DEPARTMENT OF HEALTH

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,

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

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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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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May 10, 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 informed you of imposed enforcement remedies.

On April 12, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On April 12, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 25, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 25, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 25, 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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Crystal LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 12, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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:

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,

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
May 10, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: XHFH11

Dear Administrator:

The above facility was surveyed on April 8, 2024 through April 12, 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 04/12/2024

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 4/8/24, 4/9/24, 4/11/24, and 4/12/24 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 survey resulted in an Immediate Jeopardy (IJ) at F689, when two nursing assistants used a Lumex brand full body sling with a Joerns Hoyer brand mechanical lift resulting in a fall with left femur fracture for R1. The IJ began on 4/2/24 and the immediacy was removed on 4/12/24. The above findings constituted substandard quality of care, and an extended survey was conducted on 4/11/24 and 4/12/24. The following complaint was reviewed: H52892793C (MN00102200, MN00102206) A deficiency was issued at F689. As a result of the investigation, additional deficiencies were cited at F610 and F843. 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		

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

Electronically Signed | 05/17/2024

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.

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 thoroughly investigate a fall from a mechanical lift that resulted in a broken femur for 1 of 3 residents (R1) reviewed for accidents. A report submitted to State Agency (SA) dated 4/4/24 at 7:45 p.m. indicated R1 had a fall on 4/2/24 during a transfer with a Hoyer (mechanical) lift that resulted in a left femur fracture. R1's diagnoses list included metabolic encephalopathy (a change in brain function that may cause confusion, memory loss, and/or sleepiness) and Alzheimer's Disease. R1's quarterly MDS dated 2/17/24 indicated R1	F 610	Failure to conduct proper investigation of an incident has the potential to affect all residents in the facility. The facility leadership will create an incident investigation document and educated leadership staff on the incident investigation policy and the new document on how to conduct investigations. The facility leadership will conduct an annual policy audit with a goal of 100% compliance. The DON or designee will conduct a monthly audit to assure that investigations are completed in accordance with the policy with 90% compliance rate for the next 3 month. The DON or designee will	5/17/24

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F 610	Continued From page 2 rarely/never understands or is understood, and was dependent on staff for all transfers. R1's care plan dated 2/27/24 indicated she required total assist of two staff using the Hoyer lift for all transfers. The care plan lacked indication of what size sling was to be used. On 4/2/24 at 9:30 a.m. a progress note indicated during transfer with a Joerns Hoyer lift (mechanical lift), one of the straps from the Lumex brand sling disconnected from the machine. Two staff members lowered R1 to the floor. A facility incident report dated 4/2/24 at 7:50 a.m., indicated one of the straps disconnected from the machine during transfer with Hoyer lift. The two nursing assistants involved in the incident were immediately re-educated on safety and checking that loops were secure prior to lifting residents. The director of nursing (DON) visually inspected the lift which appeared to be in good working condition. The DON asked facility maintenance to inspect lift. There was no indication in the report if the lift was inspected by maintenance or if an audit was completed on lift slings. On 4/8/24 at 4:11 p.m., the administrator stated an audit was not completed on lift slings following the incident. She did not know if the lift had been inspected. On 4/9/24 at 1:43 p.m., the DON stated she requested maintenance to inspect the lift following the incident, but did not know if that had been completed. The Hoyer lift involved in the incident was currently in use. An audit had not been	F 610	bring results of audits the QAPI every month. The DON or designee is responsible for the completion of this plan of correction.	

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 610	Continued From page 3 completed on lift slings because she had been expecting new lift slings to arrive at the facility soon. The Resident Protection policy dated 7/15 lacked direction to investigate equipment involved in a resident incident.	F 610		
F 689 SS=J	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 interview and document review, the facility failed to ensure safe transfers with a full body mechanical lift resulting in a left femur fracture for 1 of 3 residents (R1) reviewed for accidents. The facility failed to complete a comprehensive sling assessment and use appropriate slings for the mechanical lifts per manufacture instructions. The immediate jeopardy (IJ) began on 4/2/24 when two nursing assistants used a Lumex brand full body sling with a Joerns Hoyer brand mechanical lift resulting in a fall with fracture for R1. The administrator and director of nursing (DON) were notified of the IJ on 4/9/24 at 5:00 p.m. The IJ was removed on 4/12/24 at 1:00 p.m. but noncompliance remained at the lower scope and severity of a level D isolated, which indicated no	F 689	Failure to ensure that the residents environment is free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. has the potential to affect all residents in the facility. The facility leadership has incorporated training for all new hires that all transfer lifts must be used according to manufacturing guidelines. The facility will implement weekly audits for the next 3 months of slings/lifts to assure that sling and lifts are used per manufacturing guidelines with 100% compliance rate. The DON or designee will bring results of audits to QAPI for discussion.	5/17/24

