Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 5, 2025

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

RE: CCN: 245289
Cycle Start Date: December 6, 2024

Dear Administrator:

On January 13, 2025, we notified you a remedy was imposed. On April 1, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 21, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 15, 2025 be discontinued as of April 21, 2025. (42 CFR 488.417 (b))

In our letter of January 13, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 15, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency(ies) cited under K521 at the time of the December 6, 2024 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of July 1, 2025, has been forwarded to the the Centers for Medicare and Medicaid Services (CMS) Location for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 5, 2025

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

Re: Reinspection Results
Event IDs: 9B9T12, K0GM12, 552212, and C2VH12

Dear Administrator:

On January 14, 2025, February 12, 2025, April 1, 2025, and April 23, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed reinspections of your facility, to determine correction of orders found on the surveys completed on December 6, 2024, December 24, 2024, January 17, 2025, and March 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered

January 13, 2025

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

RE: CCN: 245289
Cycle Start Date: December 6, 2024

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 December 11, 2024, we informed you that we may impose enforcement remedies.

On December 24, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey 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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 6, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 6, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 6, 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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 6, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Terrace At Crystal Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 June 6, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 13, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: K0GM11

Dear Administrator:

The above facility was surveyed on December 23, 2024 through December 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The 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 number and the corresponding text of 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	C 12/24/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/23/24 through 12/24/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52892163C (MN00108814) with a deficiency cited at F880. 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.	F 000		
F 880 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		2/2/25

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

Electronically Signed | 01/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 1 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	F 880		

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F 880	Continued From page 2 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing/hand hygiene, personal protective equipment, and enhanced barrier precautions (EBP) were implemented for 2 of 2 residents (R1, R2) observed during wound care, an intravenous (IV) flush, and catheter care. Findings include: R1's Face Sheet indicated R1 had diagnoses of nondisplaced trimalleolar fracture of unspecified lower leg (broken leg), need for assistance with personal care, spondylosis without myelopathy or radiculopathy (spinal cord disorder). R1's quarterly Minimum Data Set (MDS) assessment dated 11/2/24, indicated he needed the assistance of two staff for bed mobility and eating, one staff for toileting, and he transferred independently.	F 880	F880 It is the policy of The Terrace at Crystal to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Corrective Action: Employees involved in cited violation on 12-23-2025, 12-24-2025 LPN-A & RN-A were re-educated immediately on 12.24.24 on hand-sanitation practices and following transmission-based precautions. R1 & R2 were reviewed for level of condition which remain at baseline. Identification of Other Residents: All residents are potentially at risk for violation	

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F 880	Continued From page 3 R1's cognitive test dated 8/5/24 indicated he was cognitively intact. R1's Physician Orders for wound care dated 12/11/24, directed New right ankle dressing orders. Cleanse with Vashe (wound cleanser), apply skin prep around the wound, apply Xerofoam (occlusive dressing) and cover with Mepilex (absorbent dressing) dressing daily and as needed. R1's Physician Order for his gastrostomy tube (G-Tube, feeding tube) dated 11/16/24 directed G-Tube dressing: cleanse with Vashe, apply skin prep, apply 4% lidocaine gel. Apply T-drain (sponge) gauze, secure with tape twice daily and as needed. R1's Physician Order dated 12/20/24 directed Vancomycin hydrochloride (antibiotic) intravenous solution 1250 milligram (mg)/250 milliliter (ml), use 262.5 ml intravenously one time a day for infection of the skin and/or soft tissue. Inject 262.5 ml over 90 minutes." R1 had a peripherally inserted catheter (PICC, an intravenous line going from the arm to the heart) in his right arm. R1's care plan dated 12/23/24 indicated enhanced transmission-based precautions: resident is on transmission-based precautions related to g-tube feeding and wounds. R2's Face Sheet dated 12/23/24 indicated R1 had diagnoses of osteomyelitis of vertebra sacral and sacrococcygeal region (infection of the bone in the spine), Methicillin-resistant Staphylococcus aureus (MRSA, bacterial infection), bacteremia	F 880	of infection control practices. Measures Put in Place: All residents will be reviewed for appropriate transmission-based precautions by 01.24.25. Mandatory education for all nursing staff will be conducted for infection control practices to include the importance of transmission-based precautions, risk factors and hand sanitation practices including hand sanitation between gloves changes, and when going from a dirty task to clean task while performing ADL's and treatments. Nursing leadership will audit 20% of all nursing staff for infection control practices by nursing management by compliance date of 02.02.2025 Monitoring Mechanisms: Nursing management will perform random audits on 10% of nursing staff to ensure proper infection control procedures are being followed in all areas of care. Nursing management will audit staff members performing varying cares tasks and treatments 3x weekly for the next 30 days and then 2x time weekly for the next 60 days to ensure compliance with use of proper sanitizing product. The QAPI committee will review audits for compliance with facility infection control procedures related to transmission-based precautions and hand sanitation.	

