a reclined position or having to lean forward while eating adding, "That's not comfortable for him." RN-A stated they'd reviewed if a bedside (lower) table would possibly improve his posture, too, adding aloud, "Thank you for catching that." When interviewed on 7/1/25 at 9:38 a.m., the director of nursing (DON) verified they were able to review R22's medical record and provided the Physician Order (dated 12/2024) as the only evaluation or documentation of his eating posture. DON stated staff should be, at minimum, bringing the chair-back forward during meals so R22 would be "sitting upright for meals." This was important to do "to make sure he's able to reach his food and eat comfortably." DON stated they had never noticed R22 to sit in a poor posture while at eats prior and expressed the Broda chair itself could be raised up, if needed, too. A facility' policy on wheelchair positioning or posture was requested, however, none was received. R258's quarterly minimum data set (MDS), dated 6/25/25, indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. The MDS further indicated R258 was dependent on staff for toileting, bathing and lower extremity dressing. R258's physician orders sheet, printed 7/2/25, indicated R258 had several medical diagnoses including lymphedema (a condition that causes swelling, usually in the arms or legs, due to a buildup of lymph fluid in the body's tissues) and congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs which often causes swelling in the legs and ankles). R258's electronic medical record (EMR) contained two orders for lower extremity swelling: TEDs (specialized stockings designed to prevent blood clots and reduce swelling, particularly in the legs and feet, by applying graduated compression) to bilateral lower extremities on for 12 hours off for 12 hours, dated 10/23/24 and lymphedema wraps (specialized bandages used to manage swelling by providing graduated compression, which helps move lymph fluid out of the affected area) to bilateral lower extremities daily, dated 9/17/22. R258's June treatment administration record (TAR) indicated nursing staff applied R258's lymphedema wraps	F0684		

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F0684 SS = D	Continued from page 52 once in the month of June on 6/17/25 (all other days were marked as "refused", "sleeping" or "hospitalized"). The TAR further indicated R258 TED stockiknngs were applied just once on 6/6/25 (all other days were marked as "refused", "sleeping" or "hospitalized"). R258 was hospitalized on 6/1/25 and 6/2/25. During observation and interview on 6/30/25 at 5:45 p.m., R258 was lying in bed with a sheet over her but her legs exposed. R258's bilateral legs appeared edematous and were without wraps or TED stockings. R258 stated she has not had her TED stockings on since she returned from the hospital in the beginning of June and has never worn lymphedema wraps. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she thought R258 had wraps for her legs but that she only administered medications for R258 and the nurses would do the wraps if she had them. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated R258 would often sleep during the day and be up at night, so when staff went in to do her treatments (i.e. wound care and TEDs) she would tell staff to "go away." During an interview on 7/2/25 at 9:22 a.m., the director of rehab (DOR) stated prior to R258's hospitalization the rehab staff had attempted to fit R258 for custom lymphedema wraps but she had refused the fitting appointment. The DOR stated nursing staff should be assisting R258 to apply her TED stockings daily to be worn for 12 hours on then off for 12 hours, stressing their importance to help reduce R258's edema and promote skin integrity, even if R258 was spending more time in bed post hospitalization. During an interview on 7/2/25 at 8:57 a.m., the third-floor manager and LPN-E stated prior to her hospitalization, R258 was "good about" wearing her TED stockings. LPN-E had not assessed why nursing staff were not able to apply R258's TED stockings and not assessed whether R258 would rather wear them at night while she was awake. A facility policy on edema management was request but not received.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F0686	It is the policy of The Terrace at Crystal to ensure that residents who are admitted without pressure ulcers do not develop them unless clinically unavoidable, and that residents with pressure ulcers receive the	08/26/2025

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F0686 SS = G	Continued from page 53 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: During observation, interview, and record review the facility failed to identify, implement, monitor and modify interventions to provide timely treatment and services to heal and to prevent further worsening of wounds. This failure resulted in harm for R254 when his bilateral heel pressure ulcers were not identified and addressed by facility until they progressed to stage three. Findings include: According to the national pressure injury advisory panel (NPIAP), pressure injury is defined as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. In addition, the evolution of a deep tissue pressure injury (DTI) develops from an exerted pressure about 48 hours before visible signs of purple or maroon skin. Then, about 24 hours later, the epidermis (layer of skin) lifts and reveals a dark wound bed. A stage three pressure ulcer/injury is defined as a full thickness loss of skin. R254's admissions Minimum Data Set (MDS) dated 7/17/24, and quarterly MDS dated 10/1/24, identified risk for developing pressure ulcers, had no pressure ulcers, no unhealed pressure ulcers, no unstageable pressure ulcer/injuries, and no deep tissue injuries. In addition, R254 had intact cognition, no impairment of upper and lower extremities, and was independent with self-care and mobility. R254's significant change in status (SCSA) MDS dated 11/22/24, identified two stage three pressure ulcers, with none of them present upon	F0686	Continued from page 53 appropriate treatment and services necessary to promote healing, prevent infection, and avoid new ulcer development. Resident #254 has been discharged. All current residents with identified pressure ulcers or at risk for skin breakdown were reviewed by the Wound Nurse and interdisciplinary team. Preventive strategies and treatment protocols reinforced and updated as needed to ensure alignment with best practices and resident-specific needs. The facility's "Pressure Injury Risk Assessment policy" was reviewed to make sure it supports early identification, routine skin monitoring, appropriate use of protective devices, and timely provider notification. Nursing staff received re-education on pressure ulcer prevention, proper documentation of skin assessments, timely communication of skin changes, and implementation of care plan interventions. Emphasis was placed on collaborative prevention efforts and prompt reporting of concerns. The DON and Wound Nurse/designee will conduct weekly wound audits and random skin integrity checks to ensure compliance with protocols. Audit results will be reviewed during monthly QAPI meetings to identify trends, reinforce best practices, and initiate corrective actions as needed. The Director of Nursing is responsible for overseeing ongoing compliance.	

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F0686 SS = G	Continued from page 54 his admission to facility. In addition, R254 had severe cognitive impairment and was dependent on staff for toileting, bathing, personal hygiene. Also, R254 required assistance with mobility including sit to lying and lying to sitting on side of the bed. R254's admission MDS care area assessments (CAA) dated 7/17/24, identified "Potential" risk factors for pressure ulcers. Section of form to identify "Supporting Documentation. Provide the basis/reason for items being checked, including the location & date & source" was left blank. R254's CAA for the 11/22/24, SCSA MDS identified "Actual" problem for Pressure Ulcer/Injury and, "Skin breakdown with risk for further breakdown and impaired healing related to terminal condition." The Care Plan Considerations identified current pressure ulcer would be addressed in the care plan with overall objective to "Slow or minimize decline." R254's medical diagnoses include diabetes, rheumatoid arthritis, depression, hypertension, and congestive heart failure (CHF). The Braden Scale for Predicting Pressure Ulcer Risk is an evidence-based assessment tool in health care used for predicting a patients' risk of developing pressure ulcers. It allows health care professional to implement preventive measures effectively. Scores of less than 9 indicate "Severe Risk", scores of 10-12 indicate" High Risk", scores of 13-14 indicate "Moderate Risk", and scores of 15-18 indicate a "Mild Risk". R254's Braden assessment scores (scale to assess patients' risk of developing pressure injuries) were: 7/11/24 score of 18, 9/27/24 score of 15, 10/6/24 score of 15, 11/7/24 score of 17, 11/14/24 score of 15, and 11/22/24 score of 16. R254's care plan with focus on Skin identified "resident have actual wounds to both heels and potential for impairment to skin integrity fragile skin." Date initiated was 8/15/24. CP Interventions identified "Reposition Frequently" and "Weekly treatment documentation to include measurement of each	F0686		

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F0686 SS = G	Continued from page 55 area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations" was initiated 1/5/25-four days before R254 expired. R254's provider progress notes (PN) dated 7/15/24, 7/16/24, 7/17/24, 8/21/24, 8/23/24 identified "No rash, or lesions" under Examination section of form. Provider PN dated 9/6/24 identified, "No breakdown in hands or heels" and to "monitor for acute skin care breakdown". R254's hospital discharge summary (DC) dated 9/23/24, identified hospitalization from 9/13/24 to 9/23/24 for urinary retention and urinary tract infection. DC summary identified, "no rashes, ulcerations on exposed skin surfaces". Upon admission to hospital R254 had bruising to coccyx which was identified 9/14/24, with no other skin issues identified. During review of PN dated 9/25/24 identified R254 readmitted to facility from hospitalization. PN failed to indicate any assessment or issues with skin integrity. PN dated 10/2/24 at 5:23 p.m., identified R254 "felt like[sic] had an [sic] heart attack, and would like to go to the hospital for checkup." Orders were received to send to hospital. PN dated 10/3/24 at 11:07 p.m., stated R254 returned from "hospital at 3:15 p.m." and failed to indicate any assessment or issues with skin integrity. R254's hospital DC summary dated 10/3/24, identified R254 hospitalized 10/2/24 to 10/3/24 for report of chest pain. During hospitalization on 10/2/24 a "Pressure Injury: Suspected Deep Tissue Injury" to left and right heels were first observed on 10/2/24 at 10:58 p.m., and both wounds were identified has being present "Prior to Admission". R254's weekly bath audits (BA) dated 10/7/24, 10/14/24, 10/21/24, 10/28/24, 11/4/24, 11/11/24, 11/17/24, 12/3/24, identified, "no new alterations in skin". BAs were marked as, "weekly wound assessment initiated and completed." R254's podiatry consultation noted dated 10/22/24, identified "ulcer heels" and "monitor pressure". R254 was admitted to hospice services on 11/14/24, with terminal diagnosis of congestive heart failure. R254's hospice admission note identified, "bilateral stage 3 pressure injuries on heels". R254's provider orders (PO) dated 11/22/24, initiated	F0686		

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F0686 SS = G	Continued from page 56 PO for left and right heel ulcers. The PO for left heel identified, “left Heel wound order: cleanse with vashe (wound cleanser), skin prep to area, santyl (topical medication used to clean and remove dead tissue) to wound bed and apply mepilex (a foam dressing) to area, change daily”. PO for right heel identified, “Right heel wound orders: cleanse with vashe, paint heel with betadine, cover with gauze 4x4 and wrap with kerlix, change daily”. During review of R254’s EMR, the documentation of R254’s left and right heel ulcers by infection control preventionist and facility wound nurse (IP) began on 11/12/24 by using the Skin and Wound Evaluation assessments. Measurements of wounds include: Left heel: 11/12/24: 1.5 centimeters (cm) long x 1.7 cm wide x 1.2cm deep. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. Notation of, “This is a new wound.” Right heel: 11/12/24: 5.5cm x 3.6cm x 2.2cm. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. R254’s provider PN dated 12/10/24, identified “Chief Complaint: f/u wound rounds.” PN stated pressure ulcers of left and right heel were “unstageable.” Left heel measurements were: 11/12/24: 1.73 cm x 1.27 cm, 11/15/24: 2.2cm x 1.3 cm, 11/22/24: 2.8cm x 2.6cm, 12/10/24: 3.5 cm x 4.4cm. Right heel measurements were: 11/12/24: 4.47cm x 3.0cm, 11/22/24: 4.7cm x 6.6cm, 12/10/24: 4.0cm x 6.2 cm. During review of R254’s Skin and Wound Evaluation assessment for 12/27/24, the left heel wound measurements were 2.1cm x 2.3cm x 1.2cm deep and the	F0686		

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F0686 SS = G	Continued from page 57 right heel measurements were 8.7cm x 4.4cm x 2.7cm deep. During interview with wound care provider (WP) on 7/1/25 at 8:15 a.m., WP stated facility wide wound care rounds were performed with infection control preventionist (IP) twice per week. WP stated IP developed a list of residents who needed to be seen each time. WP stated facility nurses “will tell [IP] of new wounds” and IP assessed and obtained new wound care orders. IP then added these residents to his bi-weekly wound care rounds for monitoring and managing of wounds. During interview with director of nursing (DON) on 7/2/25 at 7:37 a.m., DON stated she was familiar with R254 because DON was the nurse manager on the unit where R254 lived on during the entire time of his facility stay. DON reviewed 10/3/25 hospital DC summary and agreed the documentation identified bilateral heel DTI’s. DON reviewed R254’s electronic medical record (EMR) and stated she was unable to determine if R254’s DTIs were identified at the facility prior to R254’s hospitalization on 10/2/24. DON stated expectation of staff members who identify impaired skin issues to “report ASAP to nurse, the nurse should assess and update the provider and document [sic] it in progress note”. DON stated, first note of impaired skin issues with R254 was on 11/14/24, with the PO for wound care orders to both heels. DON stated R254’s CP “should have been updated and was not”. DON stated first indication of wound care for R254 was placed in CP on 8/15/24, but not acted on until 11/14/24, when the IP obtained the PO. DON stated importance of identifying and acting on impaired skin integrity “is to ensure appropriate interventions are initiated immediately”. DON stated she was unable to determine when R254’s DTIs occurred by looking at his EMR. During interview with LPN-B on 7/2/25 at 11:46 p.m., LPN-B stated expectation of staff to assess and “check [residents] skin upon hospital return” including feet and coccyx. LPN-B stated any new or developing skin issues should be addressed right away and provider should be contacted, orders received and notify the IP. In addition, a PN should be put in the EMR. LPN-B stated expectation of “all skin” to be checked weekly with the bath and documented in the “weekly bath audit”. During interview with LPN-A on 7/2/25 at 11:57 a.m., LPN-A stated expectation of staff to assess and “check skin” and to document in the EMR under the PN about skin condition. If there was a new skin injury, then	F0686		

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F0686 SS = G	Continued from page 58 staff were expected to “chart it and notify the wound team”. LPN-A stated CP interventions for skin care were changed and updated by the IP “when they review [the wounds]”. During interview with LPN-B on 7/2/25 at 12:53 p.m., LPN-B stated a “body audit should be done for all [residents] readmitting” to facility. LPN-B reviewed R254’s EMR and stated, “no there is nothing there.”. LPN-B stated she remembered R254 during his facility stay and stated “I remember seeing them [bilateral pressure ulcers to heels] two months before [R254] passed. Me and [IP] were doing something for [R254] and noticed it while changing his socks. I remember seeing it for the first time saying, ‘oh my God’. I did not document anything. That is [IP]’s job. IP is the wound nurse and should have done it,” and continued, “No, I do not see it was done”. During interview with medical director (MD) on 7/2/25 at 8:58 a.m., MD reviewed R254’s EMR and physician notes and stated, “I expect the facility to have assessed [R254’s] heels prior to [sic] admission to the hospital in October [10/2/24].” MD stated R254’s EMR lacked orders, progress notes, and other documentation to support identifying R254’s bilateral heel PU’s until they progressed to stage three. MD stated, “[it was] most likely avoidable.” During interview with IP on 7/2/25 at 8:28 a.m., IP stated he was familiar with R254 during his facility stay. IP reviewed R254’s EMR and stated, “[11/12/24] is when we first identified [R254’s] heel ulcers.” IP stated he did not obtain PO for R254 until 11/14/24, and IP failed to document in the PN. IP stated expectation of staff to “notify me ASAP” when there is a new or worsening skin issue, “then, I will assess and get orders from the [provider] and put the resident on ‘weekly wound rounds’”. IP stated, “we missed it and should have taken steps earlier to address [R254’s] wound to his heels.” IP reviewed R254’s hospital DC summary dated 10/3/24, and stated, “it shows there was identified DTI’s to both heels at the time. We [Facility] did not identify any concerns until 11/12/24”. IP stated R254’s bilateral heel wounds, “should have been addressed by us before 10/2/24 [when R254] was admitted to the hospital”. IP stated wound care rounds involve IP “putting names on paper for people who I look at for wound rounds and then do the rounds with the provider” and document in the EMR. IP stated the Braden documentation was used by the facility to determine pressure injury risk. During interview with hospice vice president of	F0686		

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F0686 SS = G	Continued from page 59 clinical operations (VP)-M on 7/2/24 at 11:23 a.m., VP-M reviewed R254's admission paperwork to hospice services on 11/19/24 and stated R254 had "two wounds on admission. Stage three right and left heel pressure ulcers." During interview with IP on 7/2/25 at 11:44 a.m., IP stated expectation of the nurse at facility to perform a skin integrity assessment every time a patient came back from hospital and write a PN in the EMR. IP reviewed R254's EMR and stated it failed to show a skin assessment was done and PN failed to identify any issues with skin integrity when R254 returned to the facility on 10/3/24. During interview with regional director (RD), administrator, and DON on 7/2/25 at 12:11 p.m., RD stated R254 "could have gotten it [DTI's] from the hospital or transport". Also, RD stated, "[facility] identified our documentation was not up to par" and that R254 "had a history of refusing care" despite no interventions to address any refusals. During interview and review of IP Wound Rounds notes (WRN) dated 7/1/24 to 9/17/24, and 12/3/24 to 1/3/25, with IP on 7/2/25 at 11:44 a.m., IP stated he was unable to find the WRN's for dates between 9/17/24 to 12/3/24. WRN for 8/20/24 identified a listing titled "Pressure Ulcer" with three resident names including R254 and no other information. IP reviewed his notes and EMR and was unable to determine rationale for listing R254 with PU on 8/20/24. WRN for 8/27/24 identified R254 being seen for "Rash-Ointment to be ordered." WRN dated 12/3/24, 12/6/24, 12/17/24, 12/20/24, 12/27/24, 1/3/25 identified R254 as being seen. During interview with hospice team leader (H)-TL on 7/7/25 at 9:48 a.m., H-TL identified R254's hospice nurse manager no longer works for facility and reviewed R254's hospice admission paperwork. H-TL stated R254 had two stage three PU's to his heels on admission to hospice services on 11/19/24 and stated, "facilities can just 'let them go' and not do a good job of preventing or lessening the progression of pressure ulcers" in residents who are on hospice. HT-L confirmed R254 passed away at the facility on 1/9/25. Facility policy titled Prevention of Pressure Injuries, revised April 2020 identified "Inspect the skin on a daily basis" and "Inspect pressure pointes (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.)". Facility policy titled Pressure Injury Risk Assessment, revised March 2020 identified purpose "to	F0686		

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F0686 SS = G	Continued from page 60 provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs)".	F0686		
F0688 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 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: Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 resident (R23) reviewed for limited range of motion (ROM). Findings include: R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). The MDS indicated R23 was not on a restorative nursing program during the look-back period (LBP).	F0688	It is the policy of The Terrace at Crystal to ensure that residents with limited range of motion (ROM) receive appropriate services and interventions to maintain or improve functional abilities and prevent further decline or the development of contractures. R23 care plan was reviewed and revised to include an individualized range of motion goals and appropriate interventions. Physical therapy was consulted to reassess the resident's needs and provide updated recommendations for ROM exercises and supportive positioning. All current residents with limited ROM or contracture risks were reviewed by therapy and nursing to ensure ROM interventions are in place. Facility policy, "Range of Motion Exercises policy" was reviewed and revised as necessary. Nursing staff, therapy staff, and CNAs received targeted education on recognizing residents at risk for ROM decline or contractures, performing and documenting passive and active ROM exercises and ensuring care plans are individualized. The Rehab Manager or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on residents identified with ROM needs to ensure care plans are up to date and interventions are implemented as recommended. Findings will be reviewed during the monthly QAPI meetings and corrective actions will be taken as needed. The Rehab Director and DON are responsible for ongoing compliance and ensuring that all residents receive services to prevent the decline of ROM or development of contractures.	08/26/2025

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F0688 SS = D	Continued from page 61 R23's care plan printed 6/30/25, indicated R23 required extensive assistance of two staff to turn and reposition in bed, extensive assistance of one staff to transfer between surfaces, encourage resident to participate to the fullest extent possible with each interaction, and physical and occupational therapy to evaluate and treat as per provider orders. A functional maintenance program directed nursing to assist patient with applying AFO (ankle-foot orthosis) foot brace to right foot and then ambulate 100 feet with CGA (contact guard assist) and quad cane (walking aid with a base which has four legs or prongs). The care plan identified R23 refused to walk and refused to wear the AFO brace with date of 1/4/25. R23's ROM and Mobility assessment dated 5/6/25, indicated had an impairment on onside of both upper and lower extremity and was not steady and only able to stabilize with staff assistance to move from a seated to standing position. The assessment indicated walking, moving on and off a toilet seat, and surface-to-surface transfer did not occur. R23 used a wheelchair. The assessment indicated direct care staff believed R23 was capable of increased independence in at least some ADLs and did not include interventions/exercises to ensure R23 maintained his ROM if needed. R23's physician order dated 11/16/21, included nurse to ensure resident wore AFO brace to his right foot when out of bed every shift with start date of 11/16/21. R23's Treatment Administration Record (TAR) dated June 2025, directed nurses to ensure R23 was wearing his AFO brace to right foot when out of bed every shift. All three shifts were marked as completed every day except for three morning shifts. R23's progress notes dated 12/13/25 to 7/1/25, indicated one refusal to wear AFO brace. R23's medical record did not indicate interventions/exercises for R23's right upper extremity. During observation and interview on 6/29/25 at 9:14 a.m., R23's right arm was in a sling and right-hand fingers were curled towards his palm. R23's right foot was on the wheelchair pedal and left foot was on the ground. R23 did not have a leg brace on. R23 stated staff did not complete exercises with him. During observation on 7/1/25 at 7:42 a.m., R23 was dressed and in his wheelchair. R23 had a sling on and no brace on his legs.	F0688		

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F0688 SS = D	Continued from page 62 During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his room in his wheelchair. R23 stated yes when asked if staff completed exercises with him today. R23 did not have a brace on his legs. When asked about the leg brace, R23 used his left foot to propel in his wheelchair to his closet and opened the closet. A leg brace was not found in his closet. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated they were unaware of any boot or brace for R23. NA-K stated he used to have a brace for his leg and was unsure if nursing stopped the brace. NA-K stated they completed range of motion with R23 but did not document the range of motion they completed. NA-K stated approximately four days ago they opened R23's right hand to clean it. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R23's care sheet, which indicated R23 did not walk and "AFO [right] foot when out of bed which is refused by resident". LPN-A stated staff should notify them if R23 refused the AFO brace, so LPN-A could write a progress note and let the provider or therapy know if needed. LPN-A observed R23's right hand and stated nursing could recommend therapy for R23. During interview on 7/1/25 at 12:30 p.m., NA-J stated R23's hand condition was unchanged since previous and had never seen a brace for his legs. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapy had not been recently involved with R23's right upper extremity or AFO brace. DOR expected to be notified of a change in AFO brace, and occupational therapy addressed concerns with residents' hand mobility. DOR stated R23 had MA (medical assistance) pending for insurance coverage, and the business office was involved with setting R23 up with a guardian since R23 was nonverbal. DOR reviewed R23's therapy file which included: -R23's Functional Maintenance/Restorative Nursing Program form undated (copy provided had bottom part cut off), indicated treatment recommendations to assist R23 with right foot AFO brace and walk patient 100 feet using a quad cane daily and six days per week. The goal of the recommendation was to reduce effects of debility, prevent deconditioning, and reduce risk of fall. -R23's Rehabilitation Screen dated 1/17/22, indicated R23 needed short distance ambulation with right AFO	F0688		

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F0688 SS = D	Continued from page 63 boot to reduce nursing dependency. -A physician order dated 8/24/22, directed physical therapy to evaluate and/or treat for strengthening with ambulation. -A physician order dated 1/14/24, indicated for a right AFO brace and a face-to-face for power wheelchair. -A physician order dated 1/22/24, directed physical therapy and/or occupational therapy to evaluate and treat R23 related to nerve pain and weakness in upper and lower right side. The order indicated R23 felt his upper and lower right side had a change from his baseline. No further information was provided. During interview on 7/2/25 at 10:38 a.m., LPN-E stated R23's AFO brace was important for R23's foot to help with support since R23 had a stroke. LPN-E stated the AFO brace was not in R23's room anymore, so staff were checking with therapy. LPN-E stated they were unsure how long R23's right-hand fingers had been curled and expected staff to notify nursing and therapy. During observation and interview on 7/1/25 at 11:38 a.m., LPN-A was slowly able to open R23's right-hand fingers and observe R23's palm. No skin breakdown was noted. LPN-A stated therapy should work with R23 to improve his finger mobility. During interview on 7/2/25 at 1:58 p.m., the director of nursing stated limited hand range of motion should be addressed by therapy and nursing should update the care plan and orders as indicated. The DON expected staff to follow-up immediately if a brace was found to be unavailable. The DON expected staff to prevent contractures. The facility Range of Motion Exercises policy dated October 2010, directed staff to verify if there was a physician's order for the exercise to perform and contact the provider to obtain treatment orders if there were no orders for the exercise. The policy directed staff to document the date and time the exercise was performed, the name and title of who performed the procedure, type of ROM exercise, whether the exercise was active or passive, how long the exercise was conducted, any problems or complaints made by the resident during the exercise, and reason why and intervention taken if the resident refused the treatment.	F0688		
F0689	Free of Accident Hazards/Supervision/Devices	F0689	It is the policy of The Terrace at Crystal to ensure	08/26/2025

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F0689 SS = D	Continued from page 64 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: Based on interview and document review, the facility failed to comprehensively assess and develop interventions as needed to reduce the risk of accidents or injury for 2 of 2 residents (R41, R38) reviewed with a history of substance abuse and suspected current use. In addition, the facility failed to implement interventions for 1 of 1 resident (R35) reviewed for falls. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's diagnoses list, dated 7/13/24, indicated R41 had several medical diagnoses including psychoactive substance dependence. R41's Associated Clinic of Psychology (ACP), dated 5/20/25, indicated facility staff informed the ACP practitioner of concerns of suspected substance use, which was also listed as a barrier to care on the ACP visit note. R41's electronic medical record (EMR) lacked any documented interventions, assessments, or monitoring protocols related to suspected substance use. Furthermore, there were no care plan elements or guidance in place outlining staff responsibilities or actions to take if substance use was suspected. The absence of such documentation and intervention planning presents a potential risk to R41's health and safety,	F0689	Continued from page 64 that all residents are provided with adequate supervision and assistive devices to prevent accidents, including those related to substance use and fall risk. R41 and R38 were reassessed on substance use history, current behavioral indicators, and risk factors related to unsafe behaviors. Care plans were updated. Social services contacted providers to coordinate substance abuse evaluations and mental health services, where applicable. R35, the care plan was reviewed and revised to reflect recent fall incidents. Room was searched and re-arranged for optimal safety. All residents with a history of substance abuse or falls care plans were reviewed to ensure appropriate accident prevention strategies were in place. Licensed nurses, CNAs, and social services staff received targeted education on identifying and documenting risks associated with substance use, implementing individualized safety interventions for residents with behavioral or fall risks and coordinating with interdisciplinary team members to ensure proper supervision and behavioral support The DON or will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on residents with substance use history or fall risk. Results will be reviewed during monthly QAPI meetings to identify trends and implement further corrective actions as needed. The Director of Nursing is responsible for ongoing compliance and ensuring that all residents are provided with safe environments and effective supervision.	