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F 689	Continued From page 4 actual harm with potential for more than minimal harm that was not immediate jeopardy. R1's Diagnoses List undated indicated diagnoses which included metabolic encephalopathy (chemical imbalance in the blood which causes changes in the brain) and Alzheimer's Disease. R1's quarterly Minimum Data Set (MDS) dated 2/17/24 indicated R1 rarely/never understands or is understood, and was dependent on staff for all transfers. R1's care plan dated 2/27/24 indicated she required total assist of two staff using the Hoyer lift for all transfers. The care plan lacked indication of what size sling was to be used or which brand sling to use with which mechanical lift. On 4/2/24 at 9:30 a.m. a progress note indicated during transfer with a Joerns Hoyer lift (mechanical lift), one of the straps from the Lumex brand sling disconnected from the machine. Two staff members lowered R1 to the floor. On 4/3/24 at 1:00 p.m. a progress note indicated R1's left knee was swollen and warm to the touch. R1 had facial grimacing and was moaning and groaning. An order was obtained for an x-ray. On 4/4/24 at 11:03 a.m. a progress note indicated x-ray results indicated R1 had a femur fracture. R1 was transported to the hospital. On 4/8/24 at 2:07 p.m., nursing assistant (NA)-A stated she and NA-B connected R1 (who was in bed) to the mechanical lift, verified placement of	F 689	The DON or designee is responsible for the completion of this plan of correction.	

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

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F 689	Continued From page 5	F 689		

the sling loops on the mechanical lift, and pulled the mechanical lift legs out from underneath the bed in order to transfer R1 to the chair. As they were transferring R1 in the mechanical lift, the area of the lift where the sling was hooked tilted, and the top loop of the sling slipped off the hook of the mechanical lift. NA-A observed the sling was no longer securing R1's right shoulder. She supported R1's upper body while NA-B supported R1's head, and they used the mechanical lift to lower R1 to the floor. As R1 was going down to the floor, her left foot bent, and somehow became tucked underneath her body while they lowered her to the floor. The sling size was not listed in the care plan or on the paper nursing assistant care guides. NA-A stated they (NAs) could choose the sling size by looking at a resident's body type.

On 4/8/24 at 2:48 p.m., LPN-A stated staff know which sling to use by looking at a resident's body. She did not know if slings could be used with different brands of mechanical lifts.

A sling sizing guide was requested but was not provided.

On 4/8/24 at 3:24 p.m., NA-C stated if a resident did not have a sling in their room, the nursing assistant could look at the resident's body size and pick the size sling which would fit.

On 4/8/24 at 3:37 p.m., NA-D stated sling size was not documented on the nursing assistant care sheets. If a nursing assistant was unfamiliar with a resident and needed a new sling, the nursing assistant would need to talk to another nursing assistant who knew the resident better to obtain

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	245289	A. BUILDING _____ B. WING _____	C 04/12/2024

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F 689	Continued From page 6 sling size. On 4/9/24 NA-B stated she and NA-A connected R1 to the Hoyer brand mechanical lift using a black sling (Lumex brand) with a green strap which indicated size large, verified placement of the sling loops on the mechanical lift, and pulled the mechanical lift out from underneath the bed in order to transfer R1 to the chair. As they were transferring R1 in the mechanical lift, the area of the lift where the sling was hooked tilted, and the top loop of the sling slipped off the hook of the mechanical lift. NA-A observed the sling was no longer securing R1's right shoulder. She supported R1's head, and NA-A supported R1's upper body while they used the mechanical lift to lower R1 to the floor. As R1 was going down to the floor, her left foot bent, and became tucked underneath her body. NA-B stated the sling size was not listed on the paper nursing assistant care guides. On 4/9/24 at 10:30 a.m., RN-A stated sling size was determined by the resident's weight, and NAs were able to determine which sling size to use with that information. A Joerns Hoyer full mechanical lift was observed with RN-A, who confirmed there was no indication on the lift for the weight ranges for slings. RN-A confirmed there were no weight ranges indicated with the sling sizes on the sticker or any where else on the mechanical lift. On 4/9/24 at 12:19 p.m., a customer service representative from Lumex stated Lumex slings were designed for use with Lumex brand mechanical lifts. Safety could not be assured if the Lumex slings were utilized with a different brand of	F 689		