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F 880	Continued From page 4 (bacteria in the blood), chronic osteomyelitis in left thigh (infection of the bone in the thigh), resistance to multiple antibiotics, presence of urogenital implants (a surgically inserted device into the urinary system), pressure ulcer of sacral region Stage 4 (open area extending below the fat to cartilage or bone), paraplegia incomplete (partial paralysis). R2's quarterly MDS dated 10/16/24 indicated R2 required assist of one staff with bed mobility and transfers, and . he was independent with other activities of daily living. R2's cognitive test dated 8/6/24 indicated he was cognitively intact. R2's Physician Orders for wound care dated 11/2/24 directed for superior/sacral part of wound: patient is being treated with placental membrane product (human placental tissue) do not remove dressing until reassessed by provider. If dressing falls off or is soiled, reapply foam dressing but do not clean wound bed. One time a day. R2's suprapubic catheter (tube that drains urine from the bladder through an incision in the abdomen) nursing care order, dated 6/12/23 directed catheter cares every shift. R2's care plan dated 12/23/24, indicated enhanced transmission-based precautions (infection control measures): resident is on transmission-based precautions related to suprapubic catheter and wounds. On 12/23/24 at 9:44 a.m., registered nurse (RN)-A	F 880		

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

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F 880	Continued From page 5 (the facility wound care nurse and infection preventionist) was observed doing R1's wound cares. RN-A was assisted by licensed practical nurse (LPN)-A. R1's door had an enhanced barrier precuations (EBP, infection control interventions) sign on it that indicated when to wear PPE (personal protective equipment including gowns and gloves) and for what type of contact. RN-A used hand sanitizer, donned one pair of gloves, a gown, mask, and then donned a second pair of gloves. LPN-A donned a gown, mask and one pair of gloves after using hand sanitizer. LPN-A removed R1's socks and dressing. RN-A checked R1's wound vac (equipment that uses negative pressure to pull the edges of a wound together), disconnected it and removed the adhesive dressing. RN-A doffed his second pair of gloves and without performing hand hygiene, donned a clean pair of gloves. RN-A completed R1's wound care orders while wearing double gloves. LPN-A doffed gown and gloves and exited the room. RN-A doffed the second pair of gloves, and removed R1's old GT dressing. RN-A doffed the second pair of gloves, and cleansed the GT site. LPN-A re-entered the room with gloves, mask, and no gown. LPN-A flushed R1's PICC line. On 12/23/24 at 10:27 a.m., RN-A and the assistant director of nursing (ADON) prepared to complete R2's wound cares. RN-A used hand sanitizer, donned a gown, mask and two pairs of gloves. The ADON donned a gown, mask and one pair of gloves. Both staff helped reposition R2 to remove clothes and a soiled incontinent brief. The ADON left the room. RN-A removed his second pair of gloves and without performing hand hygiene donned a clean second pair. RN-A cleansed the	F 880		

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	245289	A. BUILDING _____ B. WING _____	C 12/24/2024

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F 880	Continued From page 6 wound and doffed the second pair of gloves. RN-B applied the dressing and completed the wound care. RN-A doffed the second pair of gloves. At 10:49 a.m., RN-A opened and cut the suprapubic catheter dressing. RN-A doffed the second pair of gloves. RN-A cleansed the catheter site. RN-A doffed the second pair of gloves. RN-A applied the dressing to the catheter site. RN-A helped R2 pick out clothes and get dressed. On 12/23/24 at 1:48 p.m., RN-A stated staff should wear a gown when flushing a PICC line. Hands should be washed every time gloves are changed. He used double gloves because the disposable gowns had a thumb hole in the sleeve, and the extra material on the cuff would spread germs. So he used the first pair of gloves to tuck the thumb hole and sleeve into. He verified there was another type of gown available in the facility with a normal cuff. RN-A explained he preferred the gown with thumb holes because it was easier to take off. He provided staff with hand washing education and educated staff to change gloves and cleanse hands, but double gloving was his "own etiquette" and other staff did not double glove. On 12/23/24 at 2:21 p.m., LPN-A stated while flushing the PICC line, staff should wear a gown and gloves. She forgot to put a gown back on when she re-entered the room, it had been a busy morning. Hand hygiene should occur before and after you enter the room, and during any glove changes. Double gloving was not an acceptable practice. On 12/24/24 at 8:36 a.m., RN-B stated PPE should be worn during any personal cares, which	F 880		

