P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 23, 2022

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
July 19, 2022

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

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

Dear Administrator:

On July 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility 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.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 7, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 7, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
July 19, 2022

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

Re: Event ID: URZT11

Dear Administrator:

The above facility survey was completed on July 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 7/24/22-7/25/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED:
H52893429C (MN85293), with a deficiencies cited at (F550, F553 and F656)
H52893439C (MN84561), with deficiency cited at (F550)

The following complaint was found to be UNSUBSTANTIATED, however related deficiencies were cited.
H52893324C (MN85202), with a deficiency cited at (F609)

The following complaints were found to be UNSUBSTANTIATED:
H52893270C (MN84963)
H52893325C (MN85201)
H52893487C (MN85289)
H52893438C (MN85203 associated w/ MN85094)
H52893440C (MN84985)
H52893442C (MN85406)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		8/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents needs were addressed in a respectful and dignified manner when residents used their call light to ask for assistance (R2 and R3) and when a sign, indicating date and time cares were performed was hung on the outside a resident's (R2) door. This affected 2 of 3 residents (R2 and R3) reviewed for dignity. Findings include: R2's admission Minimum Data Set (MDS) dated 6/16/22, indicated R2's speech was clear, he was able to make himself understood and was able to understand others. R2 had no cognitive impairment. R2 required physical assistance from two staff for transfers and toilet use, and physical assistance from one staff for dressing. R2 was continent of bladder and had occasional bowel incontinence. R2's face sheet printed 7/25/22, indicated he was responsible for himself. R2's diagnoses include diabetes mellitus, hypertension, cardiovascular disease and below the knee amputation on his right. R2's diagnosis did not include cognitive impairment or other diagnosis that would indicate he was unable to make decisions regarding his	F 550	F550 Resident rights/exercise of rights. 1. Nursing staff will be directed to not hang any information which may contain medical and private information regarding resident's care in any location that is visible to any other resident, staff or visitor. 2. All residents have the potential to be affected. 3. Nursing staff will be educated on dignity, resident rights and HIIPA. 4. Social service or designee will conduct daily audits for four weeks, weekly audits for three weeks and then as needed. Any issues found will be brought to QAPI. 5. 8/18/2022	

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

care.

R2's care plan printed 7/25/22, initiated date 6/21/22, failed to identify R2's needs specific to activities of daily living (ADLs), toileting, bowel incontinence and fall risk.

On 7/24/22, at 1:59 p.m. R2 stated on 6/21/22 he put his call light on after an episode of bowel incontinence. R2 was not able to recall the exact time but stated it was during the day. R2 stated he waited approximately two hours for a staff member to come to his room to find out what he needed and before he got help. R2 stated it made him feel ashamed, like a child, "I am a grown man. This shouldn't happen." Since that incident, R2 stated he cleaned himself up after an incontinent episodes and called the staff when he is finished. R2 indicated he is worried the staff will not come when he calls, and he will have to sit in his bowel for a long period of time if he doesn't do it himself.

R3's admission MDS dated 5/31/22, indicated R3's speech was clear, vision and hearing were adequate, and she could make herself understood. R3 required physical assistance from two staff for all ADLs.

R3's quarterly review dated 7/19/22, indicated R3 was alert and oriented to person, place, time, and self. R3 was incontinent of both bowel and bladder.

R3's care plan printed 7/25/22, initiated 5/27/22, indicated R3 wore incontinence products. R3 required physical assistance from staff to check and change incontinence products every two

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 hours and as needed. R3's face sheet, printed 7/25/22, indicated R3's diagnoses included major depressive disorder and general anxiety. On 7/24/22, at 4:00 p.m. lined sheets of paper were observed on the outside of R3's door. Information on this sheet included sections for staff to fill in date, time, staff name and to indicate yes or no if care was provided. Completed information noted 7/5/22-7/9/22 and 7/17/22-7/22/22. On 7/25/22, at 7:24 a.m. R3 stated she asked for assistance earlier to change her incontinence product but did not get it. R3 indicated this had happened several times. She requested surveyor to witness long wait times and turned the call light, on to requested help. R3 agreed for the surveyor to leave the room until the call light was answered. On 7/25/22, at 7:33 a.m. two staff were observed at the nursing desk. A message bar by the nursing desk showed R3's room number, indicating her call light was on. During this time, three staff walked past R3's room. At 7:35 a.m. one staff knocked on R3's door, opened it, did not talk with R3, immediately closed the door and walked away. At 7:55 a.m. NA-C knocked on R3's door and entered the room. NA-C turned off R3's call light, then changed R3's incontinent product as requested. On 7/25/22, at 7:59 a.m. NA-C left R3's room then returned with a sheet of lined paper with sections for staff to fill in date, time, staff name and to indicate yes or no if care was provided.	F 550		

