



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 2024

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

RE: CCN: 245289
Cycle Start Date: March 27, 2024

Dear Administrator:

On April 17, 2024, we notified you a remedy was imposed. On June 27, 2024 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 June 19, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 25, 2024 be discontinued as of June 19, 2024. (42 CFR 488.417 (b))

In our letter of May 10, 2024, 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 April 12, 2024. 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 cited under K521 at the time of the March 27, 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 September 27, 2024, 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 / these deficiencies 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,

The Terrace At Crystal Llc

July 2, 2024

Page 2

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

July 2, 2024

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

Re: Reinspection Results
Event ID: 40FM12 and XHFH12

Dear Administrator:

On May 29, 2024 and June 4, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on April 4, 2024 and April 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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

April 17, 2024

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

RE: CCN: 245289
Cycle Start Date: March 27, 2024

Dear Administrator:

On April 8, 2024, we informed you that we may impose enforcement remedies.

On April 4, 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 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 June 27, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 27, 2024.

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 \$11,995, 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 June 27, 2024, 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 June 27, 2024. 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:

Susie Haben, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Midtown Square

3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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 September 27, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

The Terrace at Crystal LLC

April 17, 2024

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 17, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 40FM11

Dear Administrator:

The above facility was surveyed on April 3, 2024 through April 4, 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.

The Terrace At Crystal LLC

April 17, 2024

Page 2

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:

Susie Haben, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Midtown Square

3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,



Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2024
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 4/03/24 and 4/04/24, 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: H52892700C (MN102032) with F689 cited as a result of the investigation. H52892667C (MN101738) with deficeincy cited at F689. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609			5/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2024

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2024
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F 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a potential allegation of neglect was recognized and reported to the State agency (SA) in a timely manner for 1 of 1 resident (R1) reviewed who reported a burn to staff during therapy treatment. Findings include: R1's significant change Minimum Data Set (MDS) dated 1/16/24, indicated R1 was moderately cognitively intact, had bilateral amputation of lower extremities, coronary artery disease, heart failure, peripheral vascular disease (PVD) and diabetes mellitus. R1's Integrated Wound Care (IWC) note dated	F 609	1. Failure to report allegations of abuse, neglect, exploitation or mistreatment by the facility has the potential to affect all residents in the facility. 2. Facility will educated all staff before or on May 31st that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-0391

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F 609	Continued From page 2 9/26/23, indicated R1 was seen for ongoing assessment and management wounds left leg pressure ulcer to right stump, and bilateral wounds to middle finger. The report further indicated the right middle finger burn was 1.1 centimeter (cm) x 1.8 cm x 0.2 cm. with small serosanguineous (a combination of serous fluid and blood. It's usually a light pink to red color. This is a sign that your body is healing the wound and isn't a concern in normal amounts). The report further indicated the left middle finger burn indicated small serosanguineous with the wound measuring 2.3 cm x 2 x 0.3 cm. Note indicated a diagnosis of first degree burn of single right finger (nail) except thumb, initial encounter and burn of first degree of single left finger (nail) except thumb, initial encounter. During interview on 4/03/24 at 1:51 p.m. R1 stated he received burns on his middle fingers while in therapy using a heating pad and the following day they turned into blisters and reported this to the director of rehab (DOR) the following week but knew the nursing staff was aware. R1 then stated he was told by therapy the next time they use the heating pads on his hands they would wrap his hands first in some dressing so this would never happen again. R1 reported he was told that by a therapist but was not sure which therapist. During interview on 4/03/24 at 2:23 p.m. the DOR stated she recalled R1 received a burn on on his middle fingers. During interview on 4/03/24, at 3:00 p.m. the facility administrator stated she was not aware of the heating pad machine in the therapy office. The administrator stated she checked the risk	F 609	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 3.This training will be added to the new hire orientation and to the annual mandatory training. 4. HR will be responsible for auditing employee files quarterly to ensure that each employee training is completed with a 100% training completion goal. This audit will be conducted for the entire 2024. HR is responsible for reporting findings of audits to QAPI for review and discussion quarterly. Staff found to be out of compliance will be taken off the schedule until training is completed. 5. The Administrator and Human Resources are responsible for the completion of this plan of correction.		