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F0689 SS = D	Continued from page 65 as well as to the safety and well-being of other residents and staff in the facility. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she had not seen R41 using drugs but had suspected it on more than one occasion. TMA-B stated when she suspected R41 of substance use, R41 would be doubled over in her chair with glassy eyes, pinpoint pupils and slurred speech. TMA-B stated, "you can tell she is on something" confirming she has reported the concern to the nurse manager more than once but "nothing is getting done." TMA-B stated something needed to be done because "anything could happen". During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and licensed practical nurse (LPN)-E stated she was aware R41 had a history of substance use and stated staff have reported smelling "burning" coming from R41's room at times. LPN-E confirmed there was no care planned interventions for suspected substance abuse, but should be, stating it would be expected that staff check on R41 every 15 minutes if they suspected she was using substances. R38's significant change Minimum Data Set (MDS) dated 6/23/25, indicated R38 had intact cognition with no delusions, hallucinations, or rejection of care behaviors. The MDS indicated R38 was independent with chair/bed-to-chair transfers and could wheel 150 feet in a wheelchair independently. The MDS indicated R38 was diagnosed with heart failure, kidney disease, diabetes, anxiety, and depression. R38's hospital note dated 1/4/25, indicated R38 was brought to the emergency department due to "abnormal movements". The note indicated R38 had reported to hospital staff that he had "smoked crack cocaine" two days prior. R38's care plan dated 1/6/25, included a care plan titled "substance use disorder" and indicated R38 had tardive dyskinesia (involuntary muscle movements) related to "cocaine" use, with the sole intervention being that the resident will be offered chemical use counseling as appropriate. During an interview on 7/1/25 at 9:50 a.m., R38 stated he had used methamphetamine (meth) once, but he didn't like it so did not plan to use it again. R38 stated he had smoked crack cocaine in the past but could not	F0689		

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F0689 SS = D	Continued from page 66 recall the last time this had occurred and claimed he had never smoked crack while residing at the facility. R38 stated he was trying to get himself "completely healthy" so he wasn't using anymore and only gets "98 bucks" a month, so he couldn't buy crack now even if he wanted to. R38 confirmed he had been offered chemical use counseling, but did not want the services. During an interview on 6/29/25 at 8:58 a.m., R153 stated R38 "does crack" at night. R153 stated he hears the "click, click, click, of the lighter" but has not seen R153 use crack cocaine. R153 stated he hadn't told staff about it, but "they should know". On 6/30/25 at 1:33 p.m., R153 stated that in the last week, R38 had asked him for money to buy "crack". R153 stated R38 would barricade the door with a dresser when he was "smoking crack," and R38 told him he would hurt him if he put his call light on while he was smoking. R38 stated the last time this happened was on either Friday (6/27/25) or Saturday (6/28/25) night. During an interview on 6/29/25 at 12:55 p.m., licensed practical nurse (LPN)-B confirmed she was the nurse in charge of R38's care this shift. LPN-B stated that facility staff had suspected that R38 was using illicit drugs, but she had never observed signs or symptoms of this herself. When asked what monitoring was in place regarding R38's suspected illicit substance use, LPN-B stated they "probably should" but did not currently have any monitoring in place or a plan for if illicit substance use was suspected. During an interview on 6/30/25 at 1:57 p.m. with the administrator and director of nursing (DON), the administrator stated they had not been notified of any allegations of R153's using crack cocaine, and the DON confirmed she had also not been aware of these allegations and had not seen any symptoms of intoxication or been notified of anyone finding any drug paraphernalia, and was unsure if further assessments had been completed regarding R38's illicit substance use. During an interview on 7/2/25 at 10:01 a.m., the DON stated if a resident had a known history of illicit substance use, she would expect this to be care planned and assessed for, as well as implementing monitoring for signs or symptoms of substance abuse as well as collaborating with the provider for any additional orders if needed. The DON stated this monitoring would be outlined in either the care plan or orders. R38's medical record was reviewed, and it did not indicate that monitoring for illicit substance use was in place or that a comprehensive assessment of R38's substance	F0689		

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F0689 SS = D	Continued from page 67 abuse disorder had been completed. The facility's Substance Abuse Policy dated 6/29/25, indicated if a resident had a substance abuse disorder or displayed the potential for a substance abuse disorder, the facility would assess the residents to determine substance abuse disorder "triggers", therapies/support available, and the resident's willingness to participate in substance use disorder services. The policy indicated that facility staff would assess for substance abuse disorders and triggers upon admission, readmission, and quarterly. The policy indicated that, based on assessment outcomes, an individual care plan would be developed and provide approaches for reducing triggers for substance use. The policy indicated it was "essential" to monitor if a resident who was suspected of illegal drug use was a danger to themselves, others, and /or staff. R35 Falls R35's annual assessment dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of osteoporosis, asthma, Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required staff assistance with most activities of daily living. R35's care plan printed 6/29/25, indicated R35 was independent to turn and reposition in bed and transferred with staff supervision. R35 was at risk for fall related to Alzheimer's disease and safety awareness. The care plan indicated R35's last fall was 5/20/24. The care plan's fall interventions included: -Anticipate and meet the resident's needs dated 1/29/24. -Be sure call light within reach and encourage resident to use it for assistance as needed dated 5/16/24. -Physical therapy to evaluate dated 5/20/24. -Physical therapy to evaluate and treat as ordered or PRN (as needed) dated 10/16/24. -Obtain order for physical therapy to evaluate and treat for 12/16/24 fall dated 12/18/24. -Keep walker next to bed for fall on 12/1/24 dated 1/28/25. R35's Resident Fall Risk assessment dated 6/25/25, indicated R35 was at "high risk" for falls related to	F0689		

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F0689 SS = D	Continued from page 68 intermittent confusion, history of one to two fall in the past three months, ambulatory and incontinent, took one or two of the medications indicated in the assessment currently and/or within the last seven days, and had one or two of the indicated predisposing diseases. R35's progress notes indicated: -On 6/13/25 at 6:30 p.m., R35 was found on the floor next to the nursing station. R35 had her shoes on and stated she tried to stand up and twisted her leg and sat on the floor. R35's vital signs were noted, and R35 stated she did not have pain. R35 was able to move her upper and lower extremities without pain. R35 was helped to wheelchair with Hoyer lift and two nursing assistants. Family member (FM)-R, nurse manager, and provider were called. Neurological checks were started. -On 6/16/25 at 9:52 a.m., an interdisciplinary note indicated R35 was demented and forgot good body mechanics during movements. Physical therapy was requested to strengthen her mobility. R35's Un-witnessed Fall risk management assessment dated 6/13/25, indicated an incident description and immediate action taken which repeated information from the progress note dated 6/13/25. The assessment indicated no predisposing environmental factors, physiological factors including confusion and fear of falling, and situational factors of ambulating without assistance and using a walker. R35's electronic health record did not indicate therapy involvement after her fall. During interview on 06/29/25 at 10:56 a.m., FM-R stated R35 fell about a couple weeks ago, and R35 had no pain and did not need to be sent to the hospital. FM-R stated they did not know about any new intervention the facility implemented, and the facility continued with the current fall interventions. During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated staff stayed with residents who they found on the floor and called the nurse. NA-A stated the nurse assessed the resident and determined if 911 needed to be called or if staff could move residents using a Hoyer lift. NA-A stated fall interventions were noted in residents care plans and staff read the care plans every day. NA-A stated R35 was "not really" a fall risk but always made sure R35 had her walker and reminded R35 to lift her feet.	F0689		

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F0689 SS = D	Continued from page 69 During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses were called when a resident had an unwitnessed or witnessed fall. RN-A stated nurses took residents' vital signs, performed neurological checks, checked for injuries and range of motion. Nurses determined if the resident was safe to move or if 911 was needed. RN-A stated nurses notified the family, manager, and provider. A risk management assessment was completed of each fall to describe the situation and what interventions were implemented. RN-A stated R35 was a fall risk and stayed close to staff for monitoring. RN-A stated fall interventions prevented R35 from future falls. RN-A stated nurses obtained therapy orders if therapy was a fall intervention, so therapy could work on strengthening with residents. RN-A thought R35 was being seen by therapy. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapies most recent encounter with R35 was in September of 2024 for speech therapy. DOR stated she was at a meeting where therapy was discussed after her last fall but did not see any orders come through to start therapy with R35. DOR stated therapy orders from the provider came through nursing or the health unit coordinator and they usually received a therapy order within a couple days after discussed, and indicated R35's fall risk management was signed on 6/17/25. During interview on 7/2/25 at 11:38 a.m., licensed practical nurse (LPN)-B reviewed R35's risk management assessment related to R35's fall on 6/13/25. LPN-B stated an immediate intervention should have been implemented and verified R35 had no current therapy orders. LPN-B stated nurses were able to obtain therapy orders within 24 hours unless the order was needed over the weekend. LPN-B stated fall interventions were important to prevent falls, and physical therapy would help strengthen R35. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to implement immediate fall interventions, review and discuss falls, and update the care plan. The DON stated staff were able to get therapy orders timely to give to the therapy department. The DON stated implementation of fall interventions were important to prevent residents from repeated falls. The facility Falls - Clinical Protocol dated November 2022, directed the staff and physician to assess residents at risk for falls and residents who have fallen to identify pertinent interventions to try to	F0689		

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F0689 SS = D	Continued from page 70 prevent subsequent falls and to address the risks of clinically significant consequences of falling. The facility Falls and Fall Risk, Managing policy dated November 2022, directed staff to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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: Based on observation, interview and document review the facility failed to recognize and respond to a resident's weight gain in the facility to ensure they maintained acceptable parameters of nutritional status, such as desirable body weight, for 1 of 2 residents (R31) reviewed for nutritional status who gained 35% of their weight since admittance to the care facility. Findings include: R31's annual Minimal Data Set (MDS), dated 4/26/25, R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood	F0692	It is the policy of The Terrace at Crystal to ensure that residents maintain acceptable parameters of nutritional status, including body weight, through comprehensive assessments, interdisciplinary care planning, and appropriate clinical response. R31's nutritional history, clinical status, weight trends, and dietary orders were reviewed. The care plan was updated to reflect goals. Dietary services revised the resident's meal plan, and the physician was notified to evaluate for potential contributing factors. All residents who experienced a significant weight change (gain or loss) of 5% in one month, 7.5% in three months, or 10% in six months were reviewed and care plans updated to address weight change. Registered Dietitian and nursing staff received education on recognizing and reporting clinically significant weight changes, ensuring prompt interdisciplinary communication and clinical response and documenting weight trends, assessments, and nutrition-related interventions in the EHR. The Dietary Manager and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on resident weights. These findings will be reviewed during QAPI meetings to identify opportunities for system-wide improvements in nutritional care and monitoring practices. The Director of Nursing is responsible for ensuring ongoing compliance with F-692 and maintaining a system of early detection and intervention to promote resident nutritional well-being.	08/26/2025

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F0692 SS = D	Continued from page 71 pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes. R31's weights, listed in the electronic medical record (EMR), indicated R31 weight 165 pounds at admission to the care center and most recent weight was listed as 231 pounds, 66 pounds and a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet. R31's most recent Nutrition Data, dated 4/26/25, indicated R31's weight was "up 62.8 pounds over 6 [six] months" but lacked any interventions to address R31's significant weight gain indicating "RD [registered dietician] to follow PRN [as needed]" R31's EMR lacked any follow up from dietary or nutrition services regarding R31's weight gain. During an interview an on 6/29/25 at 10:35 a.m., R31 voiced concerns about the food quality she had been receiving at the care facility, stating it was not an appropriate diabetic diet and she had gained at least 35 pounds since being there. R31 voiced frustration at working hard to lose 60 pounds before coming to the care facility and had not had a dietician reach out about her weight gain or concerns about the food she had been receiving. During an interview on 7/1/25 at 1:02 p.m., the dietary manager (DM) stated she was aware of R31's concerns regarding the food but that R31 had chosen to exercise their "resident rights to eat what [they] want" confirming she had not spoken with R31 about their weight gain but will plan to now. During an interview on 7/2/25 at 8:57 a.m., third-floor manager and licensed practical nurse (LPN)-E confirmed she had heard complaints from R31 about the terrible food, and after review of R31's EMR, confirmed R31 had gained 66 pounds since admission. LPN-E stated the dietician was usually on top of nutritional status and should have recognized R31's significant weight gain and followed up with R31. A facility policy titled Weight Assessment and Intervention, revised 2/2022, indicated "undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes: a. the resident's target weight range (including rationale if different from ideal body weight);	F0692		

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F0692 SS = D	Continued from page 72 b. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake; c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated."	F0692		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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: Based on observation, interview and document review the facility failed to ensure a resident's pain was adequately controlled and failed to implement non-pharmacological pain interventions (i.e. heat, ice, massage, aromatherapy) if needed for adequate pain control for 1 of 2 residents (R41) reviewed for pain. Findings include: R41's quarterly Minimum Data Set (MDS), dated 5/29/25, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. The MDS lacked a pain assessment. R41's diagnoses, dated 7/3/24 indicated in R41 had several medical diagnoses including person injured in unspecified motor-vehicle accident, traffic, subsequent encounter; intervertebral disc degeneration lumbosacral region with discogenic back pain and lower extremity pain; and dorsalgia (back pain). R41's electronic medical record (EMR) contained several orders for medication and monitoring that included; oxycodone oral capsule 5 milligrams (mg) - Give 5 mg by mouth every four hours as needed for breakthrough knee pain - Max 2 doses per day, dated 6/11/25, Gabapentin	F0697	It is the policy of The Terrace at Crystal to ensure residents receive appropriate and effective pain management, including pharmacological and non-pharmacological interventions, to support comfort and quality of life. R41's pain history, pain assessments, and treatment plan were reviewed and revised in the care plan. The resident's physician was notified, and medication orders were adjusted to better manage the resident's reported pain. A full audit of residents with active pain care plans will be completed to verify that all residents have individualized, up-to-date pain interventions including both pharmacologic and non-pharmacologic methods documented and implemented as appropriate. Nursing and direct care staff received education on recognizing signs and symptoms of pain, timely documentation and reporting of pain episodes, utilizing available non-pharmacologic interventions and updating the care plan. The Director of Nursing and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months reviewing documentation for residents with pain-related diagnoses to ensure that pain assessments are completed, and interventions are individualized. Audit findings will be reviewed in the facility's QAPI meetings to evaluate effectiveness and make additional process improvements. The Director of Nursing is responsible for ensuring that pain management protocols remain compliant with regulatory expectations and that staff are trained and supported in delivering compassionate, comprehensive pain care.	08/26/2025

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F0697 SS = D	Continued from page 73 Oral Capsule - Give 300 mg by mouth two times a day for pain, dated 11/25/24, and pain monitoring every shift. R41's EMR lacked any documented evidence of pain monitoring every shift. The EMR further lacked any documented evidence of staff offering R41 non-pharmacological interventions for pain including what, if any was offered, accepted or effective to help alleviate R41's pain. R41's Pain Assessment, dated 6/23/25, indicated R41 had moderate pain over the past five days however, the section for non-medication interventions for pain was left blank. R41's Associated Clinic of Psychology note, dated 4/23/25, indicated R41 let the clinician know she was "struggling with pain" with the clinician encouraging R41 to "talk with her doctor abut pain to help mitigate." R41's care plan, dated 1/5/25, indicated R41 was at risk for pain related to previous lower extremities fractures second to motor vehicle accident. The care plan contained the following interventions, dated 7/8/24, anticipate R41's need for pain relief and respond immediately to any complaint of pain, pillows under legs when in bed, and pain meds as ordered. During observation and interview on 6/29/25 at 3:10 p.m., R41 was in visible pain and started to cry stating she struggled with pain before her car accident, in which she broke both her legs and an arm, which has exacerbated her pain, stating somedays the slightest movement is "excruciating". R41 stated she can receive 5mg of oxycodone twice a day and tells staff it is not working to control her pain but staff "look right through" her. R41 further stated she cannot sleep because of her pain and choses to sleep in her wheelchair because it is more comfortable than sleeping in bed. During an interview on 7/1/25 at 9;36 a.m., trained medication aide (TMA)-B stated she had been working at the facility for approximately two years. TMA-B stated the nursing staff ask R41's pain level when they administer her as needed oxycodone but not routinely. TMA-B also stated she had not seen any	F0697		

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F0697 SS = D	Continued from page 74 non-pharmacological pain interventions being used, stating nursing staff “just throw narcs [narcotics] at them [residents].” During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated R41 was working with the “pain doctor” for her pain but that the facility did not attempt to use non-pharmacological interventions for pain. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated she had “just recently” started putting non-pharmacological pain interventions on the treatment administration records for residents who had pain. LPN-E confirmed R41 did have pain but did not currently have staff monitoring her pain every shift and was not receiving any non-pharmacological pain interventions. A facility policy titled Pain Assessment and Management, revised 3/2020, indicated "non-pharmacological interventions maybe appropriate alone or in conjunction with medications" and include environmental (i.e. room temperature), physical (i.e. ice or heat), and cognitive or behavioral interventions (i.e. relaxation, music).	F0697		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to identify triggers or attempt to identify triggers to avoid potential re-traumatization, and failed to develop a care plan to include individualized trauma-informed approaches for 1 of 1 residents (R36) who had a history of trauma. Findings include:	F0699	The Terrace at Crystal is committed to providing trauma-informed care that recognizes and responds to residents’ past experiences and promotes a sense of safety, autonomy, and dignity. R36’s psychosocial history was reviewed and updated the care plan to include individualized, trauma-informed interventions. A full review of current residents with documented or suspected trauma histories will be conducted to ensure care plans reflect individualized trauma-informed practices. All nursing, social services, and direct care staff received education on the principles of trauma-informed care and the regulations The Social Services Director and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on individualized trauma-informed care plans are developed when indicated.	08/26/2025

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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
F0699 SS = D	Continued from page 75 R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). R36's diagnosis report, printed 7/2/25, included the following pertinent medical diagnoses: post-traumatic stress disorder, alcohol dependence, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, unspecified affective mood disorder, and chronic pain. During an interview on 6/29/25 at 10:40 a.m., R36 stated she had PTSD and had known triggers. R36 stated no staff at the facility had ever talked to her about her triggers or her trauma. R36 stated her triggers included when the staff started getting loud outside the room, when the staff came in and poked her to wake her up, and when staff came in and talked loudly to her. R36 stated again that no staff had ever talked to her about this before or asked her if there aware certain things that triggered her, and stated she would be willing to talk to staff about triggers. R36's care plan, printed 7/2/25, indicated resident reports a history of trauma related to experiencing an abusive husband/relationship and vulnerability of not being able to take care of herself. Interventions included to assist resident with identifying her personal strengths, observe resident for isolation and seclusion, and provide comfort and reassurance for resident. The care plan lacked identification of any triggers, or plan to help identify any triggers to help better care for resident. R36's Social Service Primary Care PTSD Screen, dated 2/21/24, indicated R36 was asked four questions on the PTSD screening and responded "yes" to all four questions, indicating they have had nightmares about it/thought about when they didn't want to, went out of their way to avoid situations that remind them of it, were constantly on guard, watchful or easily startled, and felt numb or detached from others, activities or surroundings. R36's Social Service Trauma Informed Care History, dated 2/21/24, identified the following information. R36 was able to identify the most difficult time in their life and indicated they had been through a life threatening or traumatic event. The following questions had "unknown" as a response: what helped get you	F0699	Continued from page 75 Findings will be reviewed monthly in the facility's QAPI meetings to assess effectiveness and guide further training or procedural adjustments. The Social Worker and Director of Nursing are responsible for ensuring ongoing compliance.	

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F0699 SS = D	Continued from page 76 through those difficult times, and what are some things that you do now to help you manage consequences of have gone through tough times. When asked about triggers, the answer typed in the box was "none." The electronic medical record (EMR) lacked follow-up assessments when R36 was readmitted to the facility, during quarterly, or annual assessment to help identify triggers. R36's care guide, printed 6/30/25, was reviewed and lacked evidence of any triggers or identification of possible triggers. During an interview on 6/30/25 at 5:16 p.m., nursing assistant (NA)-F stated they were familiar with R36. NA-F stated R36 did not have any mental health concerns, PTSD, or triggers, adding "nothing like that." During an interview on 7/1/25 at 9:41 a.m., trained medication aid (TMA)-A stated if a resident had a history of PTSD and had triggers it would be important to know what their triggers were to better care for them. TMA-A stated their triggers would be on the care sheets if a resident had PTSD. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and worked with her often. LPN-A stated she was unsure if R36 had PTSD, proceeded to verify she did on the diagnosis list, and stated R36 did not have any triggers. LPN-A stated that if R36 had any triggers, they would document that in a progress note. During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated she believed R36 had a diagnosis of PTSD, verified the diagnosis on R36's diagnosis list, and stated she was not aware of any triggers for R36. LPN-E stated she would think if she had any triggers, it would be on her care plan. LPN-E reviewed her care plan and stated there were no identified triggers on her care plan. LPN-E stated there was a section on the care plan for trauma informed care, but verified it did not identify triggers or plan to identify triggers to help better care for R36. LPN-E did not answer when asked about who assessed residents for triggers from PTSD. On 7/2/25 at 11:37 a.m., director of nursing (DON) stated if a resident had PTSD they needed to be assessed for triggers, and those triggers would be documented on the care plan to help better care for the resident. DON stated assessments for triggers were done	F0699		

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F0699 SS = D	Continued from page 77 upon admission, quarterly, annually, and as needed, and stated these assessments would help identify any triggers, and behaviors would also be monitored. A facility policy titled Trauma Informed Care, revised 3/19, identified "nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization."	F0699		
F0755 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 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). 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: Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in	F0755	The Terrace at Crystal remains committed to providing timely, resident-centered pharmaceutical services that support the highest level of care and safety. R10, the physician-ordered FORM medication was re-ordered and administered without adverse effects. The resident's current medication profile was reviewed to ensure all active orders are aligned with physician intent and administered as scheduled. All residents will be reviewed to confirm that physician-ordered medications were in stock and appropriately re-ordered within required timelines. All licensed nursing staff received education on procedures for monitoring medication reorder alerts and refill notifications, communication protocols with the pharmacy provider and timely follow up The facility's contracted pharmacy provider will also be contacted to review and enhance communication workflows related to medication refill alerts and early warnings for low stock or expired orders. The DON or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months on medication orders, focusing on timeliness of refills and compliance with reorder protocols. Director of Nursing is responsible for ensuring timely medication management systems are fully operational and continually reviewed for quality and safety.	08/26/2025

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F0755 SS = D	Continued from page 78 administration and reduce the risk of complications for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25, and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25, and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given 6/1/25, through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25, and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered.	F0755		

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F0755 SS = D	Continued from page 79 -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone. -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress note dated 6/20/25 at 4:19 p.m.,	F0755		

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F0755 SS = D	Continued from page 80 indicated R10's provider had been contacted to request a new prescription for her 2.5 mg order of oxycodone. R10's progress note dated 6/30/25 at 9:56 a.m., indicated a call was placed to the provider to get a new prescription for her oxycodone. R10's progress note dated 6/30/25 at 11:58 a.m., indicated that a voicemail was received from the provider indicating a new prescription [did not indicate what medication] was sent to the pharmacy. R10's progress notes were reviewed dated 6/1/25 through 6/30/25, and did not indicate any further requests for oxycodone were made. R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain documented. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still didn't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated she had trouble getting a new	F0755		

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F0755 SS = D	Continued from page 81 prescription from the provider, and when she did, sometime last week, she thought the pharmacy had not accepted it due to the way the dosage was written. LPN-E stated nursing staff had used oxycodone from the emergency supply until the facility ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E confirmed she had reviewed R10's medical record and the first time she saw that a new prescription for the oxycodone had been requested from the provider was on 6/20/25, although the medication ran out on 6/19/25, and she did not see that the medication was requested from the pharmacy until 6/27/25. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would have missed fewer doses of the medication or not missed any doses at all. During an interview on 7/1/25 at 12:38 p.m., the dispensing pharmacist (DP) stated she had reviewed their records for R10 and did not see any requests for oxycodone to be dispensed until 6/28/25, including the week before 6/19/25. The DP stated they had sent a new card of medication yesterday (6/30/25), but she would have expected a request from the facility before the medication was needed as it took time to prepare the medication. During an interview on 7/2/25 at 10:00 a.m., the director of nursing (DON) stated she expected nursing staff to reorder the medication from the pharmacy when the medication card only has the far-right column left in the package, or about 8 doses. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available.			
F0757	Drug Regimen is Free from Unnecessary Drugs	F0757	The Terrace at Crystal remains committed to ensuring	08/26/2025

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F0757 SS = D	Continued from page 82 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident was free from unnecessary medication by failing to attempt to decrease a resident's nicotine patch (a known psychotropic medication) despite the consulting pharmacist's and Centers for Disease Control and Prevention's recommendations for 1 of 5 residents (R7), and failed to monitor, assess, and clarify an antibiotic without an end date for 1 of 5 residents (R25) reviewed for unnecessary medications. Findings include: R7's quarterly Minimum Data Set (MDS), dated 4/26/25, indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications.	F0757	Continued from page 82 all residents are free from unnecessary medications by promoting safe, appropriate prescribing practices and thorough medication reviews. R7 nicotine replacement therapy was reassessed. The resident’s care plan was updated to ensure treatment goals align for step-down dosing. A tapering plan was implemented based on clinical appropriateness and resident preferences. R25, the antibiotic order lacking an end date was reviewed, clarified with the prescribing provider, and appropriately updated. The MAR was corrected to reflect the clarified order, including stop dates and monitoring parameters. All current residents with active orders for psychotropic medications and antibiotics were reviewed to verify clinical indication, ongoing need, presence of stop dates, dose review timelines, and supporting documentation, evidence of pharmacist review and provider communication as required Licensed nurses and unit managers received education on proper documentation and monitoring requirements for antibiotics and psychotropic medications, the importance of following pharmacist recommendations and clarifying any orders lacking duration, clinical rationale, or appropriate reassessment intervals The facility revised its protocol to require all new psychotropic and antibiotic orders to be reviewed by the nurse manager within 24 hours to confirm indication, end date (if applicable), and alignment with regulatory expectations. The Director of Nursing (DON) and/or designee will conduct weekly audits 1x per week for 2 months, then monthly for 2 months for the next 30 days to monitor compliance with unnecessary medication reviews. Audit results will be presented during monthly QAPI meetings for trend analysis and ongoing process improvements. Director of Nursing is responsible for ensuring safe and compliant medication practices are in place and maintained.	

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F0757 SS = D	Continued from page 83 R7'S electronic medical record (EMR) contained an order, dated 3/8/24, for a Nicotine Transdermal Patch 24 Hour 21 milligrams (MG) per 24 hours (Nicotine) - Apply one patch transdermal (on the skin) every 24 hours for nicotine dependence in remission. R7's most recent smoking review, dated 5/6/25, indicated that R7 was currently smoking and intended to continue to smoke. R7 was also on the facility provided list of residents who smoke. R7's care plan, dated 5/12/25, indicated R7 was a "current smoker, trying to quit, resident received Nicotine Patch each morning will sometimes refuse it." R7's monthly medication regiment reviews (MRR), dated 2/21/25, 3/24/25, 4/24/25, and 5/23/25 all indicated a pharmacist recommendation to decrease R7's nicotine patch and to discontinue it if resident was still choosing to smoke. The consultant pharmacist (CP)-A gave a rationale of nicotine being a psychotropic medication intended to help a person quit smoking by reducing nicotine dependence and manage withdrawal symptoms. CP-A further indicated the CDC advises nicotine patch doses should be lowered overtime (8-12 weeks) with a goal of stopping use of the nicotine patch completely. On the MRR dated 5/23/24, the provider had checked "agree". A handwritten note on the MRR from LPN-E, dated 5/29/25, indicated "resident [R7] refused to have patch decreased, stated that the patch keeps him from smoking, the he has not smoked in long time. Provider updated." During an interview on 6/30/25 at 5:41 p.m., trained medication aide (TMA)-C stated R7 was currently still smoking. During an interview on 6/30/25 at 5:47 p.m., trained medication aide (TMA)-D stated R7 was currently still smoking. During an interview on 7/1/25 at 8:06 a.m., R7 stated he has not smoked "in a couple of months." During an interview on 7/1/25 at 9:36 a.m., TMA-B stated she had worked at the facility for a few years and stated R7 "smoked heavily" and would still go outside to smoke daily. During an interview on 7/1/25 at 1:46 p.m., CP-A stated she had issued the recommendation to decrease R7's nicotine patch and had received a response in June from her May recommendation that the provider had agreed to	F0757		

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F0757 SS = D	Continued from page 84 decrease the dose but R7 had refused. The CP stated the intent of a nicotine patch was to assist a resident to quit smoking and was safer than smoking however, staff or R7 would not know how effective the patch was in helping R7 quit if it was not reduced, stating ideally it would be nice to reduce the dose, and ideally R7 would not be on the patch forever. CP-A further stated there were alternatives to the nicotine patch that R7 could try such as nicotine gum or lozenges to attempt to decrease R7's nicotine patch. CP-A further stated the patch should be discontinued if R7 was still smoking. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated R7 had told her he was not smoking however R7 was outside a lot, so she was unsure if R7 was still smoking or not. LPN-E stated they had tried to discontinue or reduce R7's nicotine patch but he refused and had been on the patch for a "long time" and "demanded it." LPN-E stated she had sent the provider messages that R7 was still on the nicotine patch but did not know what the provider's response was. A facility policy titled Tapering Medications and Gradual Dose Reduction, revised 4/2007, indicated attempted tapering of psychopharmacological medications shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. R25 R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R2's diagnoses included hypertension, diabetes mellitus, neurogenic bladder, aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received an antibiotic medication. R25's care plan printed 6/29/25, indicated R25 directed staff to administer antibiotic medications as ordered by physician, monitor/document side effects and effectiveness, monitor/document/report as needed adverse reactions to antibiotic therapy, and monitor/document/report as needed signs/symptoms of secondary infection related to antibiotic therapy. R25's care plan indicated R25 had legal blindness from history of traumatic brain injury. The care plan directed staff to arrange consultation with eye care practitioner as required and monitor/document/report as needed any signs/symptoms of acute eye problems.	F0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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F0757 SS = D	Continued from page 85 R25's current physician order, directed staff to give one drop of moxifloxacin hydrochloride (an antibiotic used to treat various bacterial infections) ophthalmic solution 0.5% (percent) in the right eye two times a day for bacterial conjunctivitis (also known as "pink eye"; inflammation or infection of the eyes) with a start date of 6/9/25. The order did not specify an end date. R25's medication and treatment administration record (MAR and TAR), progress notes, and provider, clinic, and hospital notes were reviewed from April 2025 to July 2025 and indicated: -4/20/23, staff were directed to write a progress note per shift on any behaviors, change in condition or any other matters related to R25. -4/11/25 to 6/3/25, staff were directed to assist R25 with a warm compress and gentle eye care to right eye twice a day to remove debris and drainage until resolved. -On 4/13/25 at 11:32 a.m., an order administration note indicated nursing waited for delivery for polymyxin B-Trimethoprim ophthalmic solution (an antibiotic combination used to treat bacterial infections of the eye) to instill one drop in right eye four times a day for conjunctivitis. Progress notes did not describe how the eye looked. At 11:47 a.m., an order administration note indicated the eye drop was administered with no other details about R25's eye. -4/16/25, indicated R25 was sent to the emergency department for concern of cornea injury and was unable to open eyes and had severe pain. -R25's After Visit Summary from Methodist Hospital dated 4/16/25, indicated R25 was seen for acute conjunctivitis of right eye and directed the facility to give moxifloxacin as prescribed. -4/17/25 to 4/18/25, staff were directed to apply one drop of moxifloxacin to right eye every hour while awake for seven days until 4/23/25 for conjunctivitis. -4/19/25 to 4/25/25, staff were directed to apply one drop of moxifloxacin to right eye twice a day for conjunctivitis. -5/2/25, R25 had an appointment at M Health Fairview Ophthalmology.	F0757		

