Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 5, 2025

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 5, 2025

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

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

Dear Administrator:

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

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2025

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

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

Dear Administrator:

On January 13, 2024, we informed you of imposed enforcement remedies.

On January 17, 2025, the Minnesota Departments of Health and Public Safety 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 immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted immediate jeopardy (Level L), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 17, 2025, the situation of immediate jeopardy to potential health and safety cited at E0015 was removed. However, continued non-compliance remains at the lower scope and severity of F.

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 February 15, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 15, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 15, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

NURSE AIDE TRAINING PROHIBITION

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 6, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why

you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 31, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 552211

Dear Administrator:

The above facility was surveyed on January 13, 2025 through January 17, 2025 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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
	00255	A. BUILDING: _____ B. WING _____	C 01/17/2025

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 1/13/25 - 1/17/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 02/10/25

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

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued. H52895125C/MN109869 The following complaints were reviewed. H52894760C/MN109756, H52894782C/MN109762 with a licensing order issued at 0960 and 0965. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the proper temperature food was served to 3 of 3 residents (R1, R7, and R9) reviewed for the residents during breakfast and lunch on the third floor of the building. This had the potential to affect all 37 residents who resided on the third floor. Findings Include: R1's quarterly Minimum Data Set (MDS) dated 12/23/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) of 15 indicating R1 was cognitively intact. R1 required set-up and clean-up assistance with activities of daily living. R1's pertinent diagnoses were cardiac failure, renal insufficiency, morbid obesity, and borderline personality (a mental disorder characterized by	2 960	Corrected.	2/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 960	Continued From page 3 unstable moods. R1 required a therapeutic diet. R7's quarterly MDS dated 11/2/24 indicated R7's cognitions status was not completed. R7 used a wheelchair for mobility. Diagnosis included hypertension, seizure disorder, metabolic encephalopathy, malnutrition, anxiety, depression, and bipolar. R9's admission MDS was not completed at the time of the survey. R9 was admitted to the facility on 1/9/24. Upon interview on 1/13/25 at 9:50 a.m. R1 stated "more times than not the food is cold by the time it gets to me." R1 stated the temperature of the food is one of the many reasons she buys her own food. Upon interview on 1/13/25 at 11:30 a.m. R7 stated his family prepares and brings his food. He stated the food is either overcooked, undercooked, and always cold. Upon interview on 1/13/25 at 12:10 a.m. trained medication assistant (TMA) stated R7 refuses to eat at the facility. She stated to listen to what the residents are saying about the food, their comments are not exaggerated. She stated she has seen cold food, undercooked food and food that looks like it had been half eaten before serving. Upon interview on 1/13/25 at 2:03 p.m. the director of food services stated he had heard a few complaints about cold food. He stated the food on the 2nd and 3rd floor of the building have steam tables the food goes on and if the staff do not deliver the food to the residents fast enough the nursing staff can heat it up.	2 960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 960	Continued From page 4 Upon interview on 1/14/25 at 12:38 p.m. the food service staff stated the nursing assistants heat-up a lot of the trays she sets-up from the steam table to be served. Upon observation on 1/14/25 at 12:45 p.m. the surveyor taste sampled the last food tray that had been set-up for a on the food cart right before getting serviced to the last resident being served in their room. The tray had a soft-shell taco with lettuce, chopped tomato and ground beef inside serviced with an ambrosia salad (fruit salad with marshmallows and whip cream) and milk. The ground beef was cold. The ambrosia salad and milk were room temperature. The resident was given a new tray. Upon observation on 1/15/25 at 8:02 a.m. yelling was hard coming from R9's room on the third floor. She was yelling "get in her, get in here now." Upon arrival of RN-A and the surveyor, the resident stated she was soiled and her food that was just dropped off was cold again. R9 had the RN-A touch a cheese filled omelet and RN-A verified the omelet was cold. R9 also stuck her finger in the oatmeal and reported it was cold. R9 stated she want she wanted a new tray promptly because she had sent back trays before and stated the staff did not return the food for up to an hour. R9 was given a new tray at 8:20 a.m. which was warm. Upon interview on 1/17/25 at 2:20 the director of nursing stated she was aware of the complaints that the food was cold. She stated she had been working on a plan and was going to present it to the new Administrator about serving the food "assisted living style" she stated with her plan the resident would have meals served for a 2-hour	2 960		