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F 609	Continued From page 3 management on the facility computer system and was unable to find anything about the situation with R1's burns to his fingers and also stated she was not the administrator during that time and was not aware and if she was she definitely would have reported the incident. Review of facility policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating revised 09/22, indicated if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected the suspicion must be reported immediately to the administrator and to other officials according to state law. Further, facility policy indicated immediately was defined as within two hours of an allegation involving abuse.	F 609			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide safety for 1 of 4 residents (R1) who sustained a burn from a heat pad machine in the therapy department and 1 of 2 residents (R2) who was documented to have a cigarette burn.	F 689			5/31/24
			1.Failure to to ensure accident free environment and provide adequate supervision and assistance devices to prevent accidents has the potential to affect all residents in the facility. 2. Facility will educated all staff before or on May 31st that the facility must provide accident free environment to all residents		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2024
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F 689	Continued From page 4 Findings include: R1's significant change minimum data set (MDS) dated 1/16/24, indicated R1 was moderately cognitively intact, had bilateral amputation of lower extremities, coronary artery disease, heart failure, peripheral vascular disease (PVD) and diabetes mellitus. R1's Care Plan (CP) reviewed 3/05/24, indicated R1 had coronary artery disease, hypertension, peripheral vascular disease and diabetes mellitus. The Care plan further indicated educate the patient on importance of good nutrition and hydration and give medications for improved blood flow or anticoagulants as needed. In addition, to report any signs or symptoms of skin problems related to PVD: redness, edema, blistering, itching, burning, bruises, cuts and other lesions. R1's Integrated Wound Care (IWC) note dated 9/26/23, indicated R1 was seen for ongoing assessment and management wounds left leg pressure ulcer to right stump, and bilateral wounds to middle finger. The report further indicated the right middle finger burn was 1.1 centimeter (cm) x 1.8 cm x 0.2 cm. with small serosanguineous (a combination of serous fluid and blood. It's usually a light pink to red color. This is a sign that your body is healing the wound and isn't a concern in normal amounts). The report further indicated the left middle finger burn indicated small serosanguineous with the wound measuring 2.3 cm x 2 x 0.3 cm. Note indicated a diagnosis of first degree burn of single right finger (nail) except thumb, initial encounter and burn of first degree of single left finger (nail) except thumb, initial encounter.	F 689	and provide adequate supervision and assistance devices to prevent accidents has the potential to affect all residents in the facility. 3. Nursing staff and therapy staff will be educated on or by May 31 that skin assessments must be accurate and incident reports must be completed for all new burns. 4.This training will be added to the new hire orientation and to the annual mandatory training. 4. The Hydrocollator Heating Unit was removed out of therapy department and decommissioned. The decision was made not to use Hydrocollator Heating Unit at the facility any longer. 5. HR will be responsible for auditing employee files quarterly to ensure that each employee training is completed with a 100% training completion goal. This audit will be conducted for the entire 2024. HR is responsible for reporting findings of audits to QAPI for review and discussion quarterly. Staff found to be out of compliance will be taken off the schedule until training is completed. 5. The Administrator and Human Resources are responsible for the completion of this plan of correction.		

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F 689	Continued From page 5 During interview on 4/03/24 at 1:51 p.m., R1 stated he received burns on his middle fingers while in therapy using a heating pad and the following day they turned into blisters and reported this to the director of rehab (DOR) the following week but knew the nursing staff was aware. R1 then stated he was told by therapy the next time they use the heating pads on his hands they would wrap his hands first in some dressing so this would never happen again. R1 reported he was told that by a therapist but was not sure which therapist. During interview on 4/03/24 at 2:23 p.m., the director of rehab (DOR) stated she recalled R1 received a burn on his middle fingers. The DOR stated the therapy department used a Hydro-Heater (heat pad machine) and when they took a pad out of the machine, they let it sit for 30 to 60 minutes and then put it in a two sided barrier and then place a towel on top of it for a third barrier. The DOR stated they use the machine and heating pad prior to passive range of motion (PROM) so resident's joints and hands warm up. In addition, the DOR stated she was not aware of any maintenance to the machine or temperature checks, but would look into it. The DOR stated she thought the machine was given to them, but was not sure. During observation and interview on 4/03/24, at 3:00 p.m., with the administrator, the DOR, and the facility administrator, the administrator stated she was not aware of the heating pad machine in the therapy room. In addition, the administrator stated she was not aware of any training for the therapy staff to use the machine nor was she aware of any maintenance on the machine. The	F 689			