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F0757 SS = D	Continued from page 86 -R25's The Terrace at Crystal – Clinical Referral dated 5/2/25, indicated R25 had a stable ocular exam from a physician. Orders listed included moxifloxacin twice a day and did not indicate an end date. A note with initials dated 5/2/25, indicated orders were already in R25's electronic health record. A second check by a nurse was dated 5/2/25. -5/6/25 to 5/18/25, staff were directed to apply one drop of moxifloxacin to right eye two times a day for central corneal opacity (a condition where the clear front part of the eye becomes cloudy or scarred and causes vision loss and a milky appearance) of the right eye. -On 5/23/25, R25 had an appointment with M Health Fairview Ophthalmology and was in the hospital on 5/23/25. -R25's Discharge Orders and paperwork dated 5/31/25, indicated R25 had bacterial keratitis (inflammation of the cornea, the clear, dome-shaped front surface of the eye) and to continue moxifloxacin. -5/31/25 to 6/2/25, staff were to apply one drop of moxifloxacin to right eye two times a day for central corneal opacity. -6/2/25 to 6/5/25, staff were directed to apply one drop of moxifloxacin to right eye two times a day for bacterial conjunctivitis. -R25's Methodist Hospital Discharge Summary dated 6/9/25, indicated R25 had keratitis of the right eye due to bacteria and exposure keratitis. The discharge summary directed staff to continue previous ophthalmologic medications, which included moxifloxacin to the right eye twice a day for bacterial conjunctivitis. The order did not include an end date. -R25's Twin Cities Physicians' provider note dated 6/26/25, indicated R25 had diagnoses of dry eyes and traumatic blindness, did not list ophthalmology on a list of specialists, and had clear eyes with no drainage. The provider note did not address R25's moxifloxacin. During observation on 6/29/25 at 10:13 a.m., R25 had a clear substance over her right eye. During observation on 6/30/25 at 5 p.m., R25's right eye color had a lighter blue hue and no redness or inflammation to the whites of her eye.	F0757		

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F0757 SS = D	Continued from page 87 During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated R25's eye looked the same and unchanged compared to previous observations, and the nurses placed drops in R25's eye. NA-A stated the nurses, nurse manager, or health unit coordinator followed up on eye appointments. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses transcribed given orders for antibiotics into the resident's electronic health record, checked resident diagnoses and allergies, and sent the order to the pharmacy. RN-A stated antibiotic orders had a frequency and duration. RN-A stated nurses should contact the provider if an end date if not given. RN-A stated they checked the resident temperature until the end of an antibiotic course. RN-A stated R25's eye was "bad" at some point and now improved. RN-A stated the facility had an infection control nurse who reviewed antibiotics and was the best person to ask about any antibiotics. During interview on 7/2/25 at 12:26 p.m., the infection preventionist (IP) stated staff monitored for side effects and effectiveness of antibiotics and looked for if symptoms resolved. The IP nurses monitored antibiotic use and infectious symptoms via progress notes until the antibiotic ended. The IP stated antibiotics should be stopped or discontinued if the provider assessed the resident and saw the resident did not need the antibiotic any longer. The IP stated the moxifloxacin order came from the hospital and would have to look at R25's paperwork to see when R25's next appointment was when asked about the lack of end date for the moxifloxacin. During interview on 7/2/25 at 1:23 p.m., nurse practitioner (NP)-A stated R25 followed an eye doctor who prescribed the moxifloxacin and directed surveyor to talk to nursing about R25's visit with the eye doctor. During interview on 7/2/25 at 1:36 p.m., medical records/health unit coordinator (HUC) stated R25 did not have another appointment scheduled for the ophthalmologist. The HUC searched through R25's medical record and was unsure if R23 went to the appointment on May 23rd, since R23 was in the hospital. The HUC called the clinic and clarified another appointment was only as needed and asked the clinic to fax the facility information from R25's last appointment. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected antibiotic orders to have a stop date or staff to update the provider to ensure if	F0757		

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F0757 SS = D	Continued from page 88 provider wanted the antibiotic continued or stopped. The DON stated residents on antibiotics should be monitored for sign and/or symptoms of infection, side effects, and medication effectiveness. The facility Antibiotic Stewardship – Orders for Antibiotics policy dated December 2016, directed antibiotic orders to include drug name, dose, frequency of administration, duration of treatment with start and stop date or number of days of therapy, route of administration, and indications for use. The policy indicated empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate, and staff and the practitioner would document the specific criteria to support the suspicion in the resident's clinical record. The policy directed the admitting nurse to review discharge and transfer paperwork for current antibiotic orders and to ensure the orders included all drug and dosing elements.	F0757		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors when a narcotic pain medication was not administered as ordered for 1 of 5 (R10) residents reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following	F0760	The Terrace at Crystal is committed to ensuring that all residents are free from significant medication errors and that medications are administered safely, accurately, and as ordered by the prescriber. For Resident #10, whose prescribed narcotic pain medication was not administered as ordered, the medication incident was promptly investigated. The attending physician notified. The MAR was reviewed, and the missed dose was documented appropriately. Audit of all residents receiving narcotic medications will be conducted to ensure that all pain medications were available in the medication cart/supply, that their MARs accurately reflected physician orders, and that the medications were administered and documented appropriately. All licensed nurses will be re-educated on the facility's medication administration policy and procedure, emphasizing the importance of administering medications as ordered, proper documentation and notification for missed or delayed doses, and timely communication with the provider and responsible party in the event of a medication error. The DON or designee will conduct random medication administration audits weekly for 4 weeks, and then monthly for 2 months focusing on residents receiving scheduled narcotic medications. Any discrepancies will be immediately addressed, and findings will be reviewed in clinical stand-up meetings and monthly QAPI.	08/26/2025

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F0760 SS = D	Continued from page 89 orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25 and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25 and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given 6/1/25 through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25 and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered. -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone.	F0760	Continued from page 89 The facility's QAPI committee will monitor for trends and ensure corrective actions are effective in preventing recurrence. Director of Nursing is responsible for ensuring compliance with safe medication practices and prevention of significant medication errors.	

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F0760 SS = D	Continued from page 90 -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain noted. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain.	F0760		

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F0760 SS = D	Continued from page 91 During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still don't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated nursing staff had used oxycodone from the emergency supply until they ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed, when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would have missed fewer doses of the medication or not missed any doses at all. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	The Terrace at Crystal is committed to ensuring medications are safely labeled and stored according to federal and state regulations to prevent errors and promote resident safety. For Resident #3, immediate corrective action was taken. The inhaled medication was returned to its original packaging, and the oral medication was relabeled with appropriate identifiers. The nurse involved received immediate re-education. A facility-wide audit was conducted on all medication carts and storage areas to ensure inhaled medications	08/26/2025

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F0761 SS = D	Continued from page 92 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed inhaled medications were stored in their correct packaging to prevent potential administration error for 1 of 5 residents (R3); and failed to ensure prescribed oral medications were labeled with minimum identifiers to ensure correct administration (i.e., right patient, right medication) for 1 of 5 residents (R3) observed to received medication during the survey. Findings include: INCORRECT STORAGE: R3's Medication Administration Record (MAR), dated 7/2025, identified R3's current physician ordered medications, directions for their use, and staff spaces to record their administration or refusal. The MAR included an order for Mometasone (a steroid medication) 50 micrograms (MCG) with directions to administer 2 sprays in each nostril once daily for a respiratory infection. The MAR listed a start date for this medication as, "06/13/2025," and scheduled administration time of 8:00 a.m. On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3. LPN-B removed various oral medications from the cart while comparing them to R3's MAR which was displayed on a laptop computer on the cart. LPN-B stated R3 had a steroid inhaler (Mometasone) scheduled to be given and then removed a clear bag with a pharmacy label attached which had R3's name listed and read, "Nasal Decong Spr	F0761	Continued from page 92 were stored in their original packaging, oral medications were labeled with at least two resident identifiers, and any unlabeled or improperly stored medications were removed and replaced as necessary. All licensed nurses were re-educated on medication storage and labeling procedures, the importance of accurate labeling to prevent medication errors, and protocols for identifying and resolving discrepancies during routine checks. The Director of Nursing or designee will perform random audits three times weekly for four weeks and then monthly for two months to verify proper labeling and packaging of medications during active med passes. Any variances will result in immediate retraining and documentation of corrective action. The facility’s QAPI committee will review audit outcomes monthly, track trends, and make policy updates or additional training recommendations as needed. Director of Nursing is responsible for ongoing compliance with F-761 medication labeling and storage regulations.	

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F0761 SS = D	Continued from page 93 [spray] 0.05%," which had directions, "2 DROP IN BOTH NOSTRILS EVERY 12 HOURS AS NEEDED FOR CONGESTION." LPN-B continued to search the upper row of the medication cart before finding another clear bag with a pharmacy label attached which had R3's name listed and read, "Mometasone [steroid medication; used for asthma] Spr 50 MCG [micrograms]," with directions listed reading, "INSTILL 2 SPRAYS IN EACH NOSTRIL ONCE DAILY." However, this bag was empty with no medication or inhaler inside. LPN-B reviewed R3's MAR and verified the Mometasone was scheduled to be given; however, the inhaler wasn't in the bag. LPN-B searched the drawer and then reviewed the nasal decongestant bag. LPN-B opened the bag and expressed the Mometasone inhaler had been placed in the wrong bag. The steroid medication was placed in the nasal decongestant bag and not the correct one. LPN-B stated they were unsure how long the medication had been stored like that and, when questioned how medications could end up stored in the wrong pharmacy labeled containers, responded aloud, "Carelessness." LPN-B stated the medications should be stored in their correct pharmacy packaging so "there's no confusion." LPN-B verified trained medication aide (TMA) staff worked on the medication carts within the building, and they reiterated correct storage of the medication was necessary to reduce the risk of residents getting the wrong medications. When interviewed on 7/1/25 at 9:42 a.m., the director of nursing (DON) stated nasal medications typically come in a "little zippy bag" from the pharmacy and should be kept in them. DON stated the correct medication should be kept inside the correct bag from the pharmacy to help ensure "accurate administration" and so staff were "giving what they're supposed to be giving." DON acknowledged medications stored in the wrong bags could lead to a medication error as the two medications (i.e., nasal decongestant / Mometasone) were different medications for different purposes. On 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A was interviewed via telephone, and they explained Mometasone was a "longer acting" medication and meant more for "ongoing therapy" versus a nasal decongestant medication. CP-A stated inhalers typically arrived to the care center in a plastic bag from the pharmacy and were usually kept inside the same bags once in the medication carts. CP-A stated staff should use one inhaler at a time to ensure they're placed back into the correct bags when done. CP-A stated having the correct inhaler stored in the correct bag helped "the double checking" when doing medication administration to ensure the right medication was being given at the right time.	F0761		

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F0761 SS = D	Continued from page 94 A facility provided Medication Storage In The Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements and, " ... Medications are kept in these containers." The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." MEDICATION NOT LABELED: R3's Order Summary Report, signed 5/15/25, identified R3's physician orders along with their administration instructions. This included an order which read, "Nicotine Polacrilex Mouth/Throat Gum ... Give 4 mg [milligrams] by mouth every 1 hours as needed for withdrawal symptoms." The order had a start date recorded, "04/11/2025." On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3 who was seated in their doorway. R3 stated they wanted their nicotine gum and LPN-B expressed they would get it. LPN-B opened the medication cart and removed a white-colored package which was labeled, "Rubgy [brand name] Nicotine Gum ... Stop Smoking Aid 4 mg," and provided it to the surveyor for review. The package was commercial and there were no pharmacy labels attached to it; nor was there any written identifier(s) to demonstrate whom the medication was for (i.e., R3). LPN-B verified the package was opened with several doses removed, and it lacked any pharmacy labeling expressing aloud, "I'm not sure why her name isn't on it." LPN-B verified the medication was not considered a "stock med" and expressed they were unsure when it had been filled or sent by the pharmacy since it wasn't labeled. LPN-B stated they believed it to be R3's supply though but verified all medications, including nicotine gum, should be labeled from the pharmacy. This was important "so we know whose it is and they [residents] get the right meds." LPN-B then removed one piece of the nicotine gum and provided it to R3. Following, at 8:27 a.m., registered nurse unit manager (RN)-A approached the mobile medication cart and LPN-B asked them aloud, "Do you know why this [gum] wouldn't be labeled from the pharmacy?" RN-A stated all medications come with a pharmacy label which should remain on the box or package. RN-A stated if staff locate a medication which doesn't have a label, then the pharmacy should be contacted for instructions on how to correct it. RN-A verified nicotine gum was considered a medication and should be labeled from the	F0761		

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F0761 SS = D	Continued from page 95 pharmacy as "we want to make sure we're giving the right medication with the right patient" adding the label helps staff to ensure the medication inside the package is correct. Later, on 7/1/25 at 8:58 a.m., RN-A stated they had just contacted the dispensing pharmacy who verified the nicotine gum should be labeled adding, "Normally, yes [should be]." RN-A stated the pharmacy was unsure why the medication was not labeled, and they were going to send a "new package" out to correct the issue. RN-A stated they told the pharmacy to investigate the situation "on their end." On 7/1/25 at 9:42 a.m., the director of nursing (DON) was interviewed. DON verified nicotine gum was considered a medication since it was listed on the MAR, and they expressed the medication should come with a pharmacy label. DON stated if staff discovered a medication that was not labeled, then they should contact the pharmacy and "get the right label on it." DON stated having medications labeled with correct information was important as it was "an identifier" to help staff know they're giving the right medication to the right person. When interviewed on 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A verified nicotine gum would be considered a medication and typically would be labeled from the pharmacy with patient name and directions for administration. CP-A explained some nicotine gum brands come wrapped in a plastic film which sometimes has the label attached and, upon being removed, the label gets destroyed at the same time. CP-A verified the medicated gum should be labeled with, at minimum, the patient's name so staff know whose it was. CP-A stated if staff found a medication without a label, then they could contact the pharmacy who could help them resolve it. Further, CP-A stated it was important to ensure medications were labeled with basic information to help "make sure it's getting to the right patient" and help reduce the risk of error. A facility provided Medication Storage in the Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements. The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." An additional facility provided Medication Ordering and Receiving from Pharmacy policy, dated 5/2022, identified medications would be labeled in accordance with facility requirements and state and/or federal law. The policy outlined labels were to be permanently affixed to the	F0761		

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F0761 SS = D	Continued from page 96 outside of the prescription container and if the label didn't fit directly onto the product then it could be affixed to the outside container adding, " ... the resident's name, at least, must be maintained directly on the actual product container."	F0761		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 3 of 3 residents (R12, R8, R153) who complained about cold food at meals. This had potential to affect a total of 25 residents identified to reside on the unit where the meals were served and sample tray tested. Findings include: R12's quarterly Minimum Data Set (MDS), dated 1/18/25, identified R12 demonstrated no delusional thinking. However, the section to record R12's cognition was dashed with, "Not Assessed [See F638]." On 6/29/25 at 10:53 a.m., R12 was interviewed about his quality of life at the care center. R12 complained about the food and described it as "garbage," and "nasty." R12 stated the meals were often served cold and he wanted warm food to eat. R8's quarterly MDS, dated 6/20/25, identified R8 demonstrated no delusional thinking. On 6/29/25 at 10:23 a.m., R8 was interviewed and expressed aloud, "The food sucks." R8 explained the kitchen rarely seemed to have meat products but rather just carb-filled food items which he disliked due to having diabetes. R8 explained the food was often served cold adding this occurred, "Most of the time." R8 stated "most of the time" the meals delivered via room tray	F0804	The Terrace at Crystal is committed to ensuring all meals are served in a timely manner, at appropriate temperatures, and in a palatable form that promotes quality of life, dignity, and nutritional intake for all residents. R12, R8, and R153 were offered fresh meals and their concerns were documented and addressed. A facility-wide audit of current food service practices will be conducted. This included tray line procedures, meal delivery timing, and temperature holding techniques from kitchen to point-of-service. Hot and cold holding equipment were inspected to ensure proper functioning. Dietary and nursing staff received education on the importance of timely meal delivery to maintain temperature and palatability Thermometers were calibrated, and a standardized Meal Temperature Monitoring Log was implemented. The Dining Services Manager and/or designee will conduct audits 1x per week for 2 months, then monthly for 2 months ensuring trays meet temperature and presentation standards. QAPI will review food quality and resident satisfaction during monthly meetings. Trends and corrective actions will be monitored and documented. The Administrator and Dining Services Manager are responsible for maintaining ongoing compliance with F-804 food service and palatability standards.	08/26/2025

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F0804 SS = E	Continued from page 97 were often served cold and the aides rarely would heat it up even if asked adding, "The aides don't do [expletive] here." R8 reiterated his displeasure with the meal service and stated, "This place just sucks." R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25, but a cognitive assessment had not yet been completed. During an interview on 6/29/25 at 8:50 a.m., R153 stated the food was "garbage," tasted like "dog food," and was always "freezing cold" when it should be hot. On 6/29/25, the following observations and interviews occurred: -At 11:52 a.m., cook (CK)-A stated they already temped the food for lunch. CK-A stated the temped the pork loin which was above 170 degrees Fahrenheit and did not need to temp the cabbage, potatoes, or other items. CK-A was unsure of where to write down the food temperatures. Dietary aide (DA)-C stated the food carts were already brought upstairs for service. DA-A was still in the kitchen collecting serving items with food in pans and covered on their cart. -At 12:03 p.m., DA-A stated they went to the second floor as soon as possible to turn on the steam table and ensure serving items were stocked. DA-A started to scoop food onto plates and serve to residents in the dining area. DA-A was not observed to temp the food before service. -At 12:42 p.m., some room trays were set up and plated on the cart and others were not. DA-A was not in the dining area. -At 12:47 p.m., DA-A returned to the dining area with a sandwich. -At 12:55 p.m., DA-A stated they plated up the last room tray. A test tray was requested, plated, and placed on the cart. Some room trays were already brought to rooms and other rooms trays were still on the cart. -At 12:59 p.m., there were still room trays on the cart and DA-A went to the kitchen on the first floor to bring up a resident's alternative meal option. -At 1:02 p.m., DA-A plated a meal for a new resident. -At 1:05 p.m., the test tray was taken for another resident.	F0804		

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F0804 SS = E	Continued from page 98 -At 1:09 p.m., DA-A stated the last tray on the cart could be used as a test tray instead of the initial one which was taken for a resident. The director of nursing (DON) sampled the pork loin, potatoes, and cabbage. The DON stated the pork loin and cabbage could be a "little warmer". During interview on 6/29/25 at 1:31 p.m., DA-A stated they heard about complaints of cold food. DA-A stated they asked others about temping food once on the steam trays and were told they did not need to temp the food. During interview on 7/1/25 at 2:20 p.m., CK-C stated they temped all the food to ensure the food was hot or cold and had a temperature log they filled in. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to temp and track all food and temp again after placed in the steam tables. CD stated temping food was important to ensure food was cooked appropriately and prevent food poisoning. During follow-up interview on 7/2/25 at 10:22 a.m., CD reviewed the temperature log and verified the pork loin and cabbage were not items listed as temped on 6/29/25 for lunch. CD expected food to be served at appropriate temperatures to avoid bacteria growth, and residents liked hot food. The facility Food: Quality and Palatability policy dated 2/2023, indicated food would be palatable, attractive, and served at a safe and appetizing temperature. The facility Time and Temperature Control and Recording policy undated, directed staff to record final cooking temperatures on the Cooking Temperature Log and check good temperatures when food was placed in steam table or hot holding unit and at least every two hours thereafter.	F0804		
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by:	F0805	The Terrace at Crystal is committed to providing all residents with diets that meet their individual nutritional needs and physician-ordered dietary texture requirements to ensure safety, adequate nutrition, and quality of life. R35's diet order was reviewed and corrected with dietary staff to ensure compliance. A facility-wide audit was conducted to review all residents with texture-modified diets to verify orders were accurately followed and residents received	08/26/2025

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F0805 SS = D	Continued from page 99 Based on observation, interview, and document review, the facility failed to provide the ordered diet texture for 1 of 2 residents (R35) reviewed for dietary texture. Findings include: R35's annual Minimum Data Set (MDS) dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. R35's Terrace at Crystal Rehabilitation Screen/Update dated 9/11/24, indicated R35 was evaluated by a speech language pathologist (SLP) to assess possibility of upgrading diet texture. SLP reported R35 was unsafe to upgrade diet and remained on a dysphagia puree diet plan. During observation on 6/29/25 at 12:03 p.m., dietary aide (DA)-A scooped food onto plates from the steam table and brought meals to the residents seated in the dining area. During observation and interview on 6/29/25 at 12:17 p.m., nursing assistant (NA)-E stated R35 could not eat "this". R35 was seated at a dining room table and had a full piece of uneaten pork loin on her plate. NA-E stated R35 was not able to chew the pork loin. R35's pork loin was replaced with minced meat with gravy over the meat. The staff returned to assisting other residents, and R35 ate independently with no difficulties. R35's meal ticket next to her plate indicated R35 had a regular diet and pureed texture. During interview on 6/29/25 at 12:51 p.m., DA-A stated they did not have pureed pork today and confirmed they served mechanical cut-up pork and no pureed pork, which included R35.	F0805	Continued from page 99 appropriate food consistencies as ordered by the care plan and physician. The Dietary Manager reviewed and revised policies and procedures related to diet texture preparation, verification, and delivery to reinforce compliance with physician orders. Dietary and nursing staff will receive education on the importance of following diet texture orders, proper communication protocols and the verification processes before meal delivery to confirm diet texture compliance. Audits will be conducted 1x per week for 2 months, then monthly for 2 months requiring modified diet textures for three months. Audit results will be reviewed in monthly QAPI meetings to identify trends and the need for further training. The Dietary Manager and DON/designee are responsible for oversight and compliance with dietary texture orders and related care planning.	

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F0805 SS = D	Continued from page 100 During interview on 6/29/25 at 1:31 p.m., DA-A stated they served resident meals according to their meal tickets, which indicated what diet and texture of food the resident was ordered. DA-A stated sometimes they were not given pureed food to serve and only ground food. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's diet but would reference the meal ticket. NA-A stated they would tell a server if they noticed a resident was not served the correct diet. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets listed diet texture, allergies, and preferences. RN-A stated it was important to follow diet orders to prevent choking for residents with dysphagia. During interview on 7/1/25 at 2:20 p.m., cook (CK)-C stated managers explained to the cooks the diet and textures they needed to prepare for the residents. CK-C stated they had a spreadsheet which described which diets residents were on. When asked to see the spreadsheet, CK-C showed a book with dietary updates related to new residents or changes in diets. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to serve residents the correct texture of food according to the meal tickets. CD stated food could be a choking hazard for a resident if not served the correct texture. During interview on 7/1/25 at 2:57 p.m., the culinary district manager (CDM) expected pureed food to be pudding consistency and not lumpy or too runny. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to follow diet orders. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident.	F0805		

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F0805 F0806 SS=D SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food allergens and/or preferences were followed for 3 of 4 residents (R258, R35, and R37) reviewed for food allergens/preferences. Findings include: R258 R258's quarterly minimum data set (MDS), dated 6/25/25, indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. R258's face sheet, printed 7/2/25, indicated R258 had several allergies including cornstarch, gluten, and soybean Oil. R258's care plan, dated 6/19/25, indicated "resident [R258] has reported food intolerances that cause abdominal pain (corn starch, dairy (butter, American Cheese & Hard Cheeses ok), egg whites (ok if cooked into things), gluten, soy, soybean oil." The care plan contained an intervention, dated 2/10/25, that directed staff to not serve "corn starch, dairy (butter, American Cheese & Hard Cheeses are ok per Debra), egg white (ok if cooked into something), gluten, soy, or soybean oil" unless requested. R258's meal ticket, used by the kitchen staff to	F0805 F0806	The Terrace at Crystal is committed to ensuring that all residents' food allergens and dietary preferences are respected and followed to promote safety, satisfaction, and overall well-being. R258, R35, and R37, dietary orders were reviewed and updated, and affected residents were provided with meals that met their specific allergen restrictions and preferences. A facility-wide audit was conducted to review all residents with documented food allergies and preferences. The Dietary Manager reviewed the facility policy on food allergen management and resident preference documentation to ensure clear procedures are in place for communication and compliance. Education was provided to dietary staff, nursing staff, and IDT on the importance of accurately identifying and adhering to resident food allergens and preferences and communication and verification protocols to prevent allergen exposure and ensure resident satisfaction. Audits will be conducted 1x per week for 2 months, then monthly for 2 months of 10% of residents with food allergens and preferences for three months. Audit findings will be reviewed at monthly QAPI meetings to identify trends and determine if additional training or process improvements are needed. The Dietary Manager and DON/designee are responsible for oversight and ensuring compliance with food allergen and preference protocols.	08/26/2025

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F0806 SS = D	Continued from page 102 communicate allergies, preference, and diet type, also indicated R258's allergy/preference to not have foods cooked in soybean oil. During observation and interview on 6/29/25 at 10:14 a.m., R258 was in her room, lying in bed with her breakfast tray on the overbed table. On the tray were what appeared to be two, untouched fried eggs. R258 stated the food at the facility was "a joke" and that she had allergies that were still served to her, including gluten and soybean oil. R258 stated the eggs were "the worst" and always cooked in soybean oil and "sometimes you lift them [the eggs] up and they are just greasy with oil." R258 stated if she eats things cooked in soybean oil it causes her to have extreme upset stomach and that if she didn't buy her own food, she "would not get enough to eat." R258 confirmed the dietary manager was aware. During an interview on 6/29/25 at 3:08 p.m., cook (CK)-A stated they use an Arrezzio 90/10 Vegetable and Olive Pomace Oil Blend. The oil blend contains 90% soybean oil and 10% olive oil. During observation on 07/01/25 at 8:51 a.m., an Arrezzio oil container was sitting next to cracked eggs in the kitchen. During an interview on 7/1/25 at 2:20 p.m., (CK)-C stated they used the Arrezzio oil for cooking and did not know of any residents who needed a different kind of oil. CK-C stated they used the oil for frying eggs, deep frying foods, and chicken breasts. CK-C stated they used butter for frying eggs at times, to grease pans, and to make cookies. During interview on 7/2/25 at 7:23 a.m., CK-B stated they used the Arrezzio oil for food like eggs unless a resident specifically stated they wanted their eggs fried with butter. CK-B stated there were two residents who requested butter instead of oil for cooking but one of those residents passed away and the other resident did not reside in the facility anymore. CK-B stated they were not aware of any current residents for whom they should avoid cooking with the oil. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated they knew of one resident, R258,	F0806		

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F0806 SS = D	Continued from page 103 who could not have soybean oil and expected staff to cook her meat and steam eggs without the soybean oil. R35 R35's annual Minimum Data Set (MDS) dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. The care plan indicated eggs caused R35 to have an upset stomach unless the eggs were cooked into food. The care plan indicated R35's preference to avoid strawberries and nuts, and R35 liked fish patties with tartar sauce, chicken, turkey porkchops, and applesauce. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. During observation and interview on 7/1/25 at 8:32 a.m., R35 sat at a dining room table and ate breakfast. Dietary aide (DA)-E stated R35's plate had pureed biscuit, pureed scrambled eggs, and oatmeal. The meal ticket next to R35 indicated "Allergies: *Strawberry Allergen*, Egg Yolk, Treenuts, Soy/Soybean Oil, *Peanut Allergen*". The meal ticket indicated "No eggs at breakfast" under the listed allergies and "NO EGGS" under the listed breakfast items. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's allergies but would reference the meal ticket. NA-A stated they would change a resident's plate if they noticed a resident was not served the correct meal. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets listed diet texture, allergies, and preferences. During interview on 7/2/25 at 10:22 a.m., the culinary director (CD) expected staff to follow residents' meal tickets and should not plate items listed as an allergy for a resident since staff may not know if the food	F0806		

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F0806 SS = D	Continued from page 104 item was an allergy or preference. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to not serve food listed as an allergy to residents for safety reasons. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. R37 R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care and was independent with eating after set-up assistance. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood. R37 stated the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated he did not eat it, but it happened again just a few days ago. R37 stated he had followed up with the social worker when this happened as it continued to happen. R37's allergy list, printed 7/2/25, lacked identification of allergy to shellfish, seafood, or fish. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: -Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions:	F0806		

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F0806 SS = D	Continued from page 105 -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions." R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences.	F0806		

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F0806 SS = D	Continued from page 106 R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." Grievance log for June 2025 indicated a grievance was filed by R37 on 6/24/25 regarding food concerns. On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants use the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they are familiar with R37 and work with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic to. CDM stated that he encouraged residents and staff to fill out grievances as this was a great way to track concerns. CDM reported R37 should not receive any sort of seafood or fish products as it was documented that he has an allergy to seafood, shellfish and fish. During an interview on 7/02/25 at 8:06 a.m., licensed social worker (LSW)-A stated she had met with R37 on 6/24/25 regarding concerns with R37's supper on 6/24/25. LSW-A stated R37 was served shrimp for dinner and verified R37 had an allergy to shellfish and should not have been served shrimp due to his allergy. LSW-A stated she had seen his dinner plate, reviewed his meal ticket, and he had not received the food that was on the meal ticket. LSW-A stated she filled out a grievance form regarding this and notified the administrator and director of nursing. LSW-A stated the	F0806		

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F0806 SS = D	Continued from page 107 grievance form was given to the dietary manager to address. LSW-A stated dinner was purchased for R37 on 6/24/25 as the kitchen was closed when R37 had come to talk to her about the meal that was given to him. During an interview on 7/02/25 at 8:20 a.m., culinary director (CD) stated she had received a grievance regarding R37 receiving a shrimp dinner on 6/24/25, which he should not have received. CD stated she followed up with R37 and staff involved. CD stated staff are to follow the meal tickets and verified in this instance they did not. R37 was to get the alternative meal, due to shellfish allergy, and R37 was served shrimp. CD stated she has provided education to dietary staff regarding the importance of following meal tickets upon receiving the grievance form. CD stated R37 has an allergy to shellfish, seafood and fish and when asked what type of allergy stated, "probably his throat swells up, probably would need an epi-pen or something." CD verified the allergy was listed on the meal ticket. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated that residents' food allergies should be listed under resident's allergies. DON verified R37's food allergies were not listed in his allergy list. The facility Food Allergies and Intolerances policy dated August 2017, directed staff to ensure residents with food intolerances and allergies were offered appropriate substitutions for foods they cannot eat. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident. The facility Dining and Food Preferences policy dated 10/2022, indicated individual tray assembly tickets identified all food items appropriate for the resident based on diet order, allergies & intolerances, and preferences.	F0806		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.	F0808	It is Terrace at Crystal's policy to ensure that therapeutic diets are prescribed by the attending physician or delegated licensed/registered dietitian, accurately ordered, implemented, and monitored to meet the specific medical and nutritional needs of each resident. R36's dietary orders were immediately updated to reflect the hospital discharge instructions for a	08/26/2025

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F0808 SS = D	Continued from page 108 §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a therapeutic diet was ordered upon return to facility per orders on hospital discharge for 1 of 1 residents (R36) reviewed for therapeutic diets. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). R36's progress note dated 4/16/25 at 5:21 p.m., indicated resident was readmitted from the hospital and had new and changed orders and to see the facility electronic medical record (EMR). R36's Hospital Discharge Summary, dated 4/16/25, indicated R36 required a consistent carbohydrate diet. During an interview on 6/29/25 at 10:37 a.m., R36 stated she was diabetic and when asked about the facility food, R36 stated "I know it is not diabetic friendly." R36 stated "I want to eat better so I don't have so many problems." R36's order summary, dated 6/30/25, indicated R36 was on a regular diet, regular texture with liquids with a start date of 4/18/25 (2 days after hospital discharge). Review of R36's paper chart or EMR did not contain an order for a regular diet. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36. LPN-A stated when a resident came back from the hospital or admitted to the facility the floor nurse entered all the orders, including diet orders, and a second nurse verified all the orders. LPN-A verified R36 was diabetic, required insulin to manage blood sugar, and stated R36 was "all over with her blood	F0808	Continued from page 108 consistent carbohydrate diet, and the resident's meal plan was adjusted accordingly. The resident and/or their representative were informed of the correction. A comprehensive audit was conducted for all current residents, regardless of admission date, and for all residents to verify that therapeutic diet orders were accurately obtained, entered into the EMR, and implemented upon admission or readmission. Missing or incorrect orders were corrected immediately. The facility's policy titled "Therapeutic Diets" was reviewed and revised as necessary. Nursing, dietary, and interdisciplinary team members received re-education on policy, emphasizing the importance of reviewing hospital discharge paperwork, verifying diet orders, and timely entry into the EMR. Licensed nurses were educated on the requirement that all therapeutic diet orders must be entered and verified prior to meal service, with any discrepancies immediately clarified with the provider. The DON/designee will audit all current residents' diet orders to ensure accuracy, followed by ongoing audits of all new admissions and readmissions from the hospital 1x per week for 2 months, then monthly for 2 months. Results of audits will be presented during monthly QAPI meetings to assess compliance, identify trends, and determine if additional corrective actions or staff education are required. The Dietary Manager and DON and/or designee are responsible for oversight of therapeutic diet accuracy and compliance.	