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F 689	Continued From page 7 mechanical lift. On 4/9/24 at 1:11 p.m., a blue Medline sling was observed in a resident wheelchair. NA-E confirmed the size XXL Medline brand sling was used with the Joerns Hoyer lift to transfer the resident from the wheelchair to the bed. NA-E also confirmed the brand of the other mechanical lift on the floor could be utilized for transfers was a Proactive brand lift. On 4/9/24 at 1:43 p.m., the DON stated the facility utilized four different brands of mechanical lifts: Hoyer, Invacare, Best Care and Proactive. The sling brand and mechanical lift brand should be the same. Hoyer brand slings were ordered and received, but had not been placed into use yet. Invacare slings had been ordered, but not received. Bestcare and Proactive slings had not been ordered. She could not guarantee a resident's sling size was documented for staff to access. The nurse managers should be selecting sling size for a resident. Manufacture's recommendations for Joerns Hoyer mechanical lift included: DO NOT use a sling unless it is recommended for use with the lift. Using other manufacturer's products on Hoyer products is potentially unsafe and could result in serious injury to patient and/or caregiver. The facility Lifting Machine, Using a Mechanical Lift policy undated directed staff to measure the resident for proper sling size and purpose, according to manufacturer's instructions. The immediate jeopardy that began on 4/2/24, was	F 689		

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F 689	Continued From page 8 removed on 4/12/24, when the facility provided a full body sling that matched the brand of full body lift and completed a comprehensive sling assessment for each resident utilizing a full body lift for transfers and started education to all staff who perform transfers or assessments. Facility education completed on 4/8/24 included a video created by the Hoyer company. Included in this video is a warning to use only Hoyer Parts. Do not interchange other manufacturer parts. This was verified by observation, interview and document review on 4/12/24.	F 689		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be	F 843		5/17/24

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F 843	Continued From page 9 exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a written transfer agreement with a hospital approved for participation under Medicare or Medicaid programs, which reasonably ensured that residents would be transferred to the hospital and ensured timely admission. This had the potential to affect all 55 residents in the facility who could require hospitalization on an emergent basis. Findings include: During a review of the facility's policies and procedures, a written transfer agreement was requested to demonstrate the facility had a transfer agreement in place with a Medicare and Medicaid participating hospital. On 4/12/24 at 1:14 p.m. the director of nursing (DON) stated she was unable to find a written transfer agreement with a hospital. A policy for transfer agreement with hospital was requested but not provided.	F 843	Failure to have a written transfer agreement with a hospital approved for participation under Medicare or Medicaid programs, which reasonably ensured that residents would be transferred to the hospital and ensured timely admission has the potential to affect all residents in the facility who could require hospitalization on an emergent basis. The Facility leadership will create a transfer agreement policy and will have a signed transfer agreement with a local hospital by or on May 31th. An annual audit of policies will be conducted by the facility leadership with a 100% compliance goal. The Administrator or its designee will be responsible for bringing audits to the QAPI committee once a year. The Administrator or designee is responsible for the completion of this plan of correction.	

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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 4/8/24, 4/9/24, 4/11/24 and 4/12/24, 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	2 000		

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2 000	Continued From page 1 licensing order was 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: H52892793C (MN00102200, MN00102206) A licensing order was issued at 4658.0520 Subp. 1 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	2 000		

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2 000	Continued From page 2 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 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure safe transfers with a full body mechanical lift resulting in a left femur fracture for 1 of 3 residents (R1) reviewed for accidents. The facility failed to complete a comprehensive sling assessment and use	2 830	Corrected	5/17/24

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2 830	Continued From page 3 appropriate slings for the mechanical lifts per manufacture instructions. The immediate jeopardy (IJ) began on 4/2/24 when two nursing assistants used a Lumex brand full body sling with a Joerns Hoyer brand mechanical lift resulting in a fall with fracture for R1. The administrator and director of nursing (DON) were notified of the IJ on 4/9/24 at 5:00 p.m. The IJ was removed on 4/12/24 at 1:00 p.m. but noncompliance remained at the lower scope and severity of a level D isolated, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. R1's Diagnoses List undated indicated diagnoses which included metabolic encephalopathy (chemical imbalance in the blood which causes changes in the brain) and Alzheimer's Disease. R1's quarterly Minimum Data Set (MDS) dated 2/17/24 indicated R1 rarely/never understands or is understood, and was dependent on staff for all transfers. R1's care plan dated 2/27/24 indicated she required total assist of two staff using the Hoyer lift for all transfers. The care plan lacked indication of what size sling was to be used or which brand sling to use with which mechanical lift. On 4/2/24 at 9:30 a.m. a progress note indicated during transfer with a Joerns Hoyer lift (mechanical lift), one of the straps from the Lumex brand sling disconnected from the machine. Two staff members lowered R1 to the floor. On 4/3/24 at 1:00 p.m. a progress note indicated	2 830		