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F 689	Continued From page 6 DOR was observed to temp the water in the Hydro-Heater with a inared thermatore and the temperature was 112 degrees (within safe range). In review of the machine with the DOR and the administrator on 4/03/24 at 3:20 p.m., a sticker was observed on the machine which indicated the last safety check and calibration was completed on 8/19, and the DOR stated it looked like that meant it must have last been maintained on 2019. The administrator stated she will have someone come out and calibrate and do a safety check on the heating pad machine in the therapy office to be safe since she was not aware of the machine in the therapy room. During an subsequent interview via email on 4/03/2024 at 4:35 p.m., the administrator provided an email indicating the heating machine was a Hydorocllator Chattanooga machine. And the staff fill it with water when it gets about 1-2 inches low. The facility provided an operational Manuel for a Chattanooga hyrocollator undated, indicated "The Hydrocollator Heating Unit is equipped with an immersion type heating element and a hydraulic capillarity thermostat which evenly maintains the HotPac temperature in the water and provides a ready supply of heated packs . It is critical to maintain the water level over the top of the HotPac to avoid damage to the heating element, the stainless steel, or the HotPac . Water is constantly lost during operation due to evaporation. Therefore, it is essential that water be added daily. The tank should also be drained, cleaned, and inspected at minimum intervals of every two weeks." In addition the manual indicated to: Excessive chlorine can be	F 689			

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F 689	Continued From page 7 detrimental to the stainless steel in the Hydrocollator Heating Unit. No bleach or any cleaner with high chlorine content should be used under any circumstance. 2 Clean regularly for optimal service and operation. 3 Fill daily with water. Water is constantly lost during operation due to evaporation. 4 Chlorine in regular tap water may be present in high enough concentrations to damage the unit. If you suspect high levels of chlorine in the Hydrocollator Heating Unit, the addition of a dechlorinator is recommended. 5 Certain additives (such as herbal teas, essential oils, etc.) will damage the HotPacs and components of the heating unit, including the stainless steel. The Hydrocollator Heating Unit was designed to heat water and HotPacs only. The addition of any such foreign substance (except dechlorinator) to the water in the unit will void the warranty. 6 Inspect the heating element for pitting and other visible damage during regular cleaning intervals. 7 Inspect the power cord for wear, fraying, and other visible damage during regular cleaning intervals. Review of a variety of therapy residents dating back to 10/2023 revealed no other residents had injuries related to heating pad burns from the therapy department. The facility lacked evidence of ongoing and adequate maintenance and cleaning of the heating pad unit, identifying safe and documented procedures for use of the equipment, posting signage near the equipment identifying only trained staff were allowed to use heating equipment, and ensuring all therapy staff were trained on the safe use of the equipment related to patient care.	F 689			

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F 689	Continued From page 8 R2's admission MDS dated 1/30/24, indicated R2 was moderately cognitively intact, had renal insufficiency, diabetes mellitus, malnutrition, anxiety and used tobacco. R2's MDS further indicated she used a wheelchair for mobility and had no burns. R2's CP dated 1/25/24, indicated R2's guardian requested an order for nicotine patch, the CP further indicated R2 frequently refused the patch and prefers to smoke about four times a day. CP indicated staff were to redirect R2 when resident was asking to smoke and update provider of any signs or symptoms of side effects to medications or if resident was observed to smoke. Review of R2's IWC note dated 3/05/24, indicated R2 was seen for evaluation and treatment to right thumb and right distal thumb. Trauma to right thumb caused from propelling wheelchair, and left middle finger has a cigarette burn that started two weeks ago measuring 1 cm x 0.4 cm. with 100% epithelial tissue. The IWC note indicated the treatment to the left middle finger cigarette burn to be first degree of single left finger nail except thumb, initial encounter. The treatment for the burn included to apply skin prep; cover with band aid, daily and as needed (prn). Will not allow any other dressing than a band aid. During interview on 4/4/24 at 9:30 a.m., receptionist at front desk stated R2 smoked independently outside and was not aware of R2 having a cigarette burn from smoking. The receptionist stated R2 passed away the end of March. During interview on 4/04/24 at 9:44 a.m., licensed	F 689			