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 NA-C wrote her name, date, time and "yes" to indicate care was provided. NA-C stated the nurse manager gave direction to complete the form. It is used because R3 will put her light on to request the same care that has already been provided. NA-C stated she was aware R3's call light was on when she heard it on the pager she was wearing and because she saw it on the message board by the nursing desk. NA-C was not aware how long R3's light was on. On 7/25/22, at 8:02 a.m. R3 was not able to indicate how long her light is on for but stated it does take a long time for staff to answer it. R3 confirmed she puts her light on frequently, "I never know when they will actually come to check on me. I get anxious when they don't come in, so I put my light on again and again." R3 stated she did not know about the sheets of paper on the outside of her door, she did not know when it started or why they were there. R3 stated she was worried staff would write whatever they wanted on the paper to make it look like they had been in her room and helped her with care even though they did not. "I feel like they don't trust me, don't believe me when I call for help. It's just another reason to not put my light on. Why should I, if they aren't going to believe that I need help?" On 7/25/22, at 1:39 p.m. nurse manager (NM)-A confirmed he directed staff to use the sheet and hang it outside R3's door. NM-A stated the sheet was used to minimize the number of staff entering R3's door. NM-A confirmed, R3 did not have a medical reason to limit the number of staff who entered her room. NM-A stated he discussed the sheet with R3 and R3 signed a risk versus benefit regarding the sheet.	F 550		

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6 On 7/25/22, at 2:06 p.m. Director of Nursing (DON) stated she expected all residents were treated with dignity. DON indicated staff were getting too comfortable with thinking they don't need to meet the resident where they are and care to the residents needed to be more person centered. DON stated she was not aware that R2 had his call light on for two hours after he was incontinent of bowel. She indicated it would likely make a resident feel depressed, sad, and mad. Further, DON was not aware of the sheets hanging outside R3's door until she worked the overnight shift on 7/24/22. DON expected a form like that was hung inside the door or inside the room on a clip board. DON stated not everyone needs to know what is happening in her room. Facility form, risk versus benefit for the sign outside R3's door was request but was not received. Facility policy on dignity was requested but was not received.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553		8/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 7 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident participation in the development and revision of care plans for 1 of 3 residents (R2) reviewed for care planning. Findings include: R2's admission Minimum Data Set (MDS) dated 6/16/22, indicated R2's speech was clear, he was able to make himself understood and was able to understand others. R2 had no cognitive impairment. R2's face sheet printed 7/25/22, indicated he was responsible for himself. R2's diagnosis did not include cognitive impairment or other diagnosis that would indicate he was unable to make	F 553	F553 Right to participate in care planning 1. R2 will be asked to actively participate in his care planning and notified in advance of revisions to his care plan. 2. All residents have the potential to be affected. 3. IDT will be re-educated on the importance of allowing residents to participate in their care planning. 4. Social services or designee to conduct weekly audits for four weeks then as needed. Any issues found will be brought to QAPI. 5. 8/18/2022	

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 8 decisions regarding his care. R2's diagnoses include diabetes mellitus, hypertension and cardiovascular disease. R2's care plan printed 7/25/22, indicated R2's diet as no added salt, and 2000cc fluid restriction. R2's care plan indicated the diet was initiated 6/26/22. Facility document, Centennial Garden Nutrition Assessment dated 6/20/22, completed for R2 and signed by the facility Dietician, indicated a request would be made for R2's diet to be written as low concentrated sweets, no added salt, and 2000cc fluid restriction. On 7/24/22, at 3:59 p.m. R2 indicated he was not aware that his diet was changed after admission. R2 stated he found out about the fluid restriction when he asked for his water pitcher to be filled and staff told him he couldn't have more water due to the fluid restriction, he was allowed specified amounts at mealtime and between meals. R2 stated he asked for a reason for the diet change, but was not given one. R2 stated he preferred to manage his own fluids and did not understand why the change was necessary. On 7/25/22, at 11:29 a.m. the Dietician (D)-A confirmed she completed the nutrition assessment for R2 and made the recommendation for the diet change. D-A stated she made her recommendation based on hospital records and interviews with facility staff. D-A confirmed she did not talk with R2 regarding the diet change. D-A expected the Dietary Director (DD) notified R2 of changes to his diet. On 7/25/22, at 12:16 p.m. DD stated she was not	F 553		