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

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2 960	Continued From page 5 time span and all the residents would come to the dining room on at the time they would choose. A facility policy titled Food Preparation and Service dated 11/2022 indicated the facility food and nutrition service employees prepare and serve food in a manner that complies with safe food handling practices. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 960		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to accommodate foods for resident allergies and/or intolerances for 1 of 3 residents (R1) reviewed. R1 had an allergy to	2 965	Corrected.	2/23/25

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	00255	A. BUILDING: _____ B. WING _____	C 01/17/2025

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

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2 965	Continued From page 6 gluten and was given gluten meals so often at the facility that R1 was buying her own food and stocking-up on foods from the facility kitchen to have when she was served a gluten meal. Findings include: R1's clinical allergy sheet dated 7/20/21 indicated R1 had allergies to soybean oil, gluten, ciprofloxacin (an antibiotic), adhesive tape, latex, and cornstarch. R1's care plan dated 8/1/21 indicated the facility was to provide and serve a no added salt diet with a 2000 cubic centimeter (CC) daily fluid restriction as ordered with (double portions). Due to many allergens R1 can be resistive to eating facility meals, so her wife brings in food. R1 prefers high protein/low carbohydrates, large entrée portions. The facility purchases sour dough bread per her request (provided at breakfast with butter pads), chicken breasts baked in olive oil, vegetarian burgers, and green beans. The facility was to document intake and output at each meal. Do not serve corn starch, dairy, (butter, American cheese and hard cheese are o.k.), egg whites o.k. if cooked into something. No gluten, soy, or soybean oil unless requested. R1's care plan dated 6/22/23 indicate R1 had an allergy to gluten (a protein found in wheat and other grains). R1's quarterly Minimum Data Set (MDS) dated 12/23/24 indicated R1 had a Brief Inventory of Mental Status of 15 indicating R1 was cognitively intact. R1 required set-up and clean-up assistance with activities of daily living. R1's pertinent diagnoses were cardiac failure, renal	2 965		

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2 965	Continued From page 7 insufficiency, morbid obesity, and borderline personality (a mental disorder characterized by unstable moods). R1 required a therapeutic diet. Upon observation on 1/13/25 at 8:33 a.m. R1 was served one slice of French toast, a sausage patty and two hard boiled eggs. Upon interview on 1/13/25 at 10:18 a.m. R1 stated there were only three or four meals a week she could eat at the facility that did not have some sort of gluten like bread, pasta, or mashed potatoes. She stated she spends "a lot" of money out of pocket each month to get her own food. R1 stated she orders hard-boiled eggs for breakfast to have in her refrigerator for when she would be served a meal with substantial gluten. R1 had over 300 photos of food served to her at the facility that contained gluten. She stated about a year-and-a-half ago she would meet with the dietician and would make-up a weekly meal plan for her. She stated since then the facility had gotten a new food vendor and a new dietician and that had not happened. Upon interview on 1/13/25 at 12:10 p.m. trained medication assistant (TMA)-A stated she was aware that R1 received many meals with gluten and was aware R1 would buy her own food. She stated she was aware that R1's care plan indicated she was allergic to gluten, but thought she had an intolerance, since she would eat gluten at times. Upon observation on 1/13/25 at 12:32 p.m. R1 was served a bratwurst on a white bun, green beans, and a brownie for lunch. She did remove the bun herself and ate the bratwurst meat. Upon interview on 1/13/25 at 1:20 p.m. a facility	2 965		