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F 880	Continued From page 7 would include flushing a PICC line. Hands should be washed before you enter the room, after gloves are taken off, when going from dirty to clean, and when hands were visibly soiled. Staff should not be using double gloves. She doesn't use the thumb hole when she uses a gown with thumb holes. On 12/24/24 at 9:09 a.m., the ADON stated there had been a lot of education provided to staff about hand hygiene. PPE should be used when flushing a PICC line. Double gloves should not be used. The gowns with thumb holes were available because they didn't expose the forearms. H used the thumb holes, but when he sanitized his hands, the extra material on the cuff was also sanitized. The facility policy Enhanced Barrier Precautions dated 11/24, directed the example of high contact resident care activities requiring the use of gown and gloves for EBPs includes device care or use (central line, urinary catheter, feeding tube). The facility policy Handwashing/Hand Hygiene undated, directed the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.	F 880		

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2 000	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: On 12/23/24 through 12/24/24, a complaint 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 licensing orders were	2 000		

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2 000	Continued From page 1 issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H52892163C (MN00108814) with a licensing order issued at 4658.0800 Subp. 3. 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 surveyor ' s 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 14-01, available at <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. 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance 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 and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing/hand hygiene, personal protective equipment, and enhanced barrier precautions (EBP) were implemented for 2 of 2 residents (R1, R2) observed during wound care, an intravenous (IV) flush, and catheter care. Findings include: R1's Face Sheet indicated R1 had diagnoses of nondisplaced trimalleolar fracture of unspecified lower leg (broken leg), need for assistance with personal care, spondylosis without myelopathy or	21385	Corrected	2/2/25

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21385	Continued From page 3 radiculopathy (spinal cord disorder). R1's quarterly Minimum Data Set (MDS) assessment dated 11/2/24, indicated he needed the assistance of two staff for bed mobility and eating, one staff for toileting, and he transferred independently. R1's cognitive test dated 8/5/24 indicated he was cognitively intact. R1's Physician Orders for wound care dated 12/11/24, directed New right ankle dressing orders. Cleanse with Vashe (wound cleanser), apply skin prep around the wound, apply Xerofoam (occlusive dressing) and cover with Mepilex (absorbent dressing) dressing daily and as needed. R1's Physician Order for his gastrostomy tube (G-Tube, feeding tube) dated 11/16/24 directed G-Tube dressing: cleanse with Vashe, apply skin prep, apply 4% lidocaine gel. Apply T-drain (sponge) gauze, secure with tape twice daily and as needed. R1's Physician Order dated 12/20/24 directed Vancomycin hydrochloride (antibiotic) intravenous solution 1250 milligram (mg)/250 milliliter (ml), use 262.5 ml intravenously one time a day for infection of the skin and/or soft tissue. Inject 262.5 ml over 90 minutes." R1 had a peripherally inserted catheter (PICC, an intravenous line going from the arm to the heart) in his right arm. R1's care plan dated 12/23/24 indicated enhanced transmission-based precautions: resident is on transmission-based precautions related to g-tube feeding and wounds.	21385		

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21385	Continued From page 4 R2's Face Sheet dated 12/23/24 indicated R1 had diagnoses of osteomyelitis of vertebra sacral and sacrococcygeal region (infection of the bone in the spine), Methicillin-resistant Staphylococcus aureus (MRSA, bacterial infection), bacteremia (bacteria in the blood), chronic osteomyelitis in left thigh (infection of the bone in the thigh), resistance to multiple antibiotics, presence of urogenital implants (a surgically inserted device into the urinary system), pressure ulcer of sacral region Stage 4 (open area extending below the fat to cartilage or bone), paraplegia incomplete (partial paralysis). R2's quarterly MDS dated 10/16/24 indicated R2 required assist of one staff with bed mobility and transfers, and . he was independent with other activities of daily living. R2's cognitive test dated 8/6/24 indicated he was cognitively intact. R2's Physician Orders for wound care dated 11/2/24 directed for superior/sacral part of wound: patient is being treated with placental membrane product (human placental tissue) do not remove dressing until reassessed by provider. If dressing falls off or is soiled, reapply foam dressing but do not clean wound bed. One time a day. R2's suprapubic catheter (tube that drains urine from the bladder through an incision in the abdomen) nursing care order, dated 6/12/23 directed catheter cares every shift. R2's care plan dated 12/23/24, indicated enhanced transmission-based precautions (infection control	21385		