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F 689	Continued From page 9 practical nurse (LPN)-A stated R2 moved to 3rd floor about a month ago and she went down to first floor to smoke independently. LPN-A stated she was not aware of her having any cigarette burns but did recall R2 needing treatments to her fingers from her getting her hands caught in her wheelchair wheels. During interview on 4/04/24, at 9:55 a.m., facility administrator, director of nursing (DON) and nurse manager on third floor stated they were all unaware of R2's burn from a cigarette to her middle finger. In addition, the DON stated had they been aware an incident report should have been completed and an investigation would have been completed since they did not know if the burn happened while R2 was at dialysis, with family or at the facility. In addition, the administrator stated she can see the residents outside her office window and never had any concerns with R2's smoking. An attempt was made to reach the Nurse Practitioner who wrote the IWC notes for R1 and R2 on 4/3 and 4/04/2024, with no response. Smoking Policy: The Terrace at Crystal-Residents effective 1/01/24, indicated the facility shall establish and maintain safe resident smoking practices. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker the evaluation will include ability to smoke safely with or without supervision (per completed Safe Smoking Evaluation). In addition a resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking related privileges, restrictions, and concerns (for example, need for close	F 689			

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F 689	Continued From page 10 monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.	F 689			

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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 4/03/24 through 4/04/24 , 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/27/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52892700C (MN102032) with a licensing order cited at 1665 as a result of the investigation. H52892667C (MN101738) No licensing order cited. 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 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	2 000			

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2 000	Continued From page 2 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			
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide safety for 1 of 4 residents (R1) who sustained a burn from a heat pad machine in the therapy department. Findings include: R1's significant change minimum data set (MDS) dated 1/16/24, indicated R1 was moderately cognitively intact, had bilateral amputation of lower extremities, coronary artery disease, heart failure, peripheral vascular disease (PVD) and diabetes mellitus. R1's Care Plan (CP) reviewed 3/05/24, indicated R1 had coronary artery disease, hypertension, peripheral vascular disease and diabetes mellitus. The Care plan further indicated educate the patient on importance of good nutrition and	21665	1.Failure provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible has the potential to affect all residents in the facility. 2. Facility will educated all staff before or on May 31st that the facility must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. 3. Nursing staff and therapy staff will be educated on or by May 31 that the facility must provide ongoing and adequate maintenance and cleaning of equipment, posting signage near the equipment identifying only trained staff were allowed to use equipment, and ensuring all staff were trained on the safe use of the equipment related to patient care.		4/27/24

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21665	Continued From page 3 hydration and give medications for improved blood flow or anticoagulants as needed. In addition, to report any signs or symptoms of skin problems related to PVD: redness, edema, blistering, itching, burning, bruises, cuts and other lesions. R1's Integrated Wound Care (IWC) note dated 9/26/23, indicated R1 was seen for ongoing assessment and management wounds left leg pressure ulcer to right stump, and bilateral wounds to middle finger. The report further indicated the right middle finger burn was 1.1 centimeter (cm) x 1.8 cm x 0.2 cm. with small serosanguineous (a combination of serous fluid and blood. It's usually a light pink to red color. This is a sign that your body is healing the wound and isn't a concern in normal amounts). The report further indicated the left middle finger burn indicated small serosanguineous with the wound measuring 2.3 cm x 2 x 0.3 cm. Note indicated a diagnosis of first degree burn of single right finger (nail) except thumb, initial encounter and burn of first degree of single left finger (nail) except thumb, initial encounter. During interview on 4/03/24 at 1:51 p.m., R1 stated he received burns on his middle fingers while in therapy using a heating pad and the following day they turned into blisters and reported this to the director of rehab (DOR) the following week but knew the nursing staff was aware. R1 then stated he was told by therapy the next time they use the heating pads on his hands they would wrap his hands first in some dressing so this would never happen again. R1 reported he was told that by a therapist but was not sure which therapist. During interview on 4/03/24 at 2:23 p.m., the	21665	4.This training will be added to the new hire orientation and to the annual mandatory training. 4. The Hydrocollator Heating Unit was removed out of therapy department and decomissioned. The decision was made not to use Hydrocollator Heating Unit at the facility. 5. HR will be responsible for auditing employee files quarterly to ensure that each employee training is completed with a 100% training completion goal. This audit will be conducted for the entire 2024. HR is responsible for reporting findings of audits to QAPI for review and discussion quarterly. Staff found to be out of compliance will be taken off the schedule until training is completed. 5. The Administrator and Human Resources are responsible for the completion of this plan of correction.		