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F0808 SS = D	Continued from page 109 sugars." LPN-A stated R36 was on a regular diet and not a diabetic diet. On 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated R36 was on a regular diet and as far as they were aware was not on a diabetic diet. LPN-E reviewed R36's EMR and verified she had many high blood sugars over 400 mg/dL (milligrams per deciliter) in June. During a follow up interview with LPN-E on 7/2/25 at 8:46 a.m., LPN-E verified the hospital discharge paperwork dated 4/16/25 included an order for a consistent carbohydrate diet, and R36 did not have any diet entered into the EMR when she returned from the hospital on 4/16/25 until a regular diet order was entered on 4/18/25. LPN-E was not able to find an order for a regular diet in the EMR. During an interview on 7/2/25 at 11:49 a.m., director of nursing (DON) stated the expectation when a resident admitted or readmitted to the facility was the orders were entered into the EMR, including diet orders, and then checked by another nurse. DON stated the unit managers should also be looking over all the orders to ensure accuracy. DON was unable to locate an order for a regular diet for R36. On 7/2/25 at 12:56 p.m., LPN-E stated they did not have an order for a regular diet for R36, and R36 should have been ordered the diabetic diet. LPN-E stated they followed up with the provider regarding this and the provider was going to put an order in for a consistent carbohydrate diet. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated the facility spoke with her today upon her arrival to the facility about a diet order for R36. NP-A stated she was going to put an order in for a low carbohydrate diet for R36. NP-A stated, "if she is compliant with the diet, it should help with her blood sugars." A facility policy titled Therapeutic Diets, revised 10/22, indicated a licensed nurse accepts the diet order form the authorized prescriber.	F0808		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	The Terrace at Crystal is committed to maintaining the highest standards of food safety and sanitation to protect all residents from foodborne illness and contamination. Identified areas were immediately corrected including	08/26/2025

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F0812 SS = F	Continued from page 110 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure opened dairy products (i.e., milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. In addition, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to These findings had potential to affect all 51 residents within the care center. Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, "How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?]," dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on	F0812	Continued from page 110 improving food storage, handling, and preparation, including proper dating of food and milk, refrigerator temperature monitoring, hair covering usage, and dish sanitation per policy. A complete cleaning and reorganization of all food storage and preparation areas were conducted. A comprehensive audit of food safety practices, including storage, labeling, refrigerator/freezer temperatures, hair covering compliance, and dish sanitation processes, was conducted across all units affecting all 59 residents. Any non-compliant items or practices were corrected, and appropriate documentation was updated. The facility's policies titled "Labeling and Dating," "Refrigerator and Freezer Temperature Monitoring," "Hair Restraint Use in Food Service," and "Dishwashing and Sanitation" were reviewed and revised as necessary. All dietary and relevant staff received education on proper food handling, labeling and dating, refrigerator temperature monitoring, hair covering requirements, and dish sanitation procedures, with return demonstrations to verify competency. Audits on food safety, including labeling and dating of all consumables, refrigerator and freezer temperature logs, hair covering use, and dish sanitation practices, will be conducted once per week for two months, then monthly for two months. Audit results will be reviewed during monthly QAPI meetings to assess compliance, address deficiencies, and determine if additional interventions or education are necessary. The Dietary Manager, Maintenance Director, and DON share responsibility for oversight of food safety, storage, and sanitation compliance.	

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F0812 SS = F	Continued from page 111 the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, "06-19-25 [10 days prior]." The milk container had a commercial stamp along the collar which outlined a 'best by' date of, "06/29/25." DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used "three days" after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, "I don't know." On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, "06-25-25 [five days prior]." DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been "rubbed off" by them just before they brought the cart up. DA-B stated the black writing read "6/9" before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, "I'm not sure." DA-B verified the milk was intended to be used for the supper meal service that evening. Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed.	F0812		

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F0812 SS = F	Continued from page 112 They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to "the number of diseases that come with it [using milk beyond that range]," adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart. On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, "Refrigerator Temperature Log," which was dated, "June 2025." The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, "06-24-25." However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, "I don't check this." DA-A verified the milk was beyond the 'best by' date and was not dated when	F0812		

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F0812 SS = F	Continued from page 113 opened, and they expressed there was enough milk in the container to serve "seven or eight" people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was "a resident fridge" used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated "the kitchen, not us" was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, "05/23/25," and "Gravy." The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, "I think it's gravy." NA-D verified the condition of the food product and dates on the tinfoil. One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, "Yea," when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, "Obviously no one was doing it." LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked "disgusting." LPN-B stated many of the food items in	F0812		

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F0812 SS = F	Continued from page 114 the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, "So things like that [surveyor findings] don't happen." On 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more "daily oversight" of tasks like that to ensure they get done. CDM explained there was a "monthly routine" to check the unit refrigerators for food dates and expirations but added, "Some people can be forgetful." CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, "Especially with the vulnerable base we have." On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, "The nursing staff will discard perishable foods on or before the 'use by' date," adding further, "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor ...)."	F0812		

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F0812 SS = F	Continued from page 115 INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished	F0812		

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F0812 SS = F	Continued from page 116 up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and "use by" date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung.	F0812		
F0880 SS = D	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.	F0880	It is the policy of The Terrace at Crystal to maintain strict adherence to current infection control standards to protect residents, staff, and visitors from infectious diseases and promote a safe care environment. For Resident #153, personal care practices were reviewed to ensure adherence to current infection control standards. Immediate corrective action was taken, including individual coaching and re-education of the involved staff on proper hand hygiene, use of	08/26/2025

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F0880 SS = D	Continued from page 117 §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 §483.71 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 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	F0880	Continued from page 117 personal protective equipment (PPE), and safe resident care techniques. Infection prevention measures were reinforced to support continued compliance with facility protocols. Residents residing in the facility have the potential to be affected by this practice. A facility-wide audit of personal care and infection control practices was conducted across all resident care areas to identify any other potential breaches. Any issues found were immediately corrected and documented. The “Handwashing/Hand Hygiene policy” was reviewed and revised as necessary. The policy reviews current infection control guidelines and standards of practice required procedures for resident personal care to minimize infection risks and staff responsibilities for compliance with infection prevention protocols. All nursing and direct care staff received comprehensive training and retraining on infection control best practices, including hand hygiene, PPE use, and environmental cleaning. Weekly observational audits of infection control compliance during personal care activities for 4 weeks and monthly for 2 months or until full compliance Audit findings and staff compliance reports during will be reviewed during monthly QAPI meetings. The Infection Control nurse and/or designee are responsible for compliance.	

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F0880 SS = D	Continued from page 118 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: Based on observation, interview, and document review, the facility failed to ensure current infection control standards of practice were followed when performing resident personal care for 1 of 4 residents (R153) observed for personal care. Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's Medical Diagnosis list dated 6/23/25, indicated R153 was diagnosed with diabetes, a stroke, and heart disease. R153's care plan dated 6/30/25, indicated R153 required the assistance of one to two staff members for bed mobility and dressing, and the assistance of two staff members for toileting and transferring. During an observation on 7/1/25 at 8:27 a.m., R153 was observed lying in bed. Nursing assistant (NA)-I and NA-J were observed assisting R153 with personal care. NA-I, with gloved hands, was observed to assist R153 with perineal care while R153 was lying on his back. NA-J was observed to assist the resident in rolling towards her, while NA-I completed perineal care on the backside. NA-I was observed, still with gloved hands, to assist the resident to apply a new pad and put on shorts. Then both aides assisted R153 to sit on the edge of the bed. NA-J was observed to position a motorized stand aide while NA-I, with gloved hands, assisted the resident to position his hand and feet on	F0880		

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F0880 SS = D	Continued from page 119 the machine. NA-J was observed to complete hand hygiene and then leave the room. NA-I with gloved hands, assisted R153 to position himself in the wheelchair and readjust his glasses. NA-I took off his gloves, gathered the trash, and left the room. NA-I was not observed to complete hand hygiene during this observation or to change gloves. During an interview on 7/1/25 at 8:50 a.m., NA-I stated he had completed hand hygiene and applied gloves before entering R153's room, taken off his gloves before leaving the room, and then, after he had thrown away the trash, he completed hand hygiene. NA-I confirmed he had otherwise not completed hand hygiene while completing R153's care. NA-I stated he was taught to complete hand hygiene before and after care but had not been told that he also needed to complete hand hygiene during care. During an interview on 7/2/25 at 9:58 a.m., the director of nursing (DON) stated staff were expected to complete hand hygiene before applying gloves, when changing gloves, after glove use, and after a task like perineal care to prevent "cross-contamination". The facility Handwashing/Hand Hygiene policy dated 8/19, indicated staff were to complete hand hygiene before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, and after removing gloves.	F0880		
F0921 SS = F	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: During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair which had the potential to affect all 51 residents, staff, and visitors of the facility. In addition, the facility failed to ensure the dish machine in the main kitchen was kept in a clean and sanitary manner and free of debris.	F0921	Facility Response F-921 It is the policy of The Terrace at Crystal to maintain a clean, sanitary, and safe environment for all residents, staff, and visitors. Areas of concern, including the dish machine, dusty fans, and marked walls, were cleaned or addressed. Staff were reminded of expectations for maintaining cleanliness and safe surroundings. A review of all resident-accessible areas was initiated to identify similar concerns. The facility's sanitation and maintenance procedures were reviewed for expectations related to cleanliness and timely repairs.	08/26/2025

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F0921 SS = F	Continued from page 120 Findings include: Walls: During observation of R15 on 6/29/25 at 10:24 a.m., R15 in resident room on second floor sitting in hospital gown with brown substance streaked on the floor. During observation and interview with R31 on 6/29/25 at 10:35 a.m., R31 stated she was disappointed in her facility stay in part due to the "environment is dirty" pointing to ceiling in her room with yellowing stain on it and a gash in the wall with brown drip stains down the wall. During observation and interview with R12 on 6/29/25 at 10:52 a.m., R12 lying in bed which was horizontally against the wall. Wall had numerous black marks along it with a yellow-colored stained area that extended on the wall for approximately half the length of his bed. R12 stated he was unhappy with the condition of the walls and would "like it addressed". R12 stated "this whole place is f***ed up" and that the facility had done nothing about it. During interview with R24 on 6/29/25 at 1:48 p.m., R24 stated "cleanliness of the place [sic] run down" R24 stated "this place is a pit". During observation and interview on the second-floor secured memory care unit in the dining room on 6/30/25 at 2:07 p.m., a baseboard in east corner of room had broken wallboard above it. Portions of the baseboard was not attached to wall due to the hole in the area. The area was approximately 18 inches long. Blue laminate edging was missing from portion of nursing desk facing the hallway. Portion was 8 inches that spanned the corner of the nursing station desk. Knee wall attached to nursing station and wall across from the nursing station had numerous scrapes and missing pain including peeling. In the dining room above chair rail in corner of it there was white corner piece that did not match color of remaining wall. The corners that came together were pulling apart showing half an inches of empty space for eighteen inches. Area also had beige staining around it. Both dining room wall frames had peeling, stained, and chipped paint on both sides. Nursing assistant (NA)-A was seated at a dining room table with resident who was in a wheelchair. Two other	F0921	Continued from page 120 Staff in maintenance, housekeeping, and dietary departments received reeducation on August 8, 2025, regarding cleaning routines and reporting procedures for sanitation or repair concerns. Ongoing monitoring began August 4, 2025, with weekly inspections for 8 weeks, then monthly for 2 months. Issues noted will be tracked and discussed in QAPI meetings to guide further action as needed. Routine maintenance tasks are scheduled to be addressed at regular intervals consistent with the facility’s preventive maintenance plan. Larger repairs requiring vendors or additional resources will be reviewed and planned collectively during QAPI meetings. Oversight will be provided by the Maintenance Director and Administrator.	

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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
F0921 SS = F	Continued from page 121 residents were in the room at the time. NA-A stated expectation of staff to report any maintenance issues to the MT-D. NA-A stated she would tell the nurse who would then fill out a work order on the computer or verbally tell MT-D of any concerns. NA-A looked around and stated, "[It] looks like [sic] needs to be repainted. Not looking good." During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:19 p.m., TMA-A stated, "need to be fixed or done painting or repairing." TMA-A stated expectation of staff to notify maintenance of work order request for MD-T to address concerns with "painting and repairing". TMA-A observed hole in the wall in dining room above the baseboard and stated, "Oh wow. Needs to be repaired." During observation and interview with director of nursing (DON) on 6/30/25 at 2:34 p.m., on the second-floor secured memory care unit pointing to the walls, baseboards, and door frames of resident rooms and also the two entrances to the dining room. DON stated, "Needs repair. The door frames need to be repaired and replaced." DON stated, "I would not like that at my home. DON stated expectation of staff to fill out a work order and submit it electronically or notify MD-T verbally. DON stated she had worked at facility for over two years and did not see any wall repairs or replacing of baseboards or painting of door frames during that time. During observation and interview with MD-T on 6/30/25 at 3:02 p.m., MD-T observed 2nd floor resident door frames, memory care security doors, baseboards, chipped, broken wallboards and stained ceiling tiles and walls and stated, "It is not homelike. I would not like it in my home. We need to replace all of the baseboards and repaint the walls. The doors are really chipped and need to be repainted." MT-D stated expectation of staff to submit work orders or notify him of repair needs verbally. "I have been working on them but was not aware of some of the issues. There is a lot." During observation on 6/30/25 at 5:08 p.m., in the 3rd floor dining room, two residents were eating supper at dining room table while television was on. Baseboards of dining room were beige in color with black markings all along them horizontally. Three rooms at end of hall	F0921		

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F0921 SS = F	Continued from page 122 had black markings along the walls, door frames to the dining room were chipped with stains and missing paint. All resident room door frames were chipped and missing paint. Walls with chair rails had wallpaper peeling or marked with nail holes visibly covered with white wallboard repair, sanded to reveal the nail heads resulting in white repair marks but nothing finished. Painted walls had visible nail holes which were never painted over to match. Section of cracked broken wallboard was visible outside two resident rooms ranging thirty inches horizontally above the baseboard. Broken wallboard that appears to be punched in running two feet above the baseboard outside a resident room. During observation and interview with MD-T on 7/1/25 at 8:24 a.m., on third floor outside resident room there was a horizontal broken portion of wall board above the baseboard which measured thirty inches. A small black winged insect was observed to fly in and out of the crack. MD-T stated, "yeah that looks like it needs to be repaired or replaced". During interview with R7 on 7/1/25 at 8:26 a.m., R7 stated his third-floor resident room, "I hate the way the walls and doors look here. It is junky and gross. Looks like they don't care about how it all looks (pointing out into the hallway)." During review of documents titled completed and active Work Orders with dates "May. 1, 2025 -Jul. 1, 2025" failed to identify maintenance concerns regarding condition of walls, floors, and door frames. During interview with facility's administrator on 7/1/25 at 10:31 a.m., the administrator stated he was aware of "these concerns. But there is no formalized plan written down or discussed to address these issues." The administrator stated condition of walls, floors and door frames "are not appealing". FANS: During observation on second floor on 6/30/25 at 2:01 p.m., a large circular floor fan was operating blowing air towards the elevator and nursing station from the lounge room. It had visible dust on the front and back shrouds while operating. Staff and residents were working and ambulating and wheeling selves past the fan.	F0921		

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F0921 SS = F	Continued from page 123 During observation on second floor secured memory care unit on 6/30/25 at 2:15 p.m., a circular fan operating from on the top of the counter of the nursing station. Visible dust and dark matter were noted on the front and back shroud of fan along with the blades of the fan. A female resident was seated next to the fan and another male resident was being transported in a wheelchair past the blowing fan by a staff member. During interview with trained medication aide (TMA)-A on 6/30/25 at 2:19 p.m., TMA-A pointed to the operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "I put it there". TMA-A stated the fan had been "on all day" and "it does need to be cleaned. The cover on the front and back are filthy. ..This is a lot of dirt blowing around." During observation and interview with director of nursing (DON) on 6/30/25 at 2:42 p.m., DON looked at the circular fan operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "It is an issue with infection control. Blowing dirty air throughout the unit. Needs to be cleaned." During observation and interview with maintenance director (MT)-D on 7/1/25 at 8:50 a.m., MT-D was wiping the shroud of a large circular floor fan in the lounge of second floor main area. MD stated, "I need to wipe it to get the dust out of it on the inside and outside of the fan." MD-T stated facility had no "specific" cleaning schedule for facility used fans. "I just do it quarterly". During observation and interview with dietary manager (D-M) on 7/1/25 at 10:10 a.m., a large circular portable fan was circulating air towards the dishwashing area of kitchen. The area had a large stainless-steel counter along one wall that contained used meal trays, utensils and kitchen pots and pans. The counter curved in the corner of the room to meet the dishwasher unit and clean dishes exited. The fan blew air from dirty portion of the counter to the clean portion where the dishes exited. D-M stated, "The dirty dishes are rinsed here (pointing to the beginning of the counter) and then they are rinsed and moved down the counter towards the dishwashing machine". D-M	F0921		

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F0921 SS = F	Continued from page 124 pointed to the circular portable fan and stated, "It should be getting wiped down. Does not look like it has been wiped because there is dust on the front cover while it is blowing towards the dishwashing area". During observation and interview on first floor hallway outside dining room on 7/1/25 at 11:08 a.m., a large circular floor fan was circulating air from the resident hallway towards the dining room. Visible dust was observed on the shroud. At 11:11 a.m., registered nurse health care consultant (HC) observed fan and stated, "needs to be wiped down. There is dust blowing across the hall onto residents and staff making it an infection control issue. We notice the dusty fans here yesterday and this fan was not cleaned or wiped down." During observation and interview on 7/1/25 at 8:33 a.m., MT-D wiping visible dust from shroud of large circular floor fan outside elevator on third floor. MT-D stated the fan had been in use for "weeks" blowing air towards the nursing station, elevator and resident rooms. During interview with administrator and regional director (MD) on 7/1/25 at 2:24 p.m., MD stated, "All fans should be cleaned". Facility policy on homelike environment was requested and not received. Dishmachine During initial tour of the kitchen on 6/29/25 at 8:17 a.m., several orangish blackish substances were observed on top of the dish machine. Dietary aide (DA)-D stated dishes which came through the dish machine were clean. DA-D stated staff washed the outside of the dish machine every one to two days. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated staff wiped the dish machine every day, and they were unsure of the orangish blackish substances on top of the dish machine. During interview on 7/1/25 at 2:57 p.m., the culinary district manager (CDM) stated the sediment on top of the dish machine came from the hood above the dish	F0921		

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F0921 SS = F	Continued from page 125 machine, and staff did their best to ensure the top of the dish machine was clean. CDM stated Ecolab did not assist with the hood or custom pieces, so the facility was trying to find a company who could fix the hood above. During interview on 7/2/25 at 2:24 p.m., the administrator stated maintenance was contacting vendors to install or replace the hood vent above the dish machine. The administrator stated Ecolab did not work on the hood above the dish machine and parts online or in a store would not fit. During interview on 7/2/25 at 2:42 p.m., the maintenance director (MT)-D stated hot steam rose from the dish machine fan and vent area and made the metal from the hood above rust and fall. MT-D stated they were aware of the issue for at least a few months, focused on higher priority facility needs, and were not aware how severe the rust fell from the hood. MT-D stated they discussed putting plastic over the dish machine when the machine was not running to scrape the hood above. The facility Warewashing policy dated 12/2024, did not indicate when to clean the dish machine. The Healthcare Services Group task descriptions for cooks and aides, indicated when staff were to complete their scheduled cleaning assignment.	F0921		
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure adequate pest control measures were in place to eliminate small black flies from the building. This had the potential to affect all 51 residents of the facility. Findings include: During observation and interview with R8 on 6/29/25 at	F0925	It is the policy of The Terrace at Crystal to maintain effective pest control measures to provide a clean, safe, and sanitary environment for all residents, staff, and visitors. A comprehensive pest control inspection was conducted throughout the building, and treatments were applied as needed to eliminate all pests. The facility has long maintained a partnership with Ecolab, a licensed and nationally recognized pest control service, which conducts routine inspections and treatments to prevent and manage pest activity throughout the building. In addition, the facility has also implemented supplemental strategies, such as placing apple cider vinegar traps in targeted areas and installing fly-attracting light devices in multiple locations throughout the facility. These combined	08/26/2025

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F0925 SS = F	Continued from page 126 10:27 a.m., in second floor resident room, several small black flies were observed flying around the room during interview. R8 stated the facility “is full” of small black flies and they are “all over the f***ing building”. R8 stated the flies “been issue for a while…last few months I guess”. R8 stated he was disappointed with facility’s lack of action to address the flies. R8 stated he was “not sure what’s being done about it”. During observation and interview with R31 on 6/29/25 at 10:35 a.m., in third floor resident room R31 stated she “occasionally sees fruit flies” both in her room and out in hallway and dining room. During observation and interview with R36 on 6/29/25 at 10:43 a.m., in third floor resident room, R36 stated facility “gets bugs in here” and was not pleased with it. During observation in second floor dining room on 6/29/25 at 12:17 p.m., a dietary aide was serving food on meal tray to a table with R22 seated in a geriatric chair. Visible little black flies were flying above the table were observed. During interview with nursing assistant (NA)-E on 6/29/25 at 1:19 p.m., NA-E stated she had noticed flies on the second floor. NA-E stated expectation of staff to notify management of flies and “Bring someone in to spray the place”. During interview with culinary aide (DA)-A on 6/29/25 at 1:31 p.m., DA-A stated she had seen “a lot more fruit flies now consistently [for] two or three weeks.” DA-A stated she did not hear any meetings or information from management regarding fruit flies. During interview with R24 on 6/29/25 at 1:48 p.m., in second floor resident room, R24 stated she had “seen some fruit flies” in the past and that her sister had mentioned it to her also when visiting. During interview with maintenance director (MT)-D on 6/30/25 at 11:14 a.m., MT-D stated he was aware of the small black flies’ “issue” in the facility through verbal reports by staff and residents and stated the pest management company “comes out once a month”. MT-D stated the monthly reports filled out by the pest service specialist (PS)-S were missing so he was unable to provide surveyor written reports. MT-D stated he knew nothing about what specific services PS-S provided to address the fly issue.	F0925	Continued from page 126 interventions have proven highly effective, resulting in a significant and measurable reduction in the presence of small black flies and fruit flies. Facility staff have been instructed to monitor fly activity daily, and any concerns are logged and reported to the Maintenance Director for immediate review and coordination with Ecolab for follow-up as needed. Staff received retraining on environmental sanitation practices that help prevent pest infestations, including proper waste management and sealing of entry points. The Maintenance Director will conduct weekly environmental rounds to look for any signs of pest activity and review reports from the monthly pest control service visits until any issues are resolved. Any findings will be documented and reviewed during QAPI meetings to ensure sustained compliance and prompt action when necessary. The Maintenance Director and Administrator are responsible for oversight and ensuring continued adherence to pest control protocols.	