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2 830	Continued From page 4 R1's left knee was swollen and warm to the touch. R1 had facial grimacing and was moaning and groaning. An order was obtained for an x-ray. On 4/4/24 at 11:03 a.m. a progress note indicated x-ray results indicated R1 had a femur fracture. R1 was transported to the hospital. On 4/8/24 at 2:07 p.m., nursing assistant (NA)-A stated she and NA-B connected R1 (who was in bed) to the mechanical lift, verified placement of the sling loops on the mechanical lift, and pulled the mechanical lift legs out from underneath the bed in order to transfer R1 to the chair. As they were transferring R1 in the mechanical lift, the area of the lift where the sling was hooked tilted, and the top loop of the sling slipped off the hook of the mechanical lift. NA-A observed the sling was no longer securing R1's right shoulder. She supported R1's upper body while NA-B supported R1's head, and they used the mechanical lift to lower R1 to the floor. As R1 was going down to the floor, her left foot bent, and somehow became tucked underneath her body while they lowered her to the floor. The sling size was not listed in the care plan or on the paper nursing assistant care guides. NA-A stated they (NAs) could choose the sling size by looking at a resident's body type. On 4/8/24 at 2:48 p.m., LPN-A stated staff know which sling to use by looking at a resident's body. She did not know if slings could be used with different brands of mechanical lifts. A sling sizing guide was requested but was not provided. On 4/8/24 at 3:24 p.m., NA-C stated if a resident	2 830		

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2 830	Continued From page 5 did not have a sling in their room, the nursing assistant could look at the resident's body size and pick the size sling which would fit. On 4/8/24 at 3:37 p.m., NA-D stated sling size was not documented on the nursing assistant care sheets. If a nursing assistant was unfamiliar with a resident and needed a new sling, the nursing assistant would need to talk to another nursing assistant who knew the resident better to obtain sling size. On 4/9/24 NA-B stated she and NA-A connected R1 to the Hoyer brand mechanical lift using a black sling (Lumex brand) with a green strap which indicated size large, verified placement of the sling loops on the mechanical lift, and pulled the mechanical lift out from underneath the bed in order to transfer R1 to the chair. As they were transferring R1 in the mechanical lift, the area of the lift where the sling was hooked tilted, and the top loop of the sling slipped off the hook of the mechanical lift. NA-A observed the sling was no longer securing R1's right shoulder. She supported R1's head, and NA-A supported R1's upper body while they used the mechanical lift to lower R1 to the floor. As R1 was going down to the floor, her left foot bent, and became tucked underneath her body. NA-B stated the sling size was not listed on the paper nursing assistant care guides. On 4/9/24 at 10:30 a.m., RN-A stated sling size was determined by the resident's weight, and NAs were able to determine which sling size to use with that information. A Joerns Hoyer full mechanical lift was observed with RN-A, who confirmed there was no indication on the lift for the weight ranges for slings. RN-A confirmed there	2 830		

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2 830	Continued From page 6 were no weight ranges indicated with the sling sizes on the sticker or any where else on the mechanical lift. On 4/9/24 at 12:19 p.m., a customer service representative from Lumex stated Lumex slings were designed for use with Lumex brand mechanical lifts. Safety could not be assured if the Lumex slings were utilized with a different brand of mechanical lift. On 4/9/24 at 1:11 p.m., a blue Medline sling was observed in a resident wheelchair. NA-E confirmed the size XXL Medline brand sling was used with the Joerns Hoyer lift to transfer the resident from the wheelchair to the bed. NA-E also confirmed the brand of the other mechanical lift on the floor could be utilized for transfers was a Proactive brand lift. On 4/9/24 at 1:43 p.m., the DON stated the facility utilized four different brands of mechanical lifts: Hoyer, Invacare, Best Care and Proactive. The sling brand and mechanical lift brand should be the same. Hoyer brand slings were ordered and received, but had not been placed into use yet. Invacare slings had been ordered, but not received. Bestcare and Proactive slings had not been ordered. She could not guarantee a resident's sling size was documented for staff to access. The nurse managers should be selecting sling size for a resident. Manufacture's recommendations for Joerns Hoyer mechanical lift included: DO NOT use a sling unless it is recommended for use with the lift. Using other manufacturer's products on Hoyer products is potentially unsafe and could result in	2 830		

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2 830	Continued From page 7 serious injury to patient and/or caregiver. The facility Lifting Machine, Using a Mechanical Lift policy undated directed staff to measure the resident for proper sling size and purpose, according to manufacturer's instructions. The immediate jeopardy that began on 4/2/24, was removed on 4/9/24, when the facility provided a full body sling that matched the brand of full body lift and completed a comprehensive sling assessment for each resident utilizing a full body lift for transfers and started education to all staff who perform transfers or assessments. Facility education completed on 4/8/24 included a video created by the Hoyer company. Included in this video is a warning to use only Hoyer Parts. Do not interchange other manufacturer parts. This was verified by observation, interview and document review on 4/9/24. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on use of mechanical lifts and sling assessments. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff members are appropriately assessing a resident for slings and use of mechanical lifts and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		