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21665	Continued From page 4 director of rehab (DOR) stated she recalled R1 received a burn on his middle fingers. The DOR stated the therapy department used a Hydro-Heater (heat pad machine) and when they took a pad out of the machine, they let it sit for 30 to 60 minutes and then put it in a two sided barrier and then place a towel on top of it for a third barrier. The DOR stated they use the machine and heating pad prior to passive range of motion (PROM) so resident's joints and hands warm up. In addition, the DOR stated she was not aware of any maintenance to the machine or temperature checks, but would look into it. The DOR stated she thought the machine was given to them, but was not sure. During observation and interview on 4/03/24, at 3:00 p.m., with the administrator, the DOR, and the facility administrator, the administrator stated she was not aware of the heating pad machine in the therapy room. In addition, the administrator stated she was not aware of any training for the therapy staff to use the machine nor was she aware of any maintenance on the machine. The DOR was observed to temp the water in the Hydro-Heater with a inared thermatore and the temperature was 112 degrees (within safe range). In review of the machine with the DOR and the administrator on 4/03/24 at 3:20 p.m., a sticker was observed on the machine which indicated the last safety check and calibration was completed on 8/19, and the DOR stated it looked like that meant it must have last been maintained on 2019. The administrator stated she will have someone come out and calibrate and do a safety check on the heating pad machine in the therapy office to be safe since she was not aware of the machine in the therapy room.	21665			

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21665	Continued From page 5 During an subsequent interview via email on 4/03/2024 at 4:35 p.m., the administrator provided an email indicating the heating machine was a Hydorocllator Chattanooga machine. And the staff fill it with water when it gets about 1-2 inches low. The facility provided an operational Manuel for a Chattanooga hyrocollator undated, indicated "The Hydrocollator Heating Unit is equipped with an immersion type heating element and a hydraulic capillarity thermostat which evenly maintains the HotPac temperature in the water and provides a ready supply of heated packs . It is critical to maintain the water level over the top of the HotPac to avoid damage to the heating element, the stainless steel, or the HotPac . Water is constantly lost during operation due to evaporation. Therefore, it is essential that water be added daily. The tank should also be drained, cleaned, and inspected at minimum intervals of every two weeks." In addition the manual indicated to: Excessive chlorine can be detrimental to the stainless steel in the Hydrocollator Heating Unit. No bleach or any cleaner with high chlorine content should be used under any circumstance. 2 Clean regularly for optimal service and operation. 3 Fill daily with water. Water is constantly lost during operation due to evaporation. 4 Chlorine in regular tap water may be present in high enough concentrations to damage the unit. If you suspect high levels of chlorine in the Hydrocollator Heating Unit, the addition of a dechlorinator is recommended. 5 Certain additives (such as herbal teas, essential oils, etc.) will damage the HotPacs and components of the heating unit, including the stainless steel. The Hydrocollator Heating Unit was designed to heat water and HotPacs only. The addition of any such foreign	21665			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2024
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21665	Continued From page 6 substance (except dechlorinator) to the water in the unit will void the warranty. 6 Inspect the heating element for pitting and other visible damage during regular cleaning intervals. 7 Inspect the power cord for wear, fraying, and other visible damage during regular cleaning intervals. Review of a variety of therapy residents dating back to 10/2023 revealed no other residents had injuries related to heating pad burns from the therapy department. The facility lacked evidence of ongoing and adequate maintenance and cleaning of the heating pad unit, identifying safe and documented procedures for use of the equipment, posting signage near the equipment identifying only trained staff were allowed to use heating equipment, and ensuring all therapy staff were trained on the safe use of the equipment related to patient care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop ongoing and adequate maintenance and cleaning of the heating pad unit, identifying safe and documented procedures for use of the heat pad machine, posting signage near the equipment identifying only trained staff are allowed to use heating pad equipment, and ensuring all therapy staff are trained on the safe use of the heating pad equipment related to patient care. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21665			