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F0925 SS = F	Continued from page 127 During observation on 6/30/25 at 2:05 p.m., in the second-floor shower room a small black fly was buzzing around. During interview with nursing assistant (NA)-A on 6/30/25 at 2:15 p.m., NA-A stated she could see and was aware of small black flies in the facility. NA-A stated she noticed black flies when the weather started to get warmer. “Looks like something needs to be done to get rid of them. They are everywhere.” NA-A stated expectation of staff to notify the “nurse” so a report could be completed and sent to MT-D. Also, all staff had ability to email or verbally communicate to MT-D about maintenance concerns, including pests. During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:22 p.m., TMA-A stated she was aware of the small black fly issues in the building from residents and other staff including her own observations. TMA-A stated MD-T was made aware by her via verbal means. TMA-A stated, “[facility] need to do something better”. During interview with director of nursing (DON) on 6/30/25 at 2:49 p.m., DON stated she was aware of the small black fly issues. “I have seen it and reported to [MT-D] within this month.” DON stated MT-D placed “some traps out” on resident units and it “still [sic]an issue”. During interview with MT-D on 6/30/25 at 3:02 p.m., MT-D stated expectation of staff to communicate facility maintenance needs including pest concerns through electronic Work Orders which can be done through the computer. MT-D stated he is also made aware of issues including pests through verbal communication also. During interview with PS-S on 7/1/25 at 9:55 a.m., PS-S stated he had been at facility in May and June of 2025 for the monthly pest control visits. “[Facility] don’t have a logbook there.” PS-S stated, “the main issue is that I noticed small flies in the kitchen [sic].” PS-S stated he spoke to administrator and “just met [MT-D] over the phone the other day.” During tour with PS-S on 7/1/25 at 1:51 p.m., PS-S stated the facility contract with the pest control company provided, “no service for the smaller flies that are going around here.” During interview with dietary manager (D)-M on 7/1/25 at 10:10 a.m., D-M stated she was aware of the flies in the kitchen area and swatted a black fly as she exited the kitchen.	F0925		

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F0925 SS = F	Continued from page 128 During review of customer service report invoice with service date of 6/11/25, the “Target Pest” column identifies “Flies-Large”. During review of the facility’s Pest Elimination Services Agreement dated 8/30/2022, the contracted services include “Outside in Large Fly Program” with frequency of “Monthly-6 Month Program”. During review of documents titled Work Orders with dates “May. 1, 2025 -Jul. 1, 2025” failed to identify concerns with pests or small black flies. During review of Grievance Tracking logs from January 2025 to June 2025, no mention of pests for “Types of Concern”. During interview with administrator and regional director (RD) on 7/1/25 at 10:25 a.m., the administrator stated he was informed of the black flies “over a month ago”. The administrator stated MT-D bought over the counter “apple things” to trap flies and “agree, [it is] still an ongoing issue”. RD stated he was not aware the monthly pest control services and service agreement failed to address small black flies. “Should be done.” Facility policy titled Pest Control, revised May 2008 identified, “Our facility shall maintain an effective pest control program.”	F0925		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Terrace at Crystal is a Special Focus Facility (SFF). On 6/29/25 - 7/2/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		08/26/2025

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

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20000	Continued from page 1 In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H52897974C (MN109554) H52897971C (MN108609) H52897972C (MN113814) H52897967C (MN106359) H52897968C (MN107818) H52897973C (MN108474) AND The following complaints were reviewed: H52897969C (MN107183) with licensing orders at 0900 and 0960 H52897970C (MN107861) with licensing orders at 0960 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically.	20000		

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20000	Continued from page 2 Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	20265	Corrected.	08/26/2025

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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
20265	Continued from page 3 E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promptly notify the provider consistently of high blood sugars for 1 of 1 residents (R36) of reviewed for notification of change. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). Section N-Medications indicated R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). During an interview on 6/29/25 at 10:45 a.m., R36 stated she had diabetes and had been told she was a "pretty fragile diabetic." R36 stated her blood sugars went up and down and sometimes she required insulin and sometimes she did not. R36's care plan, printed 7/2/25, included R36 had diabetes mellitus with the following interventions: monitor for signs and symptoms of hyperglycemia (high blood sugar); monitor for signs and symptoms of hypoglycemia (low blood sugar); obtain blood sugars per MD order; resident has an order for Dexcom (a continuous glucose monitoring system that is wearable that provides continual real-time blood sugar level reading without the need for frequent fingerstick), sensor to change every 10 days; diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. R36's June 2025 Medication Administration Record (MAR), printed 7/2/25, included the following orders: - Insulin NPH (Neutral Protamine Hagedorn- Human -Isophane) (an intermediate-acting insulin that helps manage blood sugar level in individuals with diabetes) Subcutaneous Suspension 100 unit/milliliter(ml) - Inject 11 units subcutaneously in the evening related to diabetes with a start date of 5/31/25. The record identified it was given all days except 6/14, 6/17, 6/18, and 6/17 which were marked with a "2" indicating "drug refused". The date 6/1 was marked with a "3"	20265		

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20265	Continued from page 4 indicating "absent from home with meds." - Insulin NPH Subcutaneous Suspension 100 unit/ml - Inject 7 units subcutaneously in the morning related to diabetes with a start date of 6/1/25. The record indicated it was administered all days. - Novolog (rapid acting insulin used to control blood sugar) Injection Solution 100 unit/ml - Inject as per sliding scale: if blood sugar is 151 - 225 = 1 unit; 226 - 300 = 2 units; 301 - 375 = 3 units; 376 - 450 = 4 units; 451+ = 5 units, subcutaneously with meals related to diabetes at mealtime only (give even if you skip meal) - Do not give correction dose if blood sugar is less than 150. Check blood glucose at bedtime and do not give correction insulin if blood glucose is less than 200. Start date 5/31/25. - Glucagon Nasal Powder 3 milligram(mg)/dose (dry nasal spray that helps raise blood sugar level in an emergency) 1 spray in nostril as needed for low blood sugar- unsupervised self-administration -In the event of unconscious hypoglycemia or hypoglycemic seizure. May repeat dose if no response after 15 minutes with a start date of 5/18/25. The record identified it was documented every day as "U-SA" which indicated unsupervised self-administration. - Glucose Oral Tablet Chewable (tablet used to quickly raise your blood sugar when it is low) 4 grams (gm), Give 1 tablet by mouth every 6 hours as needed with a start date of 4/16/25. The record indicated it was given on 6/1/25 at 10:32 p.m. and marked as effective and administered on 7/3/25 at 1:34 p.m. and marked as effective. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 2:49 a.m. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time	20265		

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20265	Continued from page 5 administration on 6/1/25 at 3:31 a.m. - Dexcom CGM G6 - Use to obtain glucose level three times daily before meals and at hs (bedtime) for diabetes with a start date of 6/14/24. - Emergency department to evaluate and treat blood glucose level of 833 and patient is symptomatic. One time only for diabetes with a start date of 6/1/25. Record indicated it was documented with a “9" which indicated "other/progress note" on 6/1/25 at 2:48 a.m. - Encourage patient to drink ice water and extra movement to help lower sugar. One time only for diabetes with a start date of 6/1/25 and was completed on 6/1/25 at 10:36 a.m. R36's orders lacked specific parameters on when to notify the provider regarding blood sugars. R36's Blood Sugar Summary Report, from 5/31/25 to 6/30/25, included the following blood sugar readings in milligrams per deciliter (mg/dL): 6/29/25 at 5:00 p.m. was 443 mg/dL 6/28/25 at 1:39 p.m., was 449 mg/dL 6/28/25 at 9:30 a.m., was 500 mg/dL 6/28/25 at 8:54 a.m., was 500 mg/dL 6/27/25 at 12:25 a.m., was 444 mg/dL 6/27/25 at 12:22 p.m., was 444 mg/dL 6/27/25 at 11:46 a.m., was 444 mg/dL 6/27/25 at 8:42 a.m., was 500 mg/dL 6/27/25 at 8:41 a.m., was 500 mg/dL 6/27/25 at 8:40 a.m., was 500 mg/dL 6/26/25 at 8:30 a.m., was 492 mg/dL 6/24/25 at 9:58 a.m., was 600 mg/dL 6/24/25 at 9:19 a.m., was 600 mg/dL 6/23/25 at 3:30 p.m., was 38 mg/dL 6/22/25 at 9:48 a.m., was 529 mg/dL	20265		

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20265	Continued from page 6 6/22/25 at 9:40 a.m., was 529 mg/dL 6/21/25 at 9:14 a.m., was 451 mg/dL 6/20/25 at 9:02 a.m., was 413 mg/dL 6/19/ 25 at 9:05 a.m., was 507 mg/dL 6/18/25 at 9:56 a.m., was 422 mg/dL 6/17/25 at 9:26 a.m., was 473 mg/dL 6/17/25 at 9:01 a.m., was 473 mg/dL 6/16/25 at 8:15 a.m., was 592 mg/dL 6/14/25 at 8:29 a.m., was 600 mg/dL 6/12/25 at 8:44 a.m., was 588 mg/dL 6/9/ 25 at 4:38 p.m., was 485 mg/dL 6/9/25 at 2:22 p.m., was 543 mg/dL 6/9/25 at 2:08 p.m., was 543 mg/dL 6/9/25 at 10:11 a.m., was 551mg/dL 6/9/25 at 8:48 a.m., was 55 mg/dL 6/7/25 at 2:56 p.m., was 441 mg/dL 6/7/25 at 11:13 a.m., was 501 mg/dL 6/7/25 at 11:13 a.m., was 441 mg/dL 6/4/25 at 9:46 a.m., was 424 mg/dL 6/4/25 at 9:37 a.m., was 424 mg/dL 6/1/25 at 8:15 a.m., was 546 mg/dL 5/31/25 at 10:19 p.m., was 401 mg/dL R36's progress notes reviewed from 5/31/25 to 6/30/25 and identified the following: -6/1/25 at 7:16 a.m.: resident blood sugar is 546 without any symptoms. -6/1/25 at 11:41 p.m.: Residents blood sugar was 84 upon returning to facility at 9:30 p.m., and at 10p.m. it was 41, 2 glucose tablets along with pudding, apple juice given, and blood sugar went up to 47. Resident	20265		

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20265	Continued from page 7 ate a cup of oranges and blood sugar went up to 95. -6/24/25: Resident's blood sugar was 600 at 9am so scheduled insulin and sliding scale insulin were given. Rechecked blood sugar at 11am. Message was left for provider. R36's progress notes lacked any additional updates to provider regarding R36's documented high and low blood sugars despite having 20 days of high blood sugars (some days multiple times a day) and 4 days of low blood sugars. Standing Orders for Skilled Nursing Facilities, printed 7/2/25, included the following information on page 3: -If type 1 diabetes, notify the provider if any blood glucose results are less than 70 or over 400 and/or change in condition. -Hypoglycemia - blood glucose less than 70: "If patient is symptomatic, conscious, and able to swallow or has a feeding tube: -Administer 6 oz. fruit juice, milk, other high carbohydrate beverage (e.g., Ensure, Boost), or glucose tables or gel orally or via feeding tube. -Repeat BG [blood glucose] after 15 minutes; if <70 [less than 70], repeat above intervention. -If after 2 attempts to treat and BG is still <70, notify provider." During an interview on 7/1/25 at 9:35 a.m., trained medication aid (TMA)-A stated they took blood sugars and reported the findings to the nurse on the floor. TMA-A stated some glucometers would not read the blood sugar if it was too high or low and they would get the nurse if that happened. TMA-A stated they did not notify providers of information as they reported everything to the nurse on the floor. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and had worked with her often. LPN-A stated if a blood sugar was over "300", staff were to notify the provider. LPN-A stated they would document provider notification in a progress note. LPN-A stated R36 was "all over with her blood sugars."	20265		

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20265	Continued from page 8 During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated they were familiar with R36. LPN-E stated it would vary per resident on when to notify the provider for high or low blood sugars as some residents had parameters on when to notify. LPN-E verified R36 did not have any parameters on when to notify the provider. LPN-E stated the expectation would be that after the provider was notified, it would be documented in a progress note. LPN-E reviewed R36's electronic medical record (EMR) and verified the provider was notified a few times on 6/1/25 regarding R36's high blood sugars and again on 6/24. LPN-E verified there were no other documented notifications in R36's EMR. LPN-E stated she would expect the provider to be notified if the blood sugar was over 451 as that was what insulin orders stopped at. LPN-E reviewed R36's blood sugars and verified she had many blood sugars over 400 in the month of June. During an interview on 7/2/25 at 11:38 a.m., director of nursing (DON) stated the expectation would be the nurses would follow the house standing orders if a doctor did not write specific parameters regarding when to be notified of high and/or low blood sugars. DON stated they expected the provider to be notified if a resident's blood sugar was less than 70 or greater than 400 and expected it to be documented in a progress note. DON stated the provider should have been notified regarding R36 and her blood sugars after review. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated they were familiar with R36. NP-A stated they would expect to be notified if R36's blood sugar was over 450 or below 70. NP-A stated if a resident's blood sugar was over 450, an order would be given to help decrease the blood sugar. NP-A stated when they were notified on 6/1/25 regarding R36's blood sugar being 833, orders for insulin were given to lower her blood sugar along with sending her to the emergency room to be evaluated. NP-A stated the facility communicated with the provider group through "the portal." NP-A reviewed the portal and stated they were notified only a couple of times in June regarding R36's blood sugar being high. A facility policy titled Change in a Resident's Condition or Status, dated 2/2021, indicated "Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status."SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures	20265		

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20265	Continued from page 9 related to notification of change in resident health status and who to notify. The Director of Nursing (or designee) should conduct measurable audits on residents health records to verify that change in health status is being completed and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20265		
20380	Policies Concerning Residents; Telephones CFR(s): MN Rule 4658.0200 Subp. 2 Subp. 2. Telephones. A nursing home must provide at least one non-coin-operated telephone which is accessible to residents at all times in case of emergency. A resident must have access to a telephone at a convenient location within the building for personal use. A nursing home may charge the resident for actual long distance charges that the resident incurs. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure there was reasonable access to private phone use for 1 of 1 residents (R153) reviewed who utilized the facility phone. Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's profile dated 6/23/25, indicated R153 resided on the third floor. During an observation on 7/1/25 at 1:03 p.m., R153 was observed sitting in a wheelchair in front of a long desk with multiple staff members surrounding it, including trained medication aide (TMA)-B and licensed practical nurse (LPN)-A. The long desk at the nursing station was observed at the middle of two parallel hallways on the third floor with resident's rooms and in front of an elevator. R153 was observed talking on a corded phone and asking someone to "get me out of here".	20380	Corrected.	08/26/2025

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20380	Continued from page 10 During an interview at 7/1/25 at 1:12 p.m., R153 stated that he did not have his own phone so had asked the facility staff if there was one he could use. R153 stated the "only phone" offered to him was the phone at the nursing station. R153 stated he asked staff to bring the phone to his room, but they said they couldn't, so he had argued with them about it as he didn't want to talk with his wife in front of all the staff members. R153 stated he felt like he did not have enough privacy when he had to make his phone calls at the nurse's station. During an interview on 7/1/25 at 1:14 p.m. with TMA-B and LPN-A, LPN-A stated most residents had their own phone to use but if they did not, they offered them the phone at the nurse's station. TMA-B confirmed that they had neither a cordless phone nor a private area for residents to use the phone if they wanted. During an interview on 7/1/25 at 1:16 p.m., LPN-E, the third-floor nurse manager, stated the only phone that they had to offer residents on the third floor was a phone that could be utilized at the nurse's station and a more private option was not available. During an interview at 7/2/25 at 10:04 a.m., the administrator stated if a resident was able to pay for it, facility staff would install a phone in a resident's room, otherwise residents were able to use the phone at the nursing stations. The facility's Resident Use of Telephones policy dated 3/17, indicated designated telephones were available for residents to make and receive "private" telephone calls. The policy indicated telephones will be in areas that offer privacy and accommodate wheelchair bound residents. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rights for privacy when using the telephone are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	20380		

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20380 20540	Comprehensive Resident Assessment CFR(s): MN Rule 4658.0400 Subp. 1 & 2 Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set	20380 20540	Corrected.	08/26/2025

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20540	Continued from page 12 (MDS) was completed in a thorough manner to ensure all areas of resident performance and activities preference were evaluated for 1 of 4 residents (R24) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose of providing guidance with how to complete the Resident Assessment Instrument (RAI), and it outlined an admission MDS was considered a comprehensive assessment. The manual listed a section labeled, "SECTION F: Preferences For Customary Routine and Activities," along with directions to complete the section. The directions outlined, "The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities." The manual directed to interact with the resident or, if needed, complete the staff examination if the resident is unable to respond. On 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated they were unsure if R24 would participate even, however, expressed they had never been asked or consulted on R24's activity preferences, either. R24's admission MDS, dated 5/5/25, identified R24 admitted to the care center on 4/28/25 from the acute care hospital and had multiple medical conditions including heart failure, dementia, and a history of stroke/transient ischemic attack (TIA). The MDS section labeled, "Section F - Preferences for Customary Routine and Activities," provided spacing to record answers with gathered data including an Interview for Daily Preferences (F0400) and Interview for Activity Preferences (F0500). However, the entire section of the MDS (F0300 to F0800) was either left blank or marked, "Not Assessed." R24's medical record was reviewed and lacked evidence R24 had been evaluated for their routine and/or activity preferences during the assessment reference date (ARD) period (See F679).	20540		

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20540	Continued from page 13 On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas "dashed" with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was "not acceptable." RN-O reviewed R24's medical record and verified the section of the MDS had been dashed and explained staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and "gives us [staff] an opportunity to see if the resident is progressing or declining." A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, "Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI]." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on MDS completion; then educate staff involved with the RAI process and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	20540		
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 residents (R50) reviewed for hospitalization. Findings include:	20550	Corrected.	08/26/2025

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20550	Continued from page 14 R50's Discharge-return not anticipated Minimum Data Set (MDS) dated 4/13/25 identified discharge from facility was planned and R50 discharged to "Short-Term General Hospital (acute hospital, IPPS)." During record review, R50's nursing progress noted dated 4/13/25 identified "Resident discharged from the facility to home with all her medication and instruction with her family members at 3:30 p.m." During interview with licensed practical nurse (LPN)-A on 6/30/25 at 5:01 p.m., LPN-A stated she recalled R50 and stated, "She went home it was planned". During interview with R50 on 6/30/25 at 6:00 p.m., R50 stated, "Yes I was there and discharged home." During interview with registered nurse and MDS facility liaison (RN)-MDS on 7/1/25 at 10:36 a.m., RN-MDS reviewed R50's electronic medical record (EMR) and stated R50 discharged home on 4/13/25. Further review of R50's Discharge-return not anticipated MDS dated 4/13/25, RN-MDS stated the MDS was coded incorrectly, "it is not accurate". RN-MDS stated expectation for MDS to be coded accurately was "it concerns payment sources". During interview with MDS clinician (MDS) on 7/1/25 at 12:13 p.m., MDS reviewed R50's 4/13/25 Discharge-return not anticipated MDS and confirmed, "we have [R50] dc'd [discharged] to hospital". MDS stated that "it looks like it was coded incorrectly" and "incorrectly coding will affect quality measures for the facility and impacts payment and reimbursement". Facility policy titled Certifying Accuracy of the Resident Assessment, revised 2019 state "The information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit	20550		

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20550	Continued from page 15 other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 2 residents (R37) reviewed for diet preferences/allergies. Findings include: R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood, and the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated the facility was aware of his food allergy. R37 stated he did not eat it, but it happened again just a few days ago and he had followed up with staff. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication	20555	Corrected.	08/26/2025

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20555	Continued from page 16 of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: - Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2-gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our meal	20555		

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20555	Continued from page 17 tracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents' preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions." R37's allergy list, printed 7/2/25, lacked indication of allergy to shellfish, seafood or fish. R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants used the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R37 and worked with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic too. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated residents' food allergies, and their food preferences should be listed on their care	20555		

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20555	Continued from page 18 plan. DON verified R37's food allergies and food preferences were not listed and should be on the care plan. A facility policy titled Care Plan, Comprehensive Person-Centered, reviewed 6/23, "assessment of residents are ongoing, and care plan are revised as information about the residents and the residents' conditions change." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are used and followed in order to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide routine care conferences to allow for resident participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 2 residents (R41) reviewed for care conferences. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24,	20570	Corrected.	08/26/2025

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20570	Continued from page 19 indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's electronic medical record (EMR) indicated R41 had one care conference since being admitted to the care facility. A progress note, dated 10/24/24, indicated R41 "had her care conference today at 1:00pm. Pt [patient], SW [social worker], and Nurse Manager were in attendance." During an interview on 6/29/25 at 3:07 p.m., R41 stated she had "been to maybe one" care conference since being admitted to the facility and had concerns about her care. During an interview on 7/1/25 at 8:17 a.m., licensed social worker (LSW)-A stated the resident care conferences and care plan review should be held "roughly" every three months and generally coordinate with the MDS cycle. LSW-A stated she had not held a care conference for R41 as R41 had "not been agreeable", however stated the interdisciplinary team should still meet quarterly to discuss the residents' care, even if the resident did not want to participate. LSW-A stated timely and routine care conferences were important to ensure there were no resident changes the team may have missed. During an interview on 7/2/25 at 12:06 p.m., the director of nursing stated it was expected that care conferences were held quarterly, even if the resident did not want to participate. A facility policy titled Care Plans, Comprehensive Person-Centered, revised 6/2023, indicated the interdisciplinary team would review and update the care plan at least quarterly, in conjunction with the required MDS assessment. The facility could review policies and procedures related to timely care conference and subsequent care plan revision. Social Services (or designee) should conduct measurable audits on residents' care conferences to ensure they are being conducted timely. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20570		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial	20830	Corrected.	08/26/2025

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20830	Continued from page 20 care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and develop interventions as needed to reduce the risk of accidents or injury for 2 of 2 residents (R38, R41) reviewed with a history of substance abuse and suspected current use. In addition, the facility failed to implement interventions for 1 of 1 resident (R35) reviewed for falls. Findings include: R41's quarterly minimum data set (MDS), dated 7/3/24, indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's diagnoses list, dated 7/13/24, indicated R41 had several medical diagnoses including psychoactive substance dependence. R41's Associated Clinic of Psychology (ACP), dated 5/20/25, indicated facility staff informed the ACP practitioner of concerns of suspected substance use, which was also listed as a barrier to care on the ACP visit note. R41's electronic medical record (EMR) lacked any documented interventions, assessments, or monitoring protocols related to suspected substance use. Furthermore, there were no care plan elements or guidance in place outlining staff responsibilities or actions to take if substance use was suspected. The absence of such documentation and intervention planning presents a potential risk to R41's health and safety, as well as to the safety and well-being of other residents and staff in the facility. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she had not seen R41	20830		

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20830	Continued from page 21 using drugs but had suspected it on more than one occasion. TMA-B stated when she suspected R41 of substance use, R41 would be doubled over in her chair with glassy eyes, pinpoint pupils and slurred speech. TMA-B stated, "you can tell she is on something" confirming she has reported the concern to the nurse manager more than once but "nothing is getting done." TMA-B stated something needed to be done because "anything could happen". During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and licensed practical nurse (LPN)-E stated she was aware R41 had a history of substance use and stated staff have reported smelling "burning" coming from R41's room at times. LPN-E confirmed there was no care planned interventions for suspected substance abuse, but should be, stating it would be expected that staff check on R41 every 15 minutes if they suspected she was using substances. R38's significant change Minimum Data Set (MDS) dated 6/23/25, indicated R38 had intact cognition with no delusions, hallucinations, or rejection of care behaviors. The MDS indicated R38 was independent with chair/bed-to-chair transfers and could wheel 150 feet in a wheelchair independently. The MDS indicated R38 was diagnosed with heart failure, kidney disease, diabetes, anxiety, and depression. R38's hospital note dated 1/4/25, indicated R38 was brought to the emergency department due to "abnormal movements". The note indicated R38 had reported to hospital staff that he had "smoked crack cocaine" two days prior. R38's care plan dated 1/6/25, included a care plan titled "substance use disorder" and indicated R38 had tardive dyskinesia (involuntary muscle movements) related to "cocaine" use, with the sole intervention being that the resident will be offered chemical use counseling as appropriate. During an interview on 7/1/25 at 9:50 a.m., R38 stated he had used methamphetamine (meth) once, but he didn't like it so did not plan to use it again. R38 stated he had smoked crack cocaine in the past but could not recall the last time this had occurred and claimed he had never smoked crack while residing at the facility. R38 stated he was trying to get himself "completely healthy" so he wasn't using anymore and only gets "98 bucks" a month, so he couldn't buy crack now even if he wanted to. R38 confirmed he had been offered chemical	20830		

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20830	Continued from page 22 use counseling, but did not want the services. During an interview on 6/29/25 at 8:58 a.m., R153 stated R38 "does crack" at night. R153 stated he hears the "click, click, click, of the lighter" but has not seen R153 use crack cocaine. R153 stated he hadn't told staff about it, but "they should know". On 6/30/25 at 1:33 p.m., R153 stated that in the last week, R38 had asked him for money to buy "crack". R153 stated R38 would barricade the door with a dresser when he was "smoking crack," and R38 told him he would hurt him if he put his call light on while he was smoking. R38 stated the last time this happened was on either Friday (6/27/25) or Saturday (6/28/25) night. During an interview on 6/29/25 at 12:55 p.m., licensed practical nurse (LPN)-B confirmed she was the nurse in charge of R38's care this shift. LPN-B stated that facility staff had suspected that R38 was using illicit drugs, but she had never observed signs or symptoms of this herself. When asked what monitoring was in place regarding R38's suspected illicit substance use, LPN-B stated they "probably should" but did not currently have any monitoring in place or a plan for if illicit substance use was suspected. During an interview on 6/30/25 at 1:57 p.m. with the administrator and director of nursing (DON), the administrator stated they had not been notified of any allegations of R153's using crack cocaine, and the DON confirmed she had also not been aware of these allegations and had not seen any symptoms of intoxication or been notified of anyone finding any drug paraphernalia, and was unsure if further assessments had been completed regarding R38's illicit substance use. During an interview on 7/2/25 at 10:01 a.m., the DON stated if a resident had a known history of illicit substance use, she would expect this to be care planned and assessed for, as well as implementing monitoring for signs or symptoms of substance abuse as well as collaborating with the provider for any additional orders if needed. The DON stated this monitoring would be outlined in either the care plan or orders. R38's medical record was reviewed, and it did not indicate that monitoring for illicit substance use was in place or that a comprehensive assessment of R38's substance abuse disorder had been completed. The facility's Substance Abuse Policy dated 6/29/25, indicated if a resident had a substance abuse disorder or displayed the potential for a substance abuse disorder, the facility would assess the residents to	20830		

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20830	Continued from page 23 determine substance abuse disorder "triggers", therapies/support available, and the resident's willingness to participate in substance use disorder services. The policy indicated that facility staff would assess for substance abuse disorders and triggers upon admission, readmission, and quarterly. The policy indicated that, based on assessment outcomes, an individual care plan would be developed and provide approaches for reducing triggers for substance use. The policy indicated it was "essential" to monitor if a resident who was suspected of illegal drug use was a danger to themselves, others, and /or staff. R35 Falls R35's annual assessment dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of osteoporosis, asthma, Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required staff assistance with most activities of daily living. R35's care plan printed 6/29/25, indicated R35 was independent to turn and reposition in bed and transferred with staff supervision. R35 was at risk for fall related to Alzheimer's disease and safety awareness. The care plan indicated R35's last fall was 5/20/24. The care plan's fall interventions included: -Anticipate and meet the resident's needs dated 1/29/24. -Be sure call light within reach and encourage resident to use it for assistance as needed dated 5/16/24. -Physical therapy to evaluate dated 5/20/24. -Physical therapy to evaluate and treat as ordered or PRN (as needed) dated 10/16/24. -Obtain order for physical therapy to evaluate and treat for 12/16/24 fall dated 12/18/24. -Keep walker next to bed for fall on 12/1/24 dated 1/28/25. R35's Resident Fall Risk assessment dated 6/25/25, indicated R35 was at "high risk" for falls related to intermittent confusion, history of one to two fall in the past three months, ambulatory and incontinent, took one or two of the medications indicated in the assessment currently and/or within the last seven days, and had one or two of the indicated predisposing diseases.	20830		

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20830	Continued from page 24 R35's progress notes indicated: -On 6/13/25 at 6:30 p.m., R35 was found on the floor next to the nursing station. R35 had her shoes on and stated she tried to stand up and twisted her leg and sat on the floor. R35's vital signs were noted, and R35 stated she did not have pain. R35 was able to move her upper and lower extremities without pain. R35 was helped to wheelchair with Hoyer lift and two nursing assistants. Family member (FM)-R, nurse manager, and provider were called. Neurological checks were started. -On 6/16/25 at 9:52 a.m., an interdisciplinary note indicated R35 was demented and forgot good body mechanics during movements. Physical therapy was requested to strengthen her mobility. R35's Un-witnessed Fall risk management assessment dated 6/13/25, indicated an incident description and immediate action taken which repeated information from the progress note dated 6/13/25. The assessment indicated no predisposing environmental factors, physiological factors including confusion and fear of falling, and situational factors of ambulating without assistance and using a walker. R35's electronic health record did not indicate therapy involvement after her fall. During interview on 06/29/25 at 10:56 a.m., FM-R stated R35 fell about a couple weeks ago, and R35 had no pain and did not need to be sent to the hospital. FM-R stated they did not know about any new intervention the facility implemented, and the facility continued with the current fall interventions. During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated staff stayed with residents who they found on the floor and called the nurse. NA-A stated the nurse assessed the resident and determined if 911 needed to be called or if staff could move residents using a Hoyer lift. NA-A stated fall interventions were noted in residents care plans and staff read the care plans every day. NA-A stated R35 was "not really" a fall risk but always made sure R35 had her walker and reminded R35 to lift her feet. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses were called when a resident had an unwitnessed or witnessed fall. RN-A stated nurses took residents' vital signs, performed neurological checks, checked for injuries and range of motion. Nurses determined if the resident was safe to	20830		

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20830	Continued from page 25 move or if 911 was needed. RN-A stated nurses notified the family, manager, and provider. A risk management assessment was completed of each fall to describe the situation and what interventions were implemented. RN-A stated R35 was a fall risk and stayed close to staff for monitoring. RN-A stated fall interventions prevented R35 from future falls. RN-A stated nurses obtained therapy orders if therapy was a fall intervention, so therapy could work on strengthening with residents. RN-A thought R35 was being seen by therapy. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapies most recent encounter with R35 was in September of 2024 for speech therapy. DOR stated she was at a meeting where therapy was discussed after her last fall but did not see any orders come through to start therapy with R35. DOR stated therapy orders from the provider came through nursing or the health unit coordinator and they usually received a therapy order within a couple days after discussed, and indicated R35's fall risk management was signed on 6/17/25. During interview on 7/2/25 at 11:38 a.m., licensed practical nurse (LPN)-B reviewed R35's risk management assessment related to R35's fall on 6/13/25. LPN-B stated an immediate intervention should have been implemented and verified R35 had no current therapy orders. LPN-B stated nurses were able to obtain therapy orders within 24 hours unless the order was needed over the weekend. LPN-B stated fall interventions were important to prevent falls, and physical therapy would help strengthen R35. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to implement immediate fall interventions, review and discuss falls, and update the care plan. The DON stated staff were able to get therapy orders timely to give to the therapy department. The DON stated implementation of fall interventions were important to prevent residents from repeated falls. The facility Falls - Clinical Protocol dated November 2022, directed the staff and physician to assess residents at risk for falls and residents who have fallen to identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The facility Falls and Fall Risk, Managing policy dated November 2022, directed staff to implement a resident-centered fall prevention plan to reduce the	20830		

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20830	Continued from page 26 specific risk factor(s) of falls for each resident at risk or with a history of falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff and monitor to ensure all residents were assessed for safety related to illicit substance use. The DON could educate all staff on these systems. The DON or designee could report the findings to the Quality Assurance Committee and complete audits to ensure compliance. The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 resident (R23) reviewed for limited range of motion (ROM). Findings include:	20895	Corrected.	08/26/2025