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21385	Continued From page 5 measures): resident is on transmission-based precautions related to suprapubic catheter and wounds. On 12/23/24 at 9:44 a.m., registered nurse (RN)-A (the facility wound care nurse and infection preventionist) was observed doing R1's wound cares. RN-A was assisted by licensed practical nurse (LPN)-A. R1's door had an enhanced barrier precuations (EBP, infection control interventions) sign on it that indicated when to wear PPE (personal protective equipment including gowns and gloves) and for what type of contact. RN-A used hand sanitizer, donned one pair of gloves, a gown, mask, and then donned a second pair of gloves. LPN-A donned a gown, mask and one pair of gloves after using hand sanitizer. LPN-A removed R1's socks and dressing. RN-A checked R1's wound vac (equipment that uses negative pressure to pull the edges of a wound together), disconnected it and removed the adhesive dressing. RN-A doffed his second pair of gloves and without performing hand hygiene, donned a clean pair of gloves. RN-A completed R1's wound care orders while wearing double gloves. LPN-A doffed gown and gloves and exited the room. RN-A doffed the second pair of gloves, and removed R1's old GT dressing. RN-A doffed the second pair of gloves, and cleansed the GT site. LPN-A re-entered the room with gloves, mask, and no gown. LPN-A flushed R1's PICC line. On 12/23/24 at 10:27 a.m., RN-A and the assistant director of nursing (ADON) prepared to complete R2's wound cares. RN-A used hand sanitizer, donned a gown, mask and two pairs of gloves. The ADON donned a gown, mask and one pair of gloves. Both staff helped reposition R2 to	21385		

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21385	Continued From page 6 remove clothes and a soiled incontinent brief. The ADON left the room. RN-A removed his second pair of gloves and without performing hand hygiene donned a clean second pair. RN-A cleansed the wound and doffed the second pair of gloves. RN-B applied the dressing and completed the wound care. RN-A doffed the second pair of gloves. At 10:49 a.m., RN-A opened and cut the suprapubic catheter dressing. RN-A doffed the second pair of gloves. RN-A cleansed the catheter site. RN-A doffed the second pair of gloves. RN-A applied the dressing to the catheter site. RN-A helped R2 pick out clothes and get dressed. On 12/23/24 at 1:48 p.m., RN-A stated staff should wear a gown when flushing a PICC line. Hands should be washed every time gloves are changed. He used double gloves because the disposable gowns had a thumb hole in the sleeve, and the extra material on the cuff would spread germs. So he used the first pair of gloves to tuck the thumb hole and sleeve into. He verified there was another type of gown available in the facility with a normal cuff. RN-A explained he preferred the gown with thumb holes because it was easier to take off. He provided staff with hand washing education and educated staff to change gloves and cleanse hands, but double gloving was his "own etiquette" and other staff did not double glove. On 12/23/24 at 2:21 p.m., LPN-A stated while flushing the PICC line, staff should wear a gown and gloves. She forgot to put a gown back on when she re-entered the room, it had been a busy morning. Hand hygiene should occur before and after you enter the room, and during any glove changes. Double gloving was not an acceptable practice.	21385		

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21385	Continued From page 7 On 12/24/24 at 8:36 a.m., RN-B stated PPE should be worn during any personal cares, which would include flushing a PICC line. Hands should be washed before you enter the room, after gloves are taken off, when going from dirty to clean, and when hands were visibly soiled. Staff should not be using double gloves. She doesn't use the thumb hole when she uses a gown with thumb holes. On 12/24/24 at 9:09 a.m., the ADON stated there had been a lot of education provided to staff about hand hygiene. PPE should be used when flushing a PICC line. Double gloves should not be used. The gowns with thumb holes were available because they didn't expose the forearms. H used the thumb holes, but when he sanitized his hands, the extra material on the cuff was also sanitized. The facility policy Enhanced Barrier Precautions dated 11/24, directed the example of high contact resident care activities requiring the use of gown and gloves for EBPs includes device care or use (central line, urinary catheter, feeding tube). The facility policy Handwashing/Hand Hygiene undated, directed the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise infection control policy and procedures. The DON or designee could re-educate nursing staff on infection control policies and procedures. The DON or designee	21385		

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21385	Continued From page 8 could complete an audit on staff use of PPE, EBP and hand hygiene to monitor ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		