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 9 involved in diet changes but does talk with the residents about diet and food preferences. DD confirmed she did not talk with R2 about his diet or the change to it. On 7/25/22, at 1:10 p.m. the Director of Nursing (DON) confirmed R2's diet on his care plan included low concentrated sweets, no added salt and 2000cc fluid restriction. DON indicated she expected residents and their representatives were involved in care planning. DON stated R2 should have been made aware of the change to his diet and the reason for it. Facility policy, Care Planning- Interdisciplinary Team, undated, indicated the resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.	F 553		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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, 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	F 609		8/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 10 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 report an allegation abuse to the State agency (SA) within two hours of being informed of the allegation for 1 of 1 residents (R1) reviewed for reports of abuse. Findings include: A Facility Reported Incident (FRI) submitted to the SA on 7/17/22, at 9:58 p.m. identified on 7/16/22 at approximately 12:30 p.m. R1 returned to the facility with documentation from the hospital that noted concerns included report of a facility nursing assistant "swatting or slapping" R1 which caused bruising to R1's body. On 7/17/22, R1 reported to the Dietary Director (DD) the nurse on the third floor beat her up and caused bruising. The FRI noted the date and time of the incident as 7/16/22, at 5:00 p.m. On 7/25/22, at 9:15 a.m. DD confirmed, during a meeting with R1 on 7/17/22, R1 reported the nurse working at the facility on the third floor hit her which caused bruising on both her arms. DD	F 609	F609 Reporting of alleged violations 1. Staff have been educated on the importance of reporting incidents in a timely manner. 2. All residents have the potential to be affected. 3. All IDT will be re-trained and have access to the OHFC process to be able to submit an incident. 4. The administrator and/or designee will be informed immediately when an incident has been identified to ensure the incident is reported in a timely manner. 5. The IDT will review the process at QAPI to identify potential barriers.	

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 11 stated she immediately reported it to the Director of Nursing (DON). On 7/25/22, at 9:26 a.m. The DON confirmed the hospital document, "After Visit Summary" dated 7/16/22, indicated R1 reported an allegation of abuse from a facility staff member which resulted in bruising. The DON stated she expected the nurse to read the hospital report at the time R1 returned from the hospital. When it was noted R1 made an allegation of abuse against a facility staff, the DON expected the nurse to report the allegation to either the Administrator or the DON immediately so a report could be made to the SA according to facility policy. The DON stated she was not made aware of the allegation until 7/17/22 when the DD reported it to her. Facility policy, Abuse Investigation and Reporting, review date 12/6/21, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment will be reported to the State licensing/certification agency responsible for surveying/licensing the facility. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than two hours if alleged violation involves abuse or has resulted in serious bodily injury.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		8/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan to include assessed and identified needs for 1 of 3 residents (R2) who's comprehensive care plans were reviewed. Findings include: R2's admission Minimum Data Set (MDS) dated 6/16/22, indicated R2's speech was clear, he was able to make himself understood and was able to understand others. R2 had no cognitive impairment. R2 required physical assistance from two staff for transfers and toilet use, and physical assistance from one staff for dressing. R2's face sheet printed 7/25/22, indicated he was	F 657	F657 Care plan timing and revisions 1. All residents care plans will be completed within 7 days of admission. 2. All residents have the potential to be affected. 3. IDT will be re-educated on the importance of completing care plans within the allotted timeframe. 4. Social services or designee to conduct weekly audits for four weeks then as needed. Any issues found will be brought to QAPI. 5. 8/18/2022	

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 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 13	F 657		

Continued From page 13

responsible for himself. R2's diagnoses include diabetes mellitus, hypertension, cardiovascular disease and right, below the knee amputation. R2's diagnoses did not include cognitive impairment or other diagnosis that would indicate he was unable to make decisions regarding his care.

R2's care plan printed 7/25/22, initiated date 6/21/22, failed to identify R2's needs specific to; activities of daily living (ADLs), toileting, bowel incontinence and fall risk.

On 7/25/22, at 11:13 a.m. nursing assistant (NA)-A indicated she was aware of residents' specific needs by looking at the care plan. NA-A reviewed R2's care plan and confirmed she was not able to determine R2's need for assist with ADLs or his fall risk. NA-A stated, because R2 was able to communicate his needs, she would ask him what he needed.

On 7/25/22, at 2:06 p.m. the Director of Nursing (DON) confirmed R2's care plan was not completed. DON expected the comprehensive care plan was completed per facility policy. DON stated the care plan was required so the residents received the care they needed and desired in a manner that was consistent and appropriate.

Facility policy, Care Planning- Interdisciplinary Team, undated, indicated a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 7/24/22-7/25/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52893429C (MN85293) with a licensing order issued at (0555). The following complaint was found to be SUBSTANTIATED: H52893439C (MN84561), however no related licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H52893270C (MN84963) H52893325C (MN85201) H52893324C (MN85202) H52893487C (MN85289) H52893438C (MN85203 associated w/ MN85094) H52893440C (MN84985) H52893442C (MN85406) 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/regulatio	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 n/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 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		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.	2 555		8/18/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	C 07/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 3 This MN Requirement is not met as evidenced by: SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility's policies and procedures for the resident care planning process, including revisions. The DON could educate all responsible staff. The DON could develop a monitoring system to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555	Completed	