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20895	Continued from page 27 R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). The MDS indicated R23 was not on a restorative nursing program during the look-back period (LBP). R23's care plan printed 6/30/25, indicated R23 required extensive assistance of two staff to turn and reposition in bed, extensive assistance of one staff to transfer between surfaces, encourage resident to participate to the fullest extent possible with each interaction, and physical and occupational therapy to evaluate and treat as per provider orders. A functional maintenance program directed nursing to assist patient with applying AFO (ankle-foot orthosis) foot brace to right foot and then ambulate 100 feet with CGA (contact guard assist) and quad cane (walking aid with a base which has four legs or prongs). The care plan identified R23 refused to walk and refused to wear the AFO brace with date of 1/4/25. R23's ROM and Mobility assessment dated 5/6/25, indicated had an impairment on onside of both upper and lower extremity and was not steady and only able to stabilize with staff assistance to move from a seated to standing position. The assessment indicated walking, moving on and off a toilet seat, and surface-to-surface transfer did not occur. R23 used a wheelchair. The assessment indicated direct care staff believed R23 was capable of increased independence in at least some ADLs and did not include interventions/exercises to ensure R23 maintained his ROM if needed. R23's physician order dated 11/16/21, included nurse to ensure resident wore AFO brace to his right foot when out of bed every shift with start date of 11/16/21. R23's Treatment Administration Record (TAR) dated June 2025, directed nurses to ensure R23 was wearing his AFO brace to right foot when out of bed every shift. All three shifts were marked as completed every day except for three morning shifts. R23's progress notes dated 12/13/25 to 7/1/25, indicated one refusal to wear AFO brace.	20895		

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20895	Continued from page 28 R23's medical record did not indicate interventions/exercises for R23's right upper extremity. During observation and interview on 6/29/25 at 9:14 a.m., R23's right arm was in a sling and right-hand fingers were curled towards his palm. R23's right foot was on the wheelchair pedal and left foot was on the ground. R23 did not have a leg brace on. R23 stated staff did not complete exercises with him. During observation on 7/1/25 at 7:42 a.m., R23 was dressed and in his wheelchair. R23 had a sling on and no brace on his legs. During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his room in his wheelchair. R23 stated yes when asked if staff completed exercises with him today. R23 did not have a brace on his legs. When asked about the leg brace, R23 used his left foot to propel in his wheelchair to his closet and opened the closet. A leg brace was not found in his closet. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated they were unaware of any boot or brace for R23. NA-K stated he used to have a brace for his leg and was unsure if nursing stopped the brace. NA-K stated they completed range of motion with R23 but did not document the range of motion they completed. NA-K stated approximately four days ago they opened R23's right hand to clean it. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R23's care sheet, which indicated R23 did not walk and "AFO [right] foot when out of bed which is refused by resident". LPN-A stated staff should notify them if R23 refused the AFO brace, so LPN-A could write a progress note and let the provider or therapy know if needed. LPN-A observed R23's right hand and stated nursing could recommend therapy for R23. During interview on 7/1/25 at 12:30 p.m., NA-J stated R23's hand condition was unchanged since previous and had never seen a brace for his legs. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapy had not been recently involved with R23's right upper extremity or AFO brace. DOR expected to be notified of a change in AFO brace, and occupational therapy addressed concerns with residents' hand mobility. DOR stated R23 had MA (medical assistance) pending for insurance coverage, and the business office was involved with setting R23	20895		

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20895	Continued from page 29 up with a guardian since R23 was nonverbal. DOR reviewed R23's therapy file which included: -R23's Functional Maintenance/Restorative Nursing Program form undated (copy provided had bottom part cut off), indicated treatment recommendations to assist R23 with right foot AFO brace and walk patient 100 feet using a quad cane daily and six days per week. The goal of the recommendation was to reduce effects of debility, prevent deconditioning, and reduce risk of fall. -R23's Rehabilitation Screen dated 1/17/22, indicated R23 needed short distance ambulation with right AFO boot to reduce nursing dependency. -A physician order dated 8/24/22, directed physical therapy to evaluate and/or treat for strengthening with ambulation. -A physician order dated 1/14/24, indicated for a right AFO brace and a face-to-face for power wheelchair. -A physician order dated 1/22/24, directed physical therapy and/or occupational therapy to evaluate and treat R23 related to nerve pain and weakness in upper and lower right side. The order indicated R23 felt his upper and lower right side had a change from his baseline. No further information was provided. During interview on 7/2/25 at 10:38 a.m., LPN-E stated R23's AFO brace was important for R23's foot to help with support since R23 had a stroke. LPN-E stated the AFO brace was not in R23's room anymore, so staff were checking with therapy. LPN-E stated they were unsure how long R23's right-hand fingers had been curled and expected staff to notify nursing and therapy. During observation and interview on 7/1/25 at 11:38 a.m., LPN-A was slowly able to open R23's right-hand fingers and observe R23's palm. No skin breakdown was noted. LPN-A stated therapy should work with R23 to improve his finger mobility. During interview on 7/2/25 at 1:58 p.m., the director of nursing stated limited hand range of motion should be addressed by therapy and nursing should update the care plan and orders as indicated. The DON expected staff to follow-up immediately if a brace was found to be unavailable. The DON expected staff to prevent contractures.	20895		

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20895	Continued from page 30 The facility Range of Motion Exercises policy dated October 2010, directed staff to verify if there was a physician's order for the exercise to perform and contact the provider to obtain treatment orders if there were no orders for the exercise. The policy directed staff to document the date and time the exercise was performed, the name and title of who performed the procedure, type of ROM exercise, whether the exercise was active or passive, how long the exercise was conducted, any problems or complaints made by the resident during the exercise, and reason why and intervention taken if the resident refused the treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, interview, and record review the facility failed to identify, implement, monitor and modify interventions to provide timely treatment and services to heal and to prevent further worsening of	20900	Corrected.	08/26/2025

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20900	Continued from page 31 wounds. This failure resulted in harm for R254 when his bilateral heel pressure ulcers were not identified and addressed by facility until they progressed to stage three. Findings include: According to the national pressure injury advisory panel (NPIAP), pressure injury is defined as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. In addition, the evolution of a deep tissue pressure injury (DTI) develops from an exerted pressure about 48 hours before visible signs of purple or maroon skin. Then, about 24 hours later, the epidermis (layer of skin) lifts and reveals a dark wound bed. A stage three pressure ulcer/injury is defined as a full thickness loss of skin. R254's admissions Minimum Data Set (MDS) dated 7/17/24, and quarterly MDS dated 10/1/24, identified risk for developing pressure ulcers, had no pressure ulcers, no unhealed pressure ulcers, no unstageable pressure ulcer/injuries, and no deep tissue injuries. In addition, R254 had intact cognition, no impairment of upper and lower extremities, and was independent with self-care and mobility. R254's significant change in status (SCSA) MDS dated 11/22/24, identified two stage three pressure ulcers, with none of them present upon his admission to facility. In addition, R254 had severe cognitive impairment and was dependent on staff for toileting, bathing, personal hygiene. Also, R254 required assistance with mobility including sit to lying and lying to sitting on side of the bed. R254's admission MDS care area assessments (CAA) dated 7/17/24, identified "Potential" risk factors for pressure ulcers. Section of form to identify "Supporting Documentation. Provide the basis/reason for items being checked, including the location & date & source" was left blank. R254's CAA for the 11/22/24, SCSA MDS identified "Actual" problem for Pressure Ulcer/Injury and, "Skin breakdown with risk for further breakdown and impaired healing related to terminal condition." The Care Plan Considerations identified current pressure ulcer would be addressed in the care plan with overall objective to "Slow or minimize decline." R254's medical diagnoses include diabetes, rheumatoid arthritis, depression, hypertension, and congestive heart failure (CHF).	20900		

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20900	Continued from page 32 The Braden Scale for Predicting Pressure Ulcer Risk is an evidence-based assessment tool in health care used for predicting a patients' risk of developing pressure ulcers. It allows health care professional to implement preventive measures effectively. Scores of less than 9 indicate "Severe Risk", scores of 10-12 indicate" High Risk", scores of 13-14 indicate "Moderate Risk", and scores of 15-18 indicate a "Mild Risk". R254's Braden assessment scores (scale to assess patients' risk of developing pressure injuries) were: 7/11/24 score of 18, 9/27/24 score of 15, 10/6/24 score of 15, 11/7/24 score of 17, 11/14/24 score of 15, and 11/22/24 score of 16. R254's care plan with focus on Skin identified "resident have actual wounds to both heels and potential for impairment to skin integrity fragile skin." Date initiated was 8/15/24. CP Interventions identified "Reposition Frequently" and "Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations" was initiated 1/5/25-four days before R254 expired. R254's provider progress notes (PN) dated 7/15/24, 7/16/24, 7/17/24, 8/21/24, 8/23/24 identified "No rash, or lesions" under Examination section of form. Provider PN dated 9/6/24 identified, "No breakdown in hands or heels" and to "monitor for acute skin care breakdown". R254's hospital discharge summary (DC) dated 9/23/24, identified hospitalization from 9/13/24 to 9/23/24 for urinary retention and urinary tract infection. DC summary identified, "no rashes, ulcerations on exposed skin surfaces". Upon admission to hospital R254 had bruising to coccyx which was identified 9/14/24, with no other skin issues identified. During review of PN dated 9/25/24 identified R254 readmitted to facility from hospitalization. PN failed to indicate any assessment or issues with skin integrity. PN dated 10/2/24 at 5:23 p.m., identified R254 "felt like[sic] had an [sic] heart attack, and	20900		

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20900	Continued from page 33 would like to go to the hospital for checkup." Orders were received to send to hospital. PN dated 10/3/24 at 11:07 p.m., stated R254 returned from "hospital at 3:15 p.m." and failed to indicate any assessment or issues with skin integrity. R254's hospital DC summary dated 10/3/24, identified R254 hospitalized 10/2/24 to 10/3/24 for report of chest pain. During hospitalization on 10/2/24 a "Pressure Injury: Suspected Deep Tissue Injury" to left and right heels were first observed on 10/2/24 at 10:58 p.m., and both wounds were identified has being present "Prior to Admission". R254's weekly bath audits (BA) dated 10/7/24, 10/14/24, 10/21/24, 10/28/24, 11/4/24, 11/11/24, 11/17/24, 12/3/24, identified, "no new alterations in skin". BAs were marked as, "weekly wound assessment initiated and completed." R254's podiatry consultation noted dated 10/22/24, identified "ulcer heels" and "monitor pressure". R254 was admitted to hospice services on 11/14/24, with terminal diagnosis of congestive heart failure. R254's hospice admission note identified, "bilateral stage 3 pressure injuries on heels". R254's provider orders (PO) dated 11/22/24, initiated PO for left and right heel ulcers. The PO for left heel identified, "left Heel wound order: cleanse with vashe (wound cleanser), skin prep to area, santyl (topical medication used to clean and remove dead tissue) to wound bed and apply mepilex (a foam dressing) to area, change daily". PO for right heel identified, "Right heel wound orders: cleanse with vashe, paint heel with betadine, cover with gauze 4x4 and wrap with kerlix, change daily". During review of R254's EMR, the documentation of R254's left and right heel ulcers by infection control preventionist and facility wound nurse (IP) began on 11/12/24 by using the Skin and Wound Evaluation assessments. Measurements of wounds include: Left heel: 11/12/24: 1.5 centimeters (cm) long x 1.7 cm wide x 1.2cm deep. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. Notation of, "This is a new wound." Right heel:	20900		

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20900	Continued from page 34 11/12/24: 5.5cm x 3.6cm x 2.2cm. Indicated this was a New, Stage 3 Full-Thickness skin loss and In House Acquired. R254's provider PN dated 12/10/24, identified "Chief Complaint: f/u wound rounds." PN stated pressure ulcers of left and right heel were "unstageable." Left heel measurements were: 11/12/24: 1.73 cm x 1.27 cm, 11/15/24: 2.2cm x 1.3 cm, 11/22/24: 2.8cm x 2.6cm, 12/10/24: 3.5 cm x 4.4cm. Right heel measurements were: 11/12/24: 4.47cm x 3.0cm, 11/22/24: 4.7cm x 6.6cm, 12/10/24: 4.0cm x 6.2 cm. During review of R254's Skin and Wound Evaluation assessment for 12/27/24, the left heel wound measurements were 2.1cm x 2.3cm x 1.2cm deep and the right heel measurements were 8.7cm x 4.4cm x 2.7cm deep. During interview with wound care provider (WP) on 7/1/25 at 8:15 a.m., WP stated facility wide wound care rounds were performed with infection control preventionist (IP) twice per week. WP stated IP developed a list of residents who needed to be seen each time. WP stated facility nurses "will tell [IP] of new wounds" and IP assessed and obtained new wound care orders. IP then added these residents to his bi-weekly wound care rounds for monitoring and managing of wounds. During interview with director of nursing (DON) on 7/2/25 at 7:37 a.m., DON stated she was familiar with R254 because DON was the nurse manager on the unit where R254 lived on during the entire time of his facility stay. DON reviewed 10/3/25 hospital DC summary and agreed the documentation identified bilateral heel DTI's. DON reviewed R254's electronic medical record (EMR) and stated she was unable to determine if R254's DTIs were identified at the facility prior to R254's hospitalization on 10/2/24. DON stated expectation of	20900		

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20900	Continued from page 35 staff members who identify impaired skin issues to "report ASAP to nurse, the nurse should assess and update the provider and document [sic] it in progress note". DON stated, first note of impaired skin issues with R254 was on 11/14/24, with the PO for wound care orders to both heels. DON stated R254's CP "should have been updated and was not". DON stated first indication of wound care for R254 was placed in CP on 8/15/24, but not acted on until 11/14/24, when the IP obtained the PO. DON stated importance of identifying and acting on impaired skin integrity "is to ensure appropriate interventions are initiated immediately". DON stated she was unable to determine when R254's DTIs occurred by looking at his EMR. During interview with LPN-B on 7/2/25 at 11:46 p.m., LPN-B stated expectation of staff to assess and "check [residents] skin upon hospital return" including feet and coccyx. LPN-B stated any new or developing skin issues should be addressed right away and provider should be contacted, orders received and notify the IP. In addition, a PN should be put in the EMR. LPN-B stated expectation of "all skin" to be checked weekly with the bath and documented in the "weekly bath audit". During interview with LPN-A on 7/2/25 at 11:57 a.m., LPN-A stated expectation of staff to assess and "check skin" and to document in the EMR under the PN about skin condition. If there was a new skin injury, then staff were expected to "chart it and notify the wound team". LPN-A stated CP interventions for skin care were changed and updated by the IP "when they review [the wounds]". During interview with LPN-B on 7/2/25 at 12:53 p.m., LPN-B stated a "body audit should be done for all [residents] readmitting" to facility. LPN-B reviewed R254's EMR and stated, "no there is nothing there.". LPN-B stated she remembered R254 during his facility stay and stated "I remember seeing them [bilateral pressure ulcers to heels] two months before [R254] passed. Me and [IP] were doing something for [R254] and noticed it while changing his socks. I remember seeing it for the first time saying, 'oh my God'. I did not document anything. That is [IP]'s job. IP is the wound nurse and should have done it," and continued, "No, I do not see it was done". During interview with medical director (MD) on 7/2/25 at 8:58 a.m., MD reviewed R254's EMR and physician notes and stated, "I expect the facility to have assessed [R254's] heels prior to [sic] admission to the hospital in October [10/2/24]." MD stated R254's EMR	20900		

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20900	Continued from page 36 lacked orders, progress notes, and other documentation to support identifying R254's bilateral heel PU's until they progressed to stage three. MD stated, "[it was] most likely avoidable." During interview with IP on 7/2/25 at 8:28 a.m., IP stated he was familiar with R254 during his facility stay. IP reviewed R254's EMR and stated, "[11/12/24] is when we first identified [R254's] heel ulcers." IP stated he did not obtain PO for R254 until 11/14/24, and IP failed to document in the PN. IP stated expectation of staff to "notify me ASAP" when there is a new or worsening skin issue, "then, I will assess and get orders from the [provider] and put the resident on 'weekly wound rounds'". IP stated, "we missed it and should have taken steps earlier to address [R254's] wound to his heels." IP reviewed R254's hospital DC summary dated 10/3/24, and stated, "it shows there was identified DTI's to both heels at the time. We [Facility] did not identify any concerns until 11/12/24". IP stated R254's bilateral heel wounds, "should have been addressed by us before 10/2/24 [when R254] was admitted to the hospital". IP stated wound care rounds involve IP "putting names on paper for people who I look at for wound rounds and then do the rounds with the provider" and document in the EMR. IP stated the Braden documentation was used by the facility to determine pressure injury risk. During interview with hospice vice president of clinical operations (VP)-M on 7/2/24 at 11:23 a.m., VP-M reviewed R254's admission paperwork to hospice services on 11/19/24 and stated R254 had "two wounds on admission. Stage three right and left heel pressure ulcers." During interview with IP on 7/2/25 at 11:44 a.m., IP stated expectation of the nurse at facility to perform a skin integrity assessment every time a patient came back from hospital and write a PN in the EMR. IP reviewed R254's EMR and stated it failed to show a skin assessment was done and PN failed to identify any issues with skin integrity when R254 returned to the facility on 10/3/24. During interview with regional director (RD), administrator, and DON on 7/2/25 at 12:11 p.m., RD stated R254 "could have gotten it [DTI's] from the hospital or transport". Also, RD stated, "[facility] identified our documentation was not up to par" and that R254 "had a history of refusing care" despite no interventions to address any refusals. During interview and review of IP Wound Rounds notes	20900		

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20900	Continued from page 37 (WRN) dated 7/1/24 to 9/17/24, and 12/3/24 to 1/3/25, with IP on 7/2/25 at 11:44 a.m., IP stated he was unable to find the WRN's for dates between 9/17/24 to 12/3/24. WRN for 8/20/24 identified a listing titled "Pressure Ulcer" with three resident names including R254 and no other information. IP reviewed his notes and EMR and was unable to determine rationale for listing R254 with PU on 8/20/24. WRN for 8/27/24 identified R254 being seen for "Rash-Ointment to be ordered." WRN dated 12/3/24, 12/6/24, 12/17/24, 12/20/24, 12/27/24, 1/3/25 identified R254 as being seen. During interview with hospice team leader (H)-TL on 7/7/25 at 9:48 a.m., H-TL identified R254's hospice nurse manager no longer works for facility and reviewed R254's hospice admission paperwork. H-TL stated R254 had two stage three PU's to his heels on admission to hospice services on 11/19/24 and stated, "facilities can just 'let them go' and not do a good job of preventing or lessening the progression of pressure ulcers" in residents who are on hospice. HT-L confirmed R254 passed away at the facility on 1/9/25. Facility policy titled Prevention of Pressure Injuries, revised April 2020 identified "Inspect the skin on a daily basis" and "Inspect pressure pointes (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.)". Facility policy titled Pressure Injury Risk Assessment, revised March 2020 identified purpose "to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs)". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		

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20900 20915	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 A Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene cares for 1 of 1 resident (R23) reviewed who needed assistance with fingernail care. Findings include: R23's quarterly Minimum Data Set dated 5/11/25, indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). The MDS indicated R23 needed substantial/maximal assistance with person hygiene which included combing hair, shaving, washing/drying face and hands, etc.. R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). R23's care plan printed 6/30/25, directed staff to check nail length and trim and clean on bath day and as	20900 20915	Corrected.	08/26/2025

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20915	Continued from page 39 necessary and to report any changes to the nurse. The care plan indicated R23 required extensive assist of one staff for personal hygiene. R23's Treatment Administration Record (TAR) dated June 2025, directed staff to complete a weekly skin review and/or bath, and nursing staff to open a skin review assessment and complete. The order directed staff to chart all refusals in the evening every Wednesday. The order had a start date of 7/12/23 and discontinued date of 6/27/25. R23's Weekly Bath Audit dated 6/25/25, indicated R23 received a bed bath, did not have any new skin alterations, and was not resistive to or refused bathing. The audit did not reference nail care. R23's Point of Care (POC; an app which allows care staff to document ADLs) documentation, indicated R23 refused bathing on 6/25/25. R23's recent progress notes indicated R23 was seen by podiatry for foot care on 6/17/25. R23's progress notes did not indicate fingernail care or refusals of fingernail care. During observation and interview on 6/29/25 at 9:11 a.m., R23's nails were multiple millimeters (mm) in length with dark debris underneath them. R23 stated staff assisted him with nail care, and he would like his nails cut. During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his wheelchair and dressed. R23's nails were in the same condition as the previous observation. R23 reiterated he wanted his nails cut and cleaned. During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated R23 refused to have his nails cut at times and told the nurse when he refused. NA-K stated they would cut his nails after lunch. During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A stated residents nails were trimmed on bath days and refusals should be	20915		

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20915	Continued from page 40 documented. LPN-A verified the condition of R23's nails and stated his nails needed to be trimmed. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected nail care to be completed with weekly showers and as needed to prevent infection and maintain resident dignity. The facility policy Care of Fingernails/Toenails dated February 2018, indicated nail care included daily cleaning and regular trimming, and proper nail care aided in the prevention of skin problems around the nail bed and from accidental scratching and injury to residents' skin. The policy directed staff to document the reason why and intervention taken if a resident refused nail care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents requiring assistance from facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently. The results of those audits should be taken to QAPI to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20915		
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 3 of 3 residents (R12, R8, R153) who complained about cold food at meals. This had potential to affect a total of 25 residents identified to reside on the unit where the meals were served and sample tray tested. Findings include: R12's quarterly Minimum Data Set (MDS), dated 1/18/25, identified R12 demonstrated no delusional thinking.	20960	Corrected.	08/26/2025

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20960	Continued from page 41 However, the section to record R12's cognition was dashed with, "Not Assessed [See F638]." On 6/29/25 at 10:53 a.m., R12 was interviewed about his quality of life at the care center. R12 complained about the food and described it as "garbage," and "nasty." R12 stated the meals were often served cold and he wanted warm food to eat. R8's quarterly MDS, dated 6/20/25, identified R8 demonstrated no delusional thinking. On 6/29/25 at 10:23 a.m., R8 was interviewed and expressed aloud, "The food sucks." R8 explained the kitchen rarely seemed to have meat products but rather just carb-filled food items which he disliked due to having diabetes. R8 explained the food was often served cold adding this occurred, "Most of the time." R8 stated "most of the time" the meals delivered via room tray were often served cold and the aides rarely would heat it up even if asked adding, "The aides don't do [expletive] here." R8 reiterated his displeasure with the meal service and stated, "This place just sucks." R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25, but a cognitive assessment had not yet been completed. During an interview on 6/29/25 at 8:50 a.m., R153 stated the food was "garbage," tasted like "dog food," and was always "freezing cold" when it should be hot. On 6/29/25, the following observations and interviews occurred: -At 11:52 a.m., cook (CK)-A stated they already temped the food for lunch. CK-A stated the temped the pork loin which was above 170 degrees Fahrenheit and did not need to temp the cabbage, potatoes, or other items. CK-A was unsure of where to write down the food temperatures. Dietary aide (DA)-C stated the food carts were already brought upstairs for service. DA-A was still in the kitchen collecting serving items with food in pans and covered on their cart. -At 12:03 p.m., DA-A stated they went to the second floor as soon as possible to turn on the steam table and ensure serving items were stocked. DA-A started to scoop food onto plates and serve to residents in the dining area. DA-A was not observed to temp the food before service. -At 12:42 p.m., some room trays were set up and plated on the cart and others were not. DA-A was not in the dining area. -At 12:47 p.m., DA-A returned to the dining area with a	20960		

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20960	Continued from page 42 sandwich. -At 12:55 p.m., DA-A stated they plated up the last room tray. A test tray was requested, plated, and placed on the cart. Some room trays were already brought to rooms and other rooms trays were still on the cart. -At 12:59 p.m., there were still room trays on the cart and DA-A went to the kitchen on the first floor to bring up a resident's alternative meal option. -At 1:02 p.m., DA-A plated a meal for a new resident. -At 1:05 p.m., the test tray was taken for another resident. -At 1:09 p.m., DA-A stated the last tray on the cart could be used as a test tray instead of the initial one which was taken for a resident. The director of nursing (DON) sampled the pork loin, potatoes, and cabbage. The DON stated the pork loin and cabbage could be a "little warmer". During interview on 6/29/25 at 1:31 p.m., DA-A stated they heard about complaints of cold food. DA-A stated they asked others about temping food once on the steam trays and were told they did not need to temp the food. During interview on 7/1/25 at 2:20 p.m., CK-C stated they temped all the food to ensure the food was hot or cold and had a temperature log they filled in. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to temp and track all food and temp again after placed in the steam tables. CD stated temping food was important to ensure food was cooked appropriately and prevent food poisoning. During follow-up interview on 7/2/25 at 10:22 a.m., CD reviewed the temperature log and verified the pork loin and cabbage were not items listed as temped on 6/29/25 for lunch. CD expected food to be served at appropriate temperatures to avoid bacteria growth, and residents liked hot food. The facility Food: Quality and Palatability policy dated 2/2023, indicated food would be palatable, attractive, and served at a safe and appetizing temperature. The facility Time and Temperature Control and Recording policy undated, directed staff to record final cooking temperatures on the Cooking Temperature Log and check	20960		

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20960	Continued from page 43 good temperatures when food was placed in steam table or hot holding unit and at least every two hours thereafter. SUGGESTED METHOD OF CORRECTION: The director of nutrition services, or designee, could review applicable policies and procedures to ensure timely serving of prepared food items to ensure palatability; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	20960		
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food allergens and/or preferences were followed for 3 of 4 residents (R258, R35, and R37) reviewed for food allergens/preferences. Findings include: R258 R258's quarterly minimum data set (MDS), dated 6/25/25, indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. R258's face sheet, printed 7/2/25, indicated R258 had several allergies including cornstarch, gluten, and soybean Oil. R258's care plan, dated 6/19/25, indicated "resident [R258] has reported food intolerances that cause abdominal pain (corn starch, dairy (butter, American Cheese & Hard Cheeses ok), egg whites (ok if cooked into things), gluten, soy, soybean oil." The care plan contained an intervention, dated 2/10/25, that directed staff to not serve "corn starch, dairy (butter,	20965	Corrected.	08/26/2025

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20965	Continued from page 44 American Cheese & Hard Cheeses are ok per Debra), egg white (ok if cooked into something), gluten, soy, or soybean oil" unless requested. R258's meal ticket, used by the kitchen staff to communicate allergies, preference, and diet type, also indicated R258's allergy/preference to not have foods cooked in soybean oil. During observation and interview on 6/29/25 at 10:14 a.m., R258 was in her room, lying in bed with her breakfast tray on the overbed table. On the tray were what appeared to be two, untouched fried eggs. R258 stated the food at the facility was "a joke" and that she had allergies that were still served to her, including gluten and soybean oil. R258 stated the eggs were "the worst" and always cooked in soybean oil and "sometimes you lift them [the eggs] up and they are just greasy with oil." R258 stated if she eats things cooked in soybean oil it causes her to have extreme upset stomach and that if she didn't buy her own food, she "would not get enough to eat." R258 confirmed the dietary manager was aware. During an interview on 6/29/25 at 3:08 p.m., cook (CK)-A stated they use an Arrezzio 90/10 Vegetable and Olive Pomace Oil Blend. The oil blend contains 90% soybean oil and 10% olive oil. During observation on 07/01/25 at 8:51 a.m., an Arrezzio oil container was sitting next to cracked eggs in the kitchen. During an interview on 7/1/25 at 2:20 p.m., (CK)-C stated they used the Arrezzio oil for cooking and did not know of any residents who needed a different kind of oil. CK-C stated they used the oil for frying eggs, deep frying foods, and chicken breasts. CK-C stated they used butter for frying eggs at times, to grease pans, and to make cookies. During interview on 7/2/25 at 7:23 a.m., CK-B stated they used the Arrezzio oil for food like eggs unless a resident specifically stated they wanted their eggs fried with butter. CK-B stated there were two residents who requested butter instead of oil for cooking but one of those residents passed away and the other resident did not reside in the facility anymore. CK-B stated	20965		

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20965	Continued from page 45 they were not aware of any current residents for whom they should avoid cooking with the oil. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated they knew of one resident, R258, who could not have soybean oil and expected staff to cook her meat and steam eggs without the soybean oil. R35 R35's annual Minimum Data Set (MDS) dated 3/29/25, indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. The care plan indicated eggs caused R35 to have an upset stomach unless the eggs were cooked into food. The care plan indicated R35's preference to avoid strawberries and nuts, and R35 liked fish patties with tartar sauce, chicken, turkey porkchops, and applesauce. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. During observation and interview on 7/1/25 at 8:32 a.m., R35 sat at a dining room table and ate breakfast. Dietary aide (DA)-E stated R35's plate had pureed biscuit, pureed scrambled eggs, and oatmeal. The meal ticket next to R35 indicated "Allergies: *Strawberry Allergen*, Egg Yolk, Treenuts, Soy/Soybean Oil, *Peanut Allergen*". The meal ticket indicated "No eggs at breakfast" under the listed allergies and "NO EGGS" under the listed breakfast items. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's allergies but would reference the meal ticket. NA-A stated they would change a resident's plate if they noticed a resident was not served the correct meal. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets	20965		

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20965	Continued from page 46 listed diet texture, allergies, and preferences. During interview on 7/2/25 at 10:22 a.m., the culinary director (CD) expected staff to follow residents' meal tickets and should not plate items listed as an allergy for a resident since staff may not know if the food item was an allergy or preference. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to not serve food listed as an allergy to residents for safety reasons. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. R37 R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care and was independent with eating after set-up assistance. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood. R37 stated the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated he did not eat it, but it happened again just a few days ago. R37 stated he had followed up with the social worker when this happened as it continued to happen. R37's allergy list, printed 7/2/25, lacked identification of allergy to shellfish, seafood, or fish. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: -Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up	20965		

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20965	Continued from page 47 - Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -"Administer medications as ordered. Monitor/Document for side effects and effectiveness." -"Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc." -"Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors." -"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." - "Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions." -"Provide and serve supplements as ordered: Ensure TID" -"RD to evaluate and make diet change recommendations PRN." The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: "RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says "no brown sugar on oatmeal" per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions."	20965		

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20965	Continued from page 48 R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated "Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*." Grievance log for June 2025 indicated a grievance was filed by R37 on 6/24/25 regarding food concerns. On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants use the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they are familiar with R37 and work with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a "no added salt" diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic to. CDM stated that he encouraged residents and staff to fill out grievances as this was a great way to track concerns. CDM reported R37 should not receive any sort of seafood or fish products as it was documented that he has an allergy to seafood, shellfish and fish. During an interview on 7/02/25 at 8:06 a.m., licensed social worker (LSW)-A stated she had met with R37 on 6/24/25 regarding concerns with R37's supper on 6/24/25. LSW-A stated R37 was served shrimp for dinner and verified R37 had an allergy to shellfish and should	20965		

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20965	Continued from page 49 not have been served shrimp due to his allergy. LSW-A stated she had seen his dinner plate, reviewed his meal ticket, and he had not received the food that was on the meal ticket. LSW-A stated she filled out a grievance form regarding this and notified the administrator and director of nursing. LSW-A stated the grievance form was given to the dietary manager to address. LSW-A stated dinner was purchased for R37 on 6/24/25 as the kitchen was closed when R37 had come to talk to her about the meal that was given to him. During an interview on 7/02/25 at 8:20 a.m., culinary director (CD) stated she had received a grievance regarding R37 receiving a shrimp dinner on 6/24/25, which he should not have received. CD stated she followed up with R37 and staff involved. CD stated staff are to follow the meal tickets and verified in this instance they did not. R37 was to get the alternative meal, due to shellfish allergy, and R37 was served shrimp. CD stated she has provided education to dietary staff regarding the importance of following meal tickets upon receiving the grievance form. CD stated R37 has an allergy to shellfish, seafood and fish and when asked what type of allergy stated, "probably his throat swells up, probably would need an epi-pen or something." CD verified the allergy was listed on the meal ticket. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated that residents' food allergies should be listed under resident's allergies. DON verified R37's food allergies were not listed in his allergy list. The facility Food Allergies and Intolerances policy dated August 2017, directed staff to ensure residents with food intolerances and allergies were offered appropriate substitutions for foods they cannot eat. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident. The facility Dining and Food Preferences policy dated 10/2022, indicated individual tray assembly tickets identified all food items appropriate for the resident based on diet order, allergies & intolerances, and preferences. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods given, offered, or consumed by residents reflect the nutritional needs and prevent potential food allergies	20965		

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20965	Continued from page 50 of residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food allergies. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are appropriate. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20965		
21015	Dietary Staff Requirements- Sanitary conditi CFR(s): MN Rule 4658.0610 Subp. 7 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to ensure opened dairy products (i.e., milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. These findings had potential to affect all 51 residents within the care center. Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, "How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?]," dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on	21015	Corrected.	08/26/2025

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21015	Continued from page 51 the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, "06-19-25 [10 days prior]." The milk container had a commercial stamp along the collar which outlined a 'best by' date of, "06/29/25." DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used "three days" after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, "I don't know." On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, "06-25-25 [five days prior]." DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been "rubbed off" by them just before they brought the cart up. DA-B stated the black writing read "6/9" before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, "I'm not sure." DA-B verified the milk was intended to be used for the supper meal service that evening. Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed.	21015		

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21015	Continued from page 52 They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to "the number of diseases that come with it [using milk beyond that range]," adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart. On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, "Refrigerator Temperature Log," which was dated, "June 2025." The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, "06-24-25." However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, "I don't check this." DA-A verified the milk was beyond the 'best by' date and was not dated when	21015		

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21015	Continued from page 53 opened, and they expressed there was enough milk in the container to serve "seven or eight" people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was "a resident fridge" used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated "the kitchen, not us" was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, "05/23/25," and "Gravy." The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, "I think it's gravy." NA-D verified the condition of the food product and dates on the tinfoil. One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, "Yea," when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, "Obviously no one was doing it." LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked "disgusting." LPN-B stated many of the food items in	21015		

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21015	Continued from page 54 the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, "So things like that [surveyor findings] don't happen." On 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more "daily oversight" of tasks like that to ensure they get done. CDM explained there was a "monthly routine" to check the unit refrigerators for food dates and expirations but added, "Some people can be forgetful." CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, "Especially with the vulnerable base we have." On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, "The nursing staff will discard perishable foods on or before the 'use by' date," adding further, "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor ...)."	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/02/2025**

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21015	Continued from page 55 INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished	21015		

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21015	Continued from page 56 up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and "use by" date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop, review, and/or revise policies and procedures to ensure proper hair protection worn for facial hair, ensure proper methods of drying and stacking dishware utilized, and ensure dry baking and frozen food stored to reduce contamination. The dietary manager or designee could educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21015 21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to ensure opened dairy products (i.e., milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. These findings had potential to affect all 51 residents within the care center. Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, "How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?]," dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, "06-19-25 [10 days prior]." The milk container had a commercial stamp along the collar which outlined a 'best by' date of, "06/29/25." DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from	21015 21100	Corrected.	08/26/2025

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21100	Continued from page 58 the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used "three days" after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, "I don't know." On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, "06-25-25 [five days prior]." DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been "rubbed off" by them just before they brought the cart up. DA-B stated the black writing read "6/9" before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, "I'm not sure." DA-B verified the milk was intended to be used for the supper meal service that evening. Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to "the number of diseases that come with it [using milk beyond that range]," adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart.	21100		

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21100	Continued from page 59 On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, "Refrigerator Temperature Log," which was dated, "June 2025." The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, "06-24-25." However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, "I don't check this." DA-A verified the milk was beyond the 'best by' date and was not dated when opened, and they expressed there was enough milk in the container to serve "seven or eight" people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was "a resident fridge" used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated "the kitchen, not us" was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the	21100		

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21100	Continued from page 60 refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, "05/23/25," and "Gravy." The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, "I think it's gravy." NA-D verified the condition of the food product and dates on the tinfoil. One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, "Yea," when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, "Obviously no one was doing it." LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked "disgusting." LPN-B stated many of the food items in the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, "So things like that [surveyor findings] don't happen." On 6/30/25 at 5:04 p.m., the contracted group (dietary)	21100		

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21100	Continued from page 61 district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more "daily oversight" of tasks like that to ensure they get done. CDM explained there was a "monthly routine" to check the unit refrigerators for food dates and expirations but added, "Some people can be forgetful." CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, "Especially with the vulnerable base we have." On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all "time/temperatures control for safety foods" which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a "use by date" with added text reading, "(Day 7)." In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, "The nursing staff will discard perishable foods on or before the 'use by' date," adding further, "The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor ...)." INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack	21100		

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21100	Continued from page 62 and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to	21100		

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21100	Continued from page 63 prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and "use by" date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents	21385	Corrected.	08/26/2025

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21385	Continued from page 64 and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure current infection control standards of practice were followed when performing resident personal care for 1 of 4 residents (R153) observed for personal care. Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on 6/20/25. R153's Medical Diagnosis list dated 6/23/25, indicated R153 was diagnosed with diabetes, a stroke, and heart disease. R153's care plan dated 6/30/25, indicated R153 required the assistance of one to two staff members for bed mobility and dressing, and the assistance of two staff members for toileting and transferring. During an observation on 7/1/25 at 8:27 a.m., R153 was observed lying in bed. Nursing assistant (NA)-I and NA-J were observed assisting R153 with personal care. NA-I, with gloved hands, was observed to assist R153 with perineal care while R153 was lying on his back. NA-J was observed to assist the resident in rolling towards her, while NA-I completed perineal care on the backside. NA-I was observed, still with gloved hands, to assist the resident to apply a new pad and put on shorts. Then both aides assisted R153 to sit on the edge of the bed. NA-J was observed to position a motorized stand aide while NA-I, with gloved hands, assisted the resident to position his hand and feet on the machine. NA-J was observed to complete hand hygiene and then leave the room. NA-I with gloved hands, assisted R153 to position himself in the wheelchair and readjust his glasses. NA-I took off his gloves, gathered the trash, and left the room. NA-I was not observed to complete hand hygiene during this observation or to change gloves. During an interview on 7/1/25 at 8:50 a.m., NA-I stated he had completed hand hygiene and applied gloves before entering R153's room, taken off his gloves before	21385		

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21385	Continued from page 65 leaving the room, and then, after he had thrown away the trash, he completed hand hygiene. NA-I confirmed he had otherwise not completed hand hygiene while completing R153's care. NA-I stated he was taught to complete hand hygiene before and after care but had not been told that he also needed to complete hand hygiene during care. During an interview on 7/2/25 at 9:58 a.m., the director of nursing (DON) stated staff were expected to complete hand hygiene before applying gloves, when changing gloves, after glove use, and after a task like perineal care to prevent "cross-contamination". The facility Handwashing/Hand Hygiene policy dated 8/19, indicated staff were to complete hand hygiene before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, and after removing gloves. SUGGESTED METHOD OF CORRECTION: The DON or infection control officer could develop could educate staff on the infection control program along with random audits of staff cares to ensure proper techniques are implemented. The infection control program could be integrated with the quality assurance program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426	It is Terrace at Crystal's policy to establish and maintain a comprehensive tuberculosis (TB) infection control program according to the most current CDC guidelines, including a TB infection control plan that covers all residents, employees, contractors, students, and volunteers. TB symptom screenings were completed for R21, R24, R47, and R49, and results were documented in the electronic medical record. NA-B completed the second step of the two-step Mantoux TST within the required timeframe, with results documented. LPN-C completed the required TB symptom screening, with results documented in the employee file. Licensed Practical Nurse (LPN) D completed the required IGRA blood test and TB symptom screening, with results documented in the employee file.	08/26/2025

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21426	Continued from page 66 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure that required tuberculosis (TB) testing was completed for 3 of 5 staff members (NA-B, LPN-C, LPN-D) and 4 of 5 residents (R21, R24, R47, R49) reviewed for TB screening. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of an assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for infection with mycobacterium tuberculosis. In addition to aforementioned tests, a chest x-ray, and/or medical examination by a medical practitioner was to be completed to rule out active disease. The MDH Regulations for Tuberculosis Control in Minnesota Health Care Settings dated 7/2013, indicated "a baseline TB screening is required for all health care workers. The baseline TB screening consists in three components: 1. Assessing for current symptoms of active TB disease 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step Mantoux Tuberculin Skin Test (TST) or singe interferon gamma release assay (IGRA) blood test. An employee may begin working with patients after a negative TB symptoms screen (i.e., no symptoms of active TB disease) and negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." RESIDENT R21's annual Minimum Data Set (MDS) dated 4/18/25, indicated R21 was admitted to the facility on 6/11/22,	21426	Continued from page 66 A facility-wide audit of all resident and staff TB screenings was conducted to ensure all required screenings and tests were completed and documented. Any missing screenings were completed immediately. The policies titled “Screening Residents for Tuberculosis” and “Employee Screening for Tuberculosis” were reviewed. The Infection Control Nurse and/or designee will maintain a TB Screening Tracking Log to monitor timely completion for all residents and staff. DON or designee will conduct audits of all new admissions/reentries and new hires to ensure TB screenings and testing are completed prior to resident contact. Audits will be completed 1x per week for 8 weeks, then monthly for 4 months, or until sustained compliance is verified. Results of audits will be presented at the monthly QAPI meeting for review and determination of further auditing and monitoring needs. DON and/or Infection Control Nurse are responsible for compliance.	

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21426	Continued from page 67 with a reentry date on 9/15/24. R24's admission Minimum Data Set (MDS) dated 5/5/25, indicated R24 was admitted to the facility on 4/28/25. R47's quarterly Minimum Data Set (MDS) dated 5/8/25, indicated R47 was admitted to the facility on 1/29/25. R49's admission Minimum Data Set (MDS) dated 6/4/25, indicated R49 was admitted to the facility on 5/29/25. R21, R24, R47 and R49's medical records were reviewed on 7/22/25 at 11:22 a.m., and no TB symptom screenings (a tool used to determine if active TB infection could be present) were identified. STAFF Nursing assistant (NA)-B's TB screening tool signed on 6/4/25, indicated a TST was administered on 6/4/25 and read on 6/6/25 at zero millimeters. The form had a spot labeled "test #2" which was left blank. The form indicated a "2nd step" would be administered within one to three weeks. The form had a spot labeled "date of hire" which read 6/4/25. During an interview on 6/30/25 at 4:06 p.m., the infection preventionist (IP) stated LPN-D always had a positive skin test and knew a blood test was required and had completed the test a few months ago, and stated LPN-D was asked to email the document. The IP confirmed a screening tool had not been completed, and they did not receive confirmation that a IGRA blood test was completed. LPN-D was hired on 3/19/25. Licensed practical nurse (LPN)-C was hired on 3/19/25 and completed a IGRA blood test, also known as a Quantiferon-TB Gold, that was drawn on 5/12/25 and reported on 5/14/25 with a negative test result. The IP confirmed a screening tool was not completed for LPN-C. During an interview on 7/1/25 at 2:27 p.m., the IP stated TB screenings for residents were done electronically through the electronic medical record (EMR) and titled Resident Tuberculosis Screener. The IP confirmed R21, R24, R47, R49 did not have a screening on file. The IP confirmed NA-B did not have a second	21426		

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21426	Continued from page 68 TST, LPN-C did not have a screening on file, and LPN-D never sent over test results and did not have a screening on file. During an interview on 7/2/25 at 8:34 a.m., the director of nursing (DON) stated the IP is responsible for all TB screening and testing at the facility. The expectation is that all staff and residents were screened and tested. This was important so that the residents were not put at risk and to follow all state regulations. The DON confirmed if a step 1 TST was completed, a step 2 TST must also be completed within one to three weeks. The DON also confirmed NA-B was on the schedule and worked as a nursing assistant without a second test. The DON confirmed both LPN-C and LPN-D were on the schedule and worked in the facility but was not aware that screenings or test were not completed. DON was also not aware R21, R24, R47 and R49's were not screened for TB, and stated it was important to screen all residents so that the community was not exposed. A policy, Screening Residents for Tuberculosis revised 8/19, identified "This facility shall screen all residents for tuberculosis infection and disease (TB)". A policy, Employee Screening for Tuberculosis dated 3/21, identified "all employees are screened for latent tuberculosis (LTBI) and active tuberculosis (TB) disease using skin test (TST) or in or interferon gamma release assay (IGRA) and symptoms screening prior to beginning employment". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor residents and employee TB screenings to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one-(21) days.	21426		
21435	Activity and Recreation Program; General CFR(s): MN Rule 4658.0900 Subp. 1 Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed	21435	Corrected.	08/26/2025

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21435	Continued from page 69 to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 1 of 2 residents (R24) reviewed for activities. Findings include: R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. However, the section to record R24's activity preferences and routines was left blank or marked, "Not Assessed [See F636]." On 6/29/25 at 10:46 a.m., R24 was observed lying in bed while in her room on the locked unit. R24's television was turned on and positioned along the opposite wall of her bed. R24 was interviewed and expressed aloud, "I don't know," when asked how long they'd lived at the center. R24 was dressed in a hospital-type gown and her hair appeared with a light, greasy-looking shine. R24 was asked about what, if any, activities the floor staff involve her with and she abruptly responded, "Would you leave me alone?!" Following, on 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G explained they had not really seen R24 participate in any activities at the care center adding, "She doesn't leave her bed." FM-G stated R24 had been outside "maybe once" since admitting from their recall and expressed the staff may be offering them to her and she's declining them but was unsure. FM-G stated R24 had a television in her room which she needed help to operate and expressed they were unsure if staff knew that or not adding, "I don't know they realize that." FM-G stated R24 enjoyed mystery and "murder shows" on the television. Further, FM-G reiterated they were unsure if R24 would participate in activities even, however, stated nobody from the care center had ever talked with them about her likes or dislikes for activities since she admitted.	21435		

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21435	Continued from page 70 R24's medical record was reviewed and lacked evidence R24 had been comprehensively assessed for what, if any, individual or group-based activities she would like to attend; nor did the record have evidence of any other activities (i.e., 1:1) being provided. R24's care plan, printed 7/1/25, identified all R24's current or potential concerns the facility had identified and implemented interventions to address. The care plan was reviewed and lacked any recorded focus statements, goals, or interventions for leisure and/or activities despite R24 admitting to the care center months prior. Further, the entire electronic medical record (EMR) lacked any completed tasks or progress note(s) in the system to demonstrate R24 had been provided any activities since she admitted to the care center. On 6/30/25 at 1:33 p.m., R24 was again observed lying in bed while in her room. R24's television was turned on and a day-time drama television show was on. R24 was asked about the show or if she enjoyed it, however, R24 just mumbled a response which was not discernable. R24 was asked if she was able to use the remote or needed help and just stared at the surveyor with no audible response. When interviewed on 6/30/25 at 1:36 p.m., nursing assistant (NA)-A stated they had worked with R24 prior, and expressed R24 needed help with nearly all her cares. NA-A stated R24 would rarely get up from bed and expressed it "all depends" on her mood and what she'd allow each day. NA-A stated R24 would get up to the wheelchair maybe "three to four times [week]" and then added, "She really likes to be in her room." NA-A stated they were aware of some activities happening "at the back there" on the unit, however, had only seen her at a few they could recall. NA-A stated R24 liked her "criminal shows" and would try to keep those on the television for her. NA-A stated they knew R24 enjoyed 'criminal shows' as "I work with her a lot of times," adding nobody from the care center activities' staff had ever told them which channels or shows to play for R24 adding, "I just found out on my own." NA-A verified R24 would, at times, not speak to staff and would remain silent adding R24 needed to "be in a good mood" to converse. When questioned how other staff, including pool staff, would know which shows or channels R24 enjoyed NA-A responded aloud, "That's hard." NA-A stated the staff used a "care guide" which had all residents listed on it and reviewed this with the surveyor. R24's name was listed, however, the guide lacked any information on which channels, shows, or activities R24 enjoyed or wanted. NA-A verified the guide lacked this information and expressed aloud,	21435		

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21435	Continued from page 71 "It's not there." NA-A stated having it listed on the care guide would help others adding, "Everybody works different with these people." When interviewed on 6/30/25 at 1:45 p.m., trained medication aide (TMA)-A stated they had worked with R24 prior and described her as needing "a lot of help" with cares. TMA-A explained R24 could be "real mean" sometimes and "not too often" would get up from bed. TMA-A stated physical therapy (PT) was working with her and even for them, R24 would still "not too often" get up from bed. TMA-A stated they had never seen R24 attend any activities prior and was unsure what, if any, in-room activities the staff were doing for her adding, "I haven't seen it." TMA-A stated R24 could "tell you what she wants" if she needed the television adjusted but then expressed R24 would not usually speak to people she didn't like or didn't know adding the aides often rotate amongst the units "all the time." TMA-A stated the activities personnel would know more about R24. On 6/30/25 at 1:51 p.m., the activities assistant (AA)-A was interviewed, and explained they worked on the memory care unit. AA-A stated a previous activities supervisor used to do the comprehensive assessments for residents, however, lately it had been them doing it. AA-A stated activities' likes and dislikes were tracked using a paper flow sheet on each floor and then entered into the system under the "assessments" tab. AA-A stated the activities director (AD) did the care plans adding, "We don't do that." AA-A stated the AD would likely have more information on the assessment and care planning of activities. AA-A explained they were aware of R24 and expressed aloud, "She don't come out their room." AA-A stated they do a "coffee and chat" quick with her everyday but R24 often didn't verbally respond to her. AA-A stated they "check on her" a few times every day they felt. AA-A explained they used to track activities within the EMR, however, a previous management staff told them to stop doing so as "State [MDH] can't see it," which is where the paper flow sheets came from. AA-A stated this had been the process since "like two administrators ago" from their recall. AA-A stated R24 was "not a normal person to talk to" but felt she enjoyed "the old, old shows" and "like gray and white shows" from her recall. Later, on 6/30/25 at 2:01 p.m., the AD and AA-A were interviewed and the paper flow sheets, as completed by AA-A, were provided for review. These identified a paper with rows and columns which had multiple resident room numbers on the side and spacing to record across the paper for each day of the week. These identified:	21435		

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21435	Continued from page 72 May 26 to May 31; R24's name and room number were identified. The flow sheet recorded a 1:1 was held four times, however, it didn't record any date(s) or length of time or what activities (i.e., nail care, reading news) were completed during it. June 2 to June 6; R24's name and room number were identified. The flow sheet recorded a 1:1 was held six times, once each day from Monday to Saturday, respectively. However, again, the sheet didn't record any length of time or what activities were completed during it. June 9 to June 14; R24's name and room number were identified. The flow sheet recorded a 1:1 was held five times, once each day from Monday to Wednesday, and on Friday and Saturday. The flow sheet recorded a single entry on Thursday which read, "Unv." However, again, the sheet didn't record any length of time or what activities were completed during the 1:1 sessions or an explanation for what 'unv' meant. July 12 (i.e., "7/12"); R24's name and room number were identified. R24 was not listed on the flow sheet and no activities were recorded for her. AA-A explained the 1:1's recorded on the flow sheet for R24 were the 'coffee and chat' sessions they had explained. AA-A acknowledged the charting on the flow sheet showed only once but reiterated they stopped in the room a "couple times a day" to check on her. AD explained the AA staff help complete the comprehensive assessments for each resident upon admission which were then entered into the EMR adding that should be done "as soon as they come in." From those assessments, then the care plan gets developed in the EMR. AD reviewed R24's medical record and verified it lacked any completed assessments for activities and the care plan lacked information or interventions for activities adding, "It's not in there." AD stated they felt it was completed and possibly just not entered adding, "I know we did it." AD stated the lack of assessment and care plan made it appear "like they [staff] didn't talk to her at all." AA-A stated they had search for a paper copy of the completed assessment, however, were unable to locate it adding aloud, "Maybe we missed one." However, both AD and AA-A verified residents' should be assessed and care planned for their activities preferences adding such was important, "So we know what they like and like to do." AA-A stated they would go and assess R24 now since this was identified. A facility provided Activity Programs policy, dated	21435		

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21435	Continued from page 73 3/2025, identified activities would be offered based on the comprehensive assessment and preferences of each resident. The policy outlined activities were scheduled seven (7) days a week and residents would be given opportunity to contribute to the planning, conducting and critiquing of them. The policy directed, "All activities are documented in the resident's medical record." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on activities assessment and care planning; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	21435		
21540	Unnecessary Drug Usage; Monitoring CFR(s): MN Rule 4658.1315 Subp. 2 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident was free from unnecessary medication by failing to attempt to decrease a resident's nicotine patch (a known psychotropic medication) despite the consulting pharmacist's and Centers for Disease Control and Prevention's recommendations for 1 of 5 residents (R7) reviewed for unnecessary medications.	21540	Corrected.	08/26/2025

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21540	Continued from page 74 Findings include: R7's quarterly Minimum Data Set (MDS), dated 4/26/25, indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications. R7'S electronic medical record (EMR) contained an order, dated 3/8/24, for a Nicotine Transdermal Patch 24 Hour 21 milligrams (MG) per 24 hours (Nicotine) - Apply one patch transdermal (on the skin) every 24 hours for nicotine dependence in remission. R7's most recent smoking review, dated 5/6/25, indicated that R7 was currently smoking and intended to continue to smoke. R7 was also on the facility provided list of residents who smoke. R7's care plan, dated 5/12/25, indicated R7 was a "current smoker, trying to quit, resident received Nicotine Patch each morning will sometimes refuse it." R7's monthly medication regiment reviews (MRR), dated 2/21/25, 3/24/25, 4/24/25, and 5/23/25 all indicated a pharmacist recommendation to decrease R7's nicotine patch and to discontinue it if resident was still choosing to smoke. The consultant pharmacist (CP)-A gave a rationale of nicotine being a psychotropic medication intended to help a person quit smoking by reducing nicotine dependence and manage withdrawal symptoms. CP-A further indicated the CDC advises nicotine patch doses should be lowered overtime (8-12 weeks) with a goal of stopping use of the nicotine patch completely. On the MRR dated 5/23/24, the provider had checked "agree". A handwritten note on the MRR from LPN-E, dated 5/29/25, indicated "resident [R7] refused to have patch decreased, stated that the patch keeps him from smoking, the he has not smoked in long time. Provider updated." During an interview on 6/30/25 at 5:41 p.m., trained medication aide (TMA)-C stated R7 was currently still smoking. During an interview on 6/30/25 at 5:47 p.m., trained medication aide (TMA)-D stated R7 was currently still smoking. During an interview on 7/1/25 at 8:06 a.m., R7 stated he has not smoked "in a couple of months."	21540		

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21540	Continued from page 75 During an interview on 7/1/25 at 9:36 a.m., TMA-B stated she had worked at the facility for a few years, and stated R7 "smoked heavily" and would still go outside to smoke daily. During an interview on 7/1/25 at 1:46 p.m., CP-A stated she had issued the recommendation to decrease R7's nicotine patch and had received a response in June from her May recommendation that the provider had agreed to decrease the dose but R7 had refused. The CP stated the intent of a nicotine patch was to assist a resident to quit smoking and was safer than smoking however, staff or R7 would not know how effective the patch was in helping R7 quit if it was not reduced, stating ideally it would be nice to reduce the dose, and ideally R7 would not be on the patch forever. CP-A further stated there were alternatives to the nicotine patch that R7 could try such as nicotine gum or lozenges to attempt to decrease R7's nicotine patch. CP-A further stated the patch should be discontinued if R7 was still smoking. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated R7 had told her he was not smoking however R7 was outside a lot, so she was unsure if R7 was still smoking or not. LPN-E stated they had tried to discontinue or reduce R7's nicotine patch but he refused and had been on the patch for a "long time" and "demanded it." LPN-E stated she had sent the provider messages that R7 was still on the nicotine patch but did not know what the provider's response was. A facility policy titled Tapering Medications and Gradual Dose Reduction, revised 4/2007, indicated attempted tapering of psychopharmacological medications shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. The facility could review policies and procedures related to unnecessary medications and tapering or psychotropic medications when advised. The Director of Nursing (or designee) should conduct measurable audits on residents using psychotropic medications to ensure they are necessary and at a necessary dose. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21540		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C	21545	Corrected.	08/26/2025

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21545	Continued from page 76 A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors when a narcotic pain medication was not administered as ordered for 1 of 5 (R10) residents reviewed for unnecessary medications.	21545		

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21545	Continued from page 77 Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25 and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25 and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given 6/1/25 through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25 and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered. -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to	21545		

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21545	Continued from page 78 be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone. -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain noted.	21545		

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21545	Continued from page 79 R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still don't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated nursing staff had used oxycodone from the emergency supply until they ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed, when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would have missed fewer doses of the medication or not missed any doses at all. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the	21545		

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21545	Continued from page 80 issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures for medication administration, and the policy for medication errors. The DON or designee could develop a system to educate staff and monitoring system to ensure pain medications were correctly administered . The DON or designee could monitor and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complications for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 2/17/25, indicated R10 had intact cognition. R10's quarterly MDS dated 5/20/25, indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders: - 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25, and discontinued on	21550	Corrected.	08/26/2025

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21550	Continued from page 81 6/23/25. The order was documented as given on 6/1/25 through 6/18/25, and the evening dose on 6/19/25. The medication was documented as a "9" (other/see progress notes) for the first and second dose on 6/19/25, and then 6/20/25 through the second dose on 6/23/25. - Five mg of oxycodone three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given 6/1/25, through the second dose on 6/23/25. - 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a "9" was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25. - Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25, and a "9" was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone: -dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was "not available" with no indication the medication had been re-ordered. -dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider. -dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider. -dated 6/20/25 at 9:02 p.m., indicated nursing staff were "awaiting delivery" of 2.5 mg of oxycodone. -dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription. -dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone. -dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given. -dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated	21550		

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21550	Continued from page 82 2.5 mg of oxycodone was "on order". -dated 6/22/25 at 10:03 p.m., indicated there was "no supply" of the 2.5 mg of oxycodone. -dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was "on order". -dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was "on order". -dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given. -dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available. -dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was "on order". R10's progress note dated 6/20/25 at 4:19 p.m., indicated R10's provider had been contacted to request a new prescription for her 2.5 mg order of oxycodone. R10's progress note dated 6/30/25 at 9:56 a.m., indicated a call was placed to the provider to get a new prescription for her oxycodone. R10's progress note dated 6/30/25 at 11:58 a.m., indicated that a voicemail was received from the provider indicating a new prescription [did not indicate what medication] was sent to the pharmacy. R10's progress notes were reviewed dated 6/1/25 through 6/30/25, and did not indicate any further requests for oxycodone were made. R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain documented. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone	21550		

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21550	Continued from page 83 once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt "shaky" and her pain has been "terrible" since she started missing doses, and they still didn't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated she had trouble getting a new prescription from the provider, and when she did, sometime last week, she thought the pharmacy had not accepted it due to the way the dosage was written. LPN-E stated nursing staff had used oxycodone from the emergency supply until the facility ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented "9" on the MAR, it meant that the medication wasn't given, and the reason should be documented in progress notes. LPN-E confirmed she had reviewed R10's medical record and the first time she saw that a new prescription for the oxycodone had been requested from the provider was on 6/20/25, although the medication ran out on 6/19/25, and she did not see that the medication was requested from the pharmacy until 6/27/25. LPN-E stated she would have expected her nursing staff to request the medication from the pharmacy and a new prescription as needed when there was only one column of medication left, so about eight doses. LPN-E confirmed she did not see that this had happened. LPN-E stated that if nursing staff had reordered the medication promptly, they would have realized they needed a new script sooner, and R10 would	21550		

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21550	Continued from page 84 have missed fewer doses of the medication or not missed any doses at all. During an interview on 7/1/25 at 12:38 p.m., the dispensing pharmacist (DP) stated she had reviewed their records for R10 and did not see any requests for oxycodone to be dispensed until 6/28/25, including the week before 6/19/25. The DP stated they had sent a new card of medication yesterday (6/30/25), but she would have expected a request from the facility before the medication was needed as it took time to prepare the medication. During an interview on 7/2/25 at 10:00 a.m., the director of nursing (DON) stated she expected nursing staff to reorder the medication from the pharmacy when the medication card only has the far-right column left in the package, or about 8 doses. The facility's Medication and Treatment Orders policy, dated 11/23, indicated that drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three days before the last dosage being administered, to ensure that refills are readily available. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		
21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed inhaled	21620	Corrected.	08/26/2025

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21620	Continued from page 85 medications were stored in their correct packaging to prevent potential administration error for 1 of 5 residents (R3); and failed to ensure prescribed oral medications were labeled with minimum identifiers to ensure correct administration (i.e., right patient, right medication) for 1 of 5 residents (R3) observed to received medication during the survey. Findings include: INCORRECT STORAGE: R3's Medication Administration Record (MAR), dated 7/2025, identified R3's current physician ordered medications, directions for their use, and staff spaces to record their administration or refusal. The MAR included an order for Mometasone (a steroid medication) 50 micrograms (MCG) with directions to administer 2 sprays in each nostril once daily for a respiratory infection. The MAR listed a start date for this medication as, "06/13/2025," and scheduled administration time of 8:00 a.m. On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3. LPN-B removed various oral medications from the cart while comparing them to R3's MAR which was displayed on a laptop computer on the cart. LPN-B stated R3 had a steroid inhaler (Mometasone) scheduled to be given and then removed a clear bag with a pharmacy label attached which had R3's name listed and read, "Nasal Decong Spr [spray] 0.05%," which had directions, "2 DROP IN BOTH NOSTRILS EVERY 12 HOURS AS NEEDED FOR CONGESTION." LPN-B continued to search the upper row of the medication cart before finding another clear bag with a pharmacy label attached which had R3's name listed and read, "Mometasone [steroid medication; used for asthma] Spr 50 MCG [micrograms]," with directions listed reading, "INSTILL 2 SPRAYS IN EACH NOSTRIL ONCE DAILY." However, this bag was empty with no medication or inhaler inside. LPN-B reviewed R3's MAR and verified the Mometasone was scheduled to be given; however, the inhaler wasn't in the bag. LPN-B searched the drawer and then reviewed the nasal decongestant bag. LPN-B opened the bag and expressed the Mometasone inhaler had been placed in the wrong bag. The steroid medication was placed in the nasal decongestant bag and not the correct one. LPN-B stated they were unsure how long the medication had been stored like that and, when questioned how medications could end up stored in the wrong pharmacy labeled containers, responded aloud, "Carelessness." LPN-B stated the medications should be stored in their correct pharmacy packaging so "there's	21620		

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21620	Continued from page 86 no confusion." LPN-B verified trained medication aide (TMA) staff worked on the medication carts within the building, and they reiterated correct storage of the medication was necessary to reduce the risk of residents getting the wrong medications. When interviewed on 7/1/25 at 9:42 a.m., the director of nursing (DON) stated nasal medications typically come in a "little zippy bag" from the pharmacy and should be kept in them. DON stated the correct medication should be kept inside the correct bag from the pharmacy to help ensure "accurate administration" and so staff were "giving what they're supposed to be giving." DON acknowledged medications stored in the wrong bags could lead to a medication error as the two medications (i.e., nasal decongestant / Mometasone) were different medications for different purposes. On 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A was interviewed via telephone, and they explained Mometasone was a "longer acting" medication and meant more for "ongoing therapy" versus a nasal decongestant medication. CP-A stated inhalers typically arrived to the care center in a plastic bag from the pharmacy and were usually kept inside the same bags once in the medication carts. CP-A stated staff should use one inhaler at a time to ensure they're placed back into the correct bags when done. CP-A stated having the correct inhaler stored in the correct bag helped "the double checking" when doing medication administration to ensure the right medication was being given at the right time. A facility provided Medication Storage In The Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements and, " ... Medications are kept in these containers." The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." MEDICATION NOT LABELED: R3's Order Summary Report, signed 5/15/25, identified R3's physician orders along with their administration instructions. This included an order which read, "Nicotine Polacrilex Mouth/Throat Gum ... Give 4 mg [milligrams] by mouth every 1 hours as needed for withdrawal symptoms." The order had a start date recorded, "04/11/2025." On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B	21620		

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21620	Continued from page 87 preparing medications at a mobile cart for R3 who was seated in their doorway. R3 stated they wanted their nicotine gum and LPN-B expressed they would get it. LPN-B opened the medication cart and removed a white-colored package which was labeled, "Rubgy [brand name] Nicotine Gum ... Stop Smoking Aid 4 mg," and provided it to the surveyor for review. The package was commercial and there were no pharmacy labels attached to it; nor was there any written identifier(s) to demonstrate whom the medication was for (i.e., R3). LPN-B verified the package was opened with several doses removed, and it lacked any pharmacy labeling expressing aloud, "I'm not sure why her name isn't on it." LPN-B verified the medication was not considered a "stock med" and expressed they were unsure when it had been filled or sent by the pharmacy since it wasn't labeled. LPN-B stated they believed it to be R3's supply though but verified all medications, including nicotine gum, should be labeled from the pharmacy. This was important "so we know whose it is and they [residents] get the right meds." LPN-B then removed one piece of the nicotine gum and provided it to R3. Following, at 8:27 a.m., registered nurse unit manager (RN)-A approached the mobile medication cart and LPN-B asked them aloud, "Do you know why this [gum] wouldn't be labeled from the pharmacy?" RN-A stated all medications come with a pharmacy label which should remain on the box or package. RN-A stated if staff locate a medication which doesn't have a label, then the pharmacy should be contacted for instructions on how to correct it. RN-A verified nicotine gum was considered a medication and should be labeled from the pharmacy as "we want to make sure we're giving the right medication with the right patient" adding the label helps staff to ensure the medication inside the package is correct. Later, on 7/1/25 at 8:58 a.m., RN-A stated they had just contacted the dispensing pharmacy who verified the nicotine gum should be labeled adding, "Normally, yes [should be]." RN-A stated the pharmacy was unsure why the medication was not labeled, and they were going to send a "new package" out to correct the issue. RN-A stated they told the pharmacy to investigate the situation "on their end." On 7/1/25 at 9:42 a.m., the director of nursing (DON) was interviewed. DON verified nicotine gum was considered a medication since it was listed on the MAR, and they expressed the medication should come with a pharmacy label. DON stated if staff discovered a medication that was not labeled, then they should contact the pharmacy and "get the right label on it." DON stated having medications labeled with correct	21620		

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21620	Continued from page 88 information was important as it was "an identifier" to help staff know they're giving the right medication to the right person. When interviewed on 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A verified nicotine gum would be considered a medication and typically would be labeled from the pharmacy with patient name and directions for administration. CP-A explained some nicotine gum brands come wrapped in a plastic film which sometimes has the label attached and, upon being removed, the label gets destroyed at the same time. CP-A verified the medicated gum should be labeled with, at minimum, the patient's name so staff know whose it was. CP-A stated if staff found a medication without a label, then they could contact the pharmacy who could help them resolve it. Further, CP-A stated it was important to ensure medications were labeled with basic information to help "make sure it's getting to the right patient" and help reduce the risk of error. A facility provided Medication Storage in the Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements. The policy added, "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." An additional facility provided Medication Ordering and Receiving from Pharmacy policy, dated 5/2022, identified medications would be labeled in accordance with facility requirements and state and/or federal law. The policy outlined labels were to be permanently affixed to the outside of the prescription container and if the label didn't fit directly onto the product then it could be affixed to the outside container adding, " ... the resident's name, at least, must be maintained directly on the actual product container." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on pharmacy labeling and actions to address un-labeled items; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	21620		
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment,	21665	Corrected.	08/26/2025

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21665	Continued from page 89 allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair which had the potential to affect all 51 residents, staff, and visitors of the facility. Findings include: Walls: During observation of R15 on 6/29/25 at 10:24 a.m., R15 in resident room on second floor sitting in hospital gown with brown substance streaked on the floor. During observation and interview with R31 on 6/29/25 at 10:35 a.m., R31 stated she was disappointed in her facility stay in part due to the "environment is dirty" pointing to ceiling in her room with yellowing stain on it and a gash in the wall with brown drip stains down the wall. During observation and interview with R12 on 6/29/25 at 10:52 a.m., R12 lying in bed which was horizontally against the wall. Wall had numerous black marks along it with a yellow-colored stained area that extended on the wall for approximately half the length of his bed. R12 stated he was unhappy with the condition of the walls and would "like it addressed". R12 stated "this whole place is f***ed up" and that the facility had done nothing about it. During interview with R24 on 6/29/25 at 1:48 p.m., R24 stated "cleanliness of the place [sic] run down" R24 stated "this place is a pit". During observation and interview on the second-floor secured memory care unit in the dining room on 6/30/25 at 2:07 p.m., a baseboard in east corner of room had broken wallboard above it. Portions of the baseboard was not attached to wall due to the hole in the area. The area was approximately 18 inches long. Blue laminate edging was missing from portion of nursing desk facing the hallway. Portion was 8 inches that spanned the corner of the nursing station desk. Knee	21665		

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21665	Continued from page 90 wall attached to nursing station and wall across from the nursing station had numerous scrapes and missing pain including peeling. In the dining room above chair rail in corner of it there was white corner piece that did not match color of remaining wall. The corners that came together were pulling apart showing half an inches of empty space for eighteen inches. Area also had beige staining around it. Both dining room wall frames had peeling, stained, and chipped paint on both sides. Nursing assistant (NA)-A was seated at a dining room table with resident who was in a wheelchair. Two other residents were in the room at the time. NA-A stated expectation of staff to report any maintenance issues to the MT-D. NA-A stated she would tell the nurse who would then fill out a work order on the computer or verbally tell MT-D of any concerns. NA-A looked around and stated, "[It] looks like [sic] needs to be repainted. Not looking good." During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:19 p.m., TMA-A stated, "need to be fixed or done painting or repairing." TMA-A stated expectation of staff to notify maintenance of work order request for MD-T to address concerns with "painting and repairing". TMA-A observed hole in the wall in dining room above the baseboard and stated, "Oh wow. Needs to be repaired." During observation and interview with director of nursing (DON) on 6/30/25 at 2:34 p.m., on the second-floor secured memory care unit pointing to the walls, baseboards, and door frames of resident rooms and also the two entrances to the dining room. DON stated, "Needs repair. The door frames need to be repaired and replaced." DON stated, "I would not like that at my home. DON stated expectation of staff to fill out a work order and submit it electronically or notify MD-T verbally. DON stated she had worked at facility for over two years and did not see any wall repairs or replacing of baseboards or painting of door frames during that time. During observation and interview with MD-T on 6/30/25 at 3:02 p.m., MD-T observed 2nd floor resident door frames, memory care security doors, baseboards, chipped, broken wallboards and stained ceiling tiles and walls and stated, "It is not homelike. I would not like it in my home. We need to replace all of the baseboards and repaint the walls. The doors are really chipped and need to be repainted." MT-D stated	21665		

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21665	Continued from page 91 expectation of staff to submit work orders or notify him of repair needs verbally. "I have been working on them but was not aware of some of the issues. There is a lot." During observation on 6/30/25 at 5:08 p.m., in the 3rd floor dining room, two residents were eating supper at dining room table while television was on. Baseboards of dining room were beige in color with black markings all along them horizontally. Three rooms at end of hall had black markings along the walls, door frames to the dining room were chipped with stains and missing paint. All resident room door frames were chipped and missing paint. Walls with chair rails had wallpaper peeling or marked with nail holes visibly covered with white wallboard repair, sanded to reveal the nail heads resulting in white repair marks but nothing finished. Painted walls had visible nail holes which were never painted over to match. Section of cracked broken wallboard was visible outside two resident rooms ranging thirty inches horizontally above the baseboard. Broken wallboard that appears to be punched in running two feet above the baseboard outside a resident room. During observation and interview with MD-T on 7/1/25 at 8:24 a.m., on third floor outside resident room there was a horizontal broken portion of wall board above the baseboard which measured thirty inches. A small black winged insect was observed to fly in and out of the crack. MD-T stated, "yeah that looks like it needs to be repaired or replaced". During interview with R7 on 7/1/25 at 8:26 a.m., R7 stated his third-floor resident room, "I hate the way the walls and doors look here. It is junky and gross. Looks like they don't care about how it all looks (pointing out into the hallway)." During review of documents titled completed and active Work Orders with dates "May. 1, 2025 -Jul. 1, 2025" failed to identify maintenance concerns regarding condition of walls, floors, and door frames. During interview with facility's administrator on 7/1/25 at 10:31 a.m., the administrator stated he was aware of "these concerns. But there is no formalized plan written down or discussed to address these issues." The administrator stated condition of walls, floors and door frames "are not appealing".	21665		

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21665	Continued from page 92 FANS: During observation on second floor on 6/30/25 at 2:01 p.m., a large circular floor fan was operating blowing air towards the elevator and nursing station from the lounge room. It had visible dust on the front and back shrouds while operating. Staff and residents were working and ambulating and wheeling selves past the fan. During observation on second floor secured memory care unit on 6/30/25 at 2:15 p.m., a circular fan operating from on the top of the counter of the nursing station. Visible dust and dark matter were noted on the front and back shroud of fan along with the blades of the fan. A female resident was seated next to the fan and another male resident was being transported in a wheelchair past the blowing fan by a staff member. During interview with trained medication aide (TMA)-A on 6/30/25 at 2:19 p.m., TMA-A pointed to the operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "I put it there". TMA-A stated the fan had been "on all day" and "it does need to be cleaned. The cover on the front and back are filthy. ..This is a lot of dirt blowing around." During observation and interview with director of nursing (DON) on 6/30/25 at 2:42 p.m., DON looked at the circular fan operating fan on top of the counter of the nursing station in the second-floor memory care unit and stated, "It is an issue with infection control. Blowing dirty air throughout the unit. Needs to be cleaned." During observation and interview with maintenance director (MT)-D on 7/1/25 at 8:50 a.m., MT-D was wiping the shroud of a large circular floor fan in the lounge of second floor main area. MD stated, "I need to wipe it to get the dust out of it on the inside and outside of the fan." MD-T stated facility had no "specific" cleaning schedule for facility used fans. "I just do it quarterly". During observation and interview with dietary manager (D-M) on 7/1/25 at 10:10 a.m., a large circular	21665		

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21665	Continued from page 93 portable fan was circulating air towards the dishwashing area of kitchen. The area had a large stainless-steel counter along one wall that contained used meal trays, utensils and kitchen pots and pans. The counter curved in the corner of the room to meet the dishwasher unit and clean dishes exited. The fan blew air from dirty portion of the counter to the clean portion where the dishes exited. D-M stated, "The dirty dishes are rinsed here (pointing to the beginning of the counter) and then they are rinsed and moved down the counter towards the dishwashing machine". D-M pointed to the circular portable fan and stated, "It should be getting wiped down. Does not look like it has been wiped because there is dust on the front cover while it is blowing towards the dishwashing area". During observation and interview on first floor hallway outside dining room on 7/1/25 at 11:08 a.m., a large circular floor fan was circulating air from the resident hallway towards the dining room. Visible dust was observed on the shroud. At 11:11 a.m., registered nurse health care consultant (HC) observed fan and stated, "needs to be wiped down. There is dust blowing across the hall onto residents and staff making it an infection control issue. We notice the dusty fans here yesterday and this fan was not cleaned or wiped down." During observation and interview on 7/1/25 at 8:33 a.m., MT-D wiping visible dust from shroud of large circular floor fan outside elevator on third floor. MT-D stated the fan had been in use for "weeks" blowing air towards the nursing station, elevator and resident rooms. During interview with administrator and regional director (MD) on 7/1/25 at 2:24 p.m., MD stated, "All fans should be cleaned". Facility policy on homelike environment was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.	21665		

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21665	Continued from page 94 TIME PERIOD FOR CORRECTION: 21 days	21665		
21730	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 11 Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure adequate pest control measures were in place to eliminate small black flies from the building. This had the potential to affect all 51 residents of the facility. Findings include: During observation and interview with R8 on 6/29/25 at 10:27 a.m., in second floor resident room, several small black flies were observed flying around the room during interview. R8 stated the facility “is full” of small black flies and they are “all over the f***ing building”. R8 stated the flies “been issue for a while…last few months I guess”. R8 stated he was disappointed with facility’s lack of action to address the flies. R8 stated he was “not sure what’s being done about it”. During observation and interview with R31 on 6/29/25 at 10:35 a.m., in third floor resident room R31 stated she “occasionally sees fruit flies” both in her room and out in hallway and dining room. During observation and interview with R36 on 6/29/25 at 10:43 a.m., in third floor resident room, R36 stated facility “gets bugs in here” and was not pleased with it. During observation in second floor dining room on 6/29/25 at 12:17 p.m., a dietary aide was serving food on meal tray to a table with R22 seated in a geriatric chair. Visible little black flies were flying above the table were observed. During interview with nursing assistant (NA)-E on 6/29/25 at 1:19 p.m., NA-E stated she had noticed flies	21730	Corrected.	08/26/2025

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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, Minnesota, 55422**

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21730	Continued from page 95 on the second floor. NA-E stated expectation of staff to notify management of flies and “Bring someone in to spray the place”. During interview with culinary aide (DA)-A on 6/29/25 at 1:31 p.m., DA-A stated she had seen “a lot more fruit flies now consistently [for] two or three weeks.” DA-A stated she did not hear any meetings or information from management regarding fruit flies. During interview with R24 on 6/29/25 at 1:48 p.m., in second floor resident room, R24 stated she had “seen some fruit flies” in the past and that her sister had mentioned it to her also when visiting. During interview with maintenance director (MT)-D on 6/30/25 at 11:14 a.m., MT-D stated he was aware of the small black flies’ “issue” in the facility through verbal reports by staff and residents and stated the pest management company “comes out once a month”. MT-D stated the monthly reports filled out by the pest service specialist (PS)-S were missing so he was unable to provide surveyor written reports. MT-D stated he knew nothing about what specific services PS-S provided to address the fly issue. During observation on 6/30/25 at 2:05 p.m., in the second-floor shower room a small black fly was buzzing around. During interview with nursing assistant (NA)-A on 6/30/25 at 2:15 p.m., NA-A stated she could see and was aware of small black flies in the facility. NA-A stated she noticed black flies when the weather started to get warmer. “Looks like something needs to be done to get rid of them. They are everywhere.” NA-A stated expectation of staff to notify the “nurse” so a report could be completed and sent to MT-D. Also, all staff had ability to email or verbally communicate to MT-D about maintenance concerns, including pests. During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:22 p.m., TMA-A stated she was aware of the small black fly issues in the building from residents and other staff including her own observations. TMA-A stated MD-T was made aware by her via verbal means. TMA-A stated, “[facility] need to do something better”. During interview with director of nursing (DON) on 6/30/25 at 2:49 p.m., DON stated she was aware of the small black fly issues. “I have seen it and reported to [MT-D] within this month.” DON stated MT-D placed “some	21730		

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21730	Continued from page 96 traps out" on resident units and it "still [sic]an issue". During interview with MT-D on 6/30/25 at 3:02 p.m., MT-D stated expectation of staff to communicate facility maintenance needs including pest concerns through electronic Work Orders which can be done through the computer. MT-D stated he is also made aware of issues including pests through verbal communication also. During interview with PS-S on 7/1/25 at 9:55 a.m., PS-S stated he had been at facility in May and June of 2025 for the monthly pest control visits. "[Facility] don't have a logbook there." PS-S stated, "the main issue is that I noticed small flies in the kitchen [sic]." PS-S stated he spoke to administrator and "just met [MT-D] over the phone the other day." During tour with PS-S on 7/1/25 at 1:51 p.m., PS-S stated the facility contract with the pest control company provided, "no service for the smaller flies that are going around here." During interview with dietary manager (D)-M on 7/1/25 at 10:10 a.m., D-M stated she was aware of the flies in the kitchen area and swatted a black fly as she exited the kitchen. During review of customer service report invoice with service date of 6/11/25, the "Target Pest" column identifies "Flies-Large". During review of the facility's Pest Elimination Services Agreement dated 8/30/2022, the contracted services include "Outside in Large Fly Program" with frequency of "Monthly-6 Month Program". During review of documents titled Work Orders with dates "May. 1, 2025 -Jul. 1, 2025" failed to identify concerns with pests or small black flies. During review of Grievance Tracking logs from January 2025 to June 2025, no mention of pests for "Types of Concern". During interview with administrator and regional director (RD) on 7/1/25 at 10:25 a.m., the administrator stated he was informed of the black flies "over a month ago". The administrator stated MT-D bought over the counter "apple things" to trap flies and "agree, [it is] still an ongoing issue". RD stated he was not aware the monthly pest control services and service agreement failed to address small black flies. "Should be done."	21730		

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21730	Continued from page 97 Facility policy titled Pest Control, revised May 2008 identified, “Our facility shall maintain an effective pest control program.” SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative pest control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21730		
21825	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 9 Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	21825	Corrected.	08/26/2025

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21825	Continued from page 98 failed to obtain and document an informed consent, including with explanation of risk and benefits, before giving psychotropic medications for 2 of 5 residents (R24, R25) reviewed for unnecessary medication use. Findings include: R24 R24's admission Minimum Data Set (MDS), dated 5/5/25, identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. The MDS recorded R24 as having severe cognitive impairment and consuming both antipsychotic and antidepressant medications. R24's Order Summary Report, signed 5/15/25, identified R24's current physician-ordered medications and treatments along with their respective start date(s). These included orders for duloxetine (antidepressant medication) 20 milligrams (mg) once daily, haloperidol (an antipsychotic medication) with multiple doses ordered daily, and mirtazapine (antidepressant medication) 7.5 mg every bedtime. These medications all had a start date recorded of, "04/29/2025." R24's Medication Administration Record (MAR), dated 6/2025, identified R24's medications along with staff initials to demonstrate their respective administration. The orders for duloxetine, haloperidol, and mirtazapine were listed and each of these medications were recorded as administered for the entire month period. On 7/1/25 at 12:28 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they were R24's financial guardian and were very involved in her (R24) care decisions, too. FM-G stated R24 had been on the antidepressant medication since she was hospitalized a few months prior due to being "very combative" with staff members there. FM-G stated there had been no discussion from the care center about the duloxetine or mirtazapine medications thus far to their recall and then abruptly asked the surveyor aloud, "What are the side effects?!" R24's medical record was reviewed and lacked evidence a signed or verbal consent for use of the medication was obtained prior to them being provided. Further, the record lacked evidence the risks or expected benefits of the medication regimen had been reviewed or discussed with R24 or their responsible family member prior to initiation of the medications.	21825		

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21825	Continued from page 99 When interviewed on 7/1/25 at 12:41 p.m., licensed practical nurse (LPN)-B explained the "admitting nurse" was the person who typically obtained consent for psychotropic medications from the resident or family upon admission. LPN-B stated this was done with "a form we have them sign" about the medications, and there should be a separate one for each psychotropic ordered. The forms were then scanned into the electronic medical record (EMR). LPN-B reviewed R24's medical record, including hard chart and EMR, and expressed they were unable to locate any consents for the mirtazapine or duloxetine adding, "We're missing those two." LPN-B stated R24 had family members who were involved with her care and mentioned FM-G by name as the person who helped R24 sign paperwork and make decisions. LPN-B verified they were unable to locate evidence of a signed, informed consent being obtained for the two psychotropic medications adding they'd looked "everywhere that I would know to look [for them]." LPN-B stated mirtazapine and duloxetine both should have had a signed consent due to their potential side effects adding, "Those medications just have to have consent." When interviewed on 7/1/25 at 12:56 p.m., social worker (SW)-A stated nursing was responsible to get medication consents. SW-A added, "Nursing will do that." On 7/1/25 at 3:43 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R24's medical record for the consents. DON stated the admitting nurse should obtain all required consents and document them on paper before getting them scanned into the medical record. DON verified they were unable to locate any signed consents for R24's duloxetine or mirtazapine adding, "I didn't [find them]." DON added, "Something didn't get done." DON stated they would start education with the nurses to ensure consents were obtained moving forward adding obtaining consent was important so the patient "understands the risk and benefits [of the medication]." DON added, "It's part of the state regs [regulations]." R25 R25's quarterly Minimum Data Set (MDS) dated 6/13/25, indicated R25 had severely impaired cognitive skills for daily decision making. R25's diagnoses included aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medication.	21825		

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21825	Continued from page 100 R25's Medication Administration Record dated June 2025, indicated R25 received risperidone (an antipsychotic medication) 1 milligram by mouth at bedtime for severe, recurrent major depressive disorder with psychotic symptoms with a start date of 6/10/25. R25's medical record lacked evidence of an informed consent for risperidone. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated the admitting nurse obtained psychotropic medication consents for new admissions. RN-A stated if there was a change in psychotropic medication there was usually an associated clinic of psychology (ACP) provider involved who spoke with the resident or resident representative about the change in dosage first. If the ACP provider did not involve the responsible party, then nursing would obtain the consent for the psychotropic medication. During interview on 7/2/25 at 11:20 a.m., the director of nursing (DON) stated nursing obtained the consent for risperidone today, since they did not find a risperidone consent form in R25's medical record. During follow-up interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to obtain consents for psychotropic medications. The DON stated it was important to ensure the resident or responsible part were aware of the risks and benefits of the medication before administration. The facility Antipsychotic Medication Use policy dated December 2016, directed the attending physician and other staff to gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy did not specifically address informed consent to educate a resident or responsible party on the side effect/risks and benefits of antipsychotic medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on informed consent and the process to obtain such with psychotropic medications; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	21825		
21880	Patients & Residents of HC Fac.Bill of Rights	21880	Corrected.	08/26/2025

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21880	Continued from page 101 CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to appropriately follow up on continued and repeated voiced grievances of provided food for a diabetic diet for 1 of 2 residents (R31) reviewed for grievances who gained 35% of their weight since being admitted to the care facility. Findings include: R31's annual Minimal Data Set (MDS), dated 4/26/25, R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood	21880		

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21880	Continued from page 102 pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes. R31's weights, listed in the electronic medical record (EMR), indicated R31 weighed 165 pounds at admission to the care center and their most recent weight was listed as 231 pounds, a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet. R31's EMR lacked any progress notes from dietary or nutritional services and lacked any mention of R31's food concerns despite repeated vocal complaints. The facility's grievance log for the past six months was reviewed and also lacked any mention of R31's voiced complaints about the food she was receiving. During an interview on 6/29/25 at 10:35 a.m., R31 stated she had to buy her own fridge and food to ensure she had foods to eat that would work within her diabetic diet, stating she should be on a diabetic diet but feels the facility does not follow it. R31 stated she had told multiple people about her food concerns but had not worked with the dietician at the care facility. During an interview on 7/1/25 at 10:48 a.m., licensed practical nurse (LPN)-B stated the food at the facility had been an issue for "over a year" stating they don't offer R31"diabetic options" such as sugar free items or syrup. LPN-B confirmed R31 had voiced her complaints plenty of times and R31 would often say, "they know I'm on a diabetic diet and give me all these carbs". LPN-B further stated many times R31 would make the decision not to eat the food that was served to her. LPN-B stated dietary was aware of the complaints. During an interview on 7/1/25 at 11:58 a.m., the certified dietary (district) manager (CDM) stated if a resident had an order for a diabetic diet, then the system would automatically push starch items to half portions or substitute out that item for a different item. The CDM stated they had started education with diabetic residents to help them understand that they might still see carbs on their plate even if they were on a diabetic diet and to help the residents "understand where we [the facility] are coming from regarding diabetic diets." The CDM stated R31 was on a consistent carbohydrate diet, not a renal diet, which would include more carbs than a renal diet. The CDM further stated R31 was a vocal person so the assumption was that everyone had heard her concerns, however,	21880		

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21880	Continued from page 103 "sometimes word doesn't travel as well as we would like - we are working to have better communication between the floor staff and us". During an interview on 7/1/25 at 12:49 p.m., LPN-A stated R31 complained about the facility food all the time and voiced complaints about not getting food consistent with a diabetic diet. LPN-A stated she let the nurse manager know about R31's complaints but had not noticed any changes. During an interview on 7/2/25 at 8:57 a.m., the third-floor nurse manager, LPN-E, stated she had heard complaints from R31 about how terrible the food was but did not recall any complaints specific to her diabetic diet. During an interview on 7/2/25 at 10:15 a.m., licensed social worker (LSW)-A, who was the grievance officer at the facility, stated she would have expected to hear about repeated concerns relating to food or receiving proper diets, confirming she did not have any formal grievances for R31. A facility policy titled Grievances/Complaints - Staff Responsibility, revised 10/2017, indicated should a staff member overhear or be the recipient of a complaint voiced by a resident concerning care in the facility, including food, the staff member is encouraged to help, or guide, the resident to file a written complaint with the facility. The facility could review policies and procedures related to grievances. The Administrator (or designee) should conduct measurable audits on grievances to ensure resident concerns are being documented and addressed. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21880		