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2 965	Continued From page 8 cook stated he was aware that R1 had a soy and gluten allergy. He stated the kitchen did not cook with soy. He verified that R1 does get gluten, and he is not certain if she eats it. Her meal ticket indicated "no gluten." The cook stated R1 was supposed to meet with the dietician to discuss meal options, but since he did not have any specific instructions from either the dietician or the food service director, he did not prepare any gluten free meals. Upon interview on 1/13/25 at 2:03 p.m. the director of food services stated he was not aware that R1 had a soy and gluten allergy. He stated if he were aware that someone in the facility had gluten free needs, he would have requested a special menu from the dietician or nursing staff. In addition, he would set-up a clean area in the kitchen for the least amount of risk of cross contamination to the gluten free food. Upon interview on 1/14/25 11:15 a.m. the dietician stated when she started her position in 6/2024 the previous dietician told her that R1 had a gluten intolerance not a true allergy. She stated that R1's meal ticket indicated a gluten free diet. The dietician believed the facility had a communication problem due to staff turnaround. She stated she had never been told to set-up a "gluten free" diet with R1. Upon interview on 1/17/24 at 2:20 p.m. the director of nursing (DON) stated the facility dietary department needed an overhaul. She was unaware R1 was not receiving the diet her care plan indicated. The DON was not certain if R1 had an allergy or intolerance but stated either way the facility needed to follow the care plan. A facility policy titled Resident Food Preferences	2 965		

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2 965	Continued From page 9 dated 7/2021 indicated: Upon the resident's admission (or within twenty-four (24) hours after their admission) the dietitian or nursing staff will identify a resident's food preferences. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. The dietitian and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations that might conflict with the resident's food preferences. The dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The physician and dietitian will communicate the risks and benefits of specialized therapeutic vs. liberalized diets. Therapeutic diets will be ordered only after the resident/representative agrees with and consents to such a diet. The resident has the right not to comply with therapeutic diets. If the resident refuses or is unhappy with their diet, the staff will create a care plan that the resident is satisfied with. Documenting that a resident is refusing meals due to "non-compliance" with diet orders is not appropriate. The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. The facility's quality assessment and performance improvement (QAPI) committee will periodically review issues related to food preferences and meals to try to identify more	2 965		

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2 965	Continued From page 10 widespread concerns about meal offerings, food preparation, etc. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 965		

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F 000	INITIAL COMMENTS On 1/13/25 - 1/17/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H5285125C/MN109868. The following complaints were reviewed. H52894760C/MN109756, H52894782C/MN109762 with a deficiencies issued at F550, F656, F692, F804, F806, and F808. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 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.	F 550		2/28/25

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

Electronically Signed | 02/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See 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 550	Continued From page 1 §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 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 interview and record review the facility failed to ensure that 1 of 2 residents (R6) reviewed received services in a dignified manner to promote quality of life when staff failed to respond timely to call light and provide assistance	F 550	The facility ensures that the resident can exercise his or he rights without interference, coercion, discrimination or reprisal from the facility. The call light policy was reviewed and revised to reflect	

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F 550	Continued From page 2 per residents needs resulting in R6 missing time with family. Findings include: R6's admission Minimum Data Set (MDS) dated 11/14/24, indicted R6 had a Brief Inventory of Mental Status (BIMs) score of 15 indicated R6 was cognitively intact. R6 required maximum assistance with lower body dressing, toileting, transferring and bathing. R6's pertinent diagnoses were severe obesity with alveolar hypoventilation (a breathing disorder in which a person with obesity breathes too slowly, resulting in too much carbon dioxide and not enough oxygen in the blood), diabetes, thyroid disorder, chronic pain, and lymphedema (swelling in the body due to build-up of lymphatic fluid) and chronic pain. R6's care plan dated 11/11/24, indicated R6 required a mechanical lift Hoyer with the assistance of two for transfers. R6's care plan dated 11/11/24 indicated staff was to encourage R6 to use his light to call for assistance. R6's care plan dated 11/11/24 indicated staff was to be sure R6's call light was within reach and encourage R6 to use it for assistance as needed. R6 needed prompt response to all requests for assistance. R6's care plan dated 11/26/24 indicated R6 preferred to get up in the morning between 10:00 a.m. and 11:00 a.m. A facility device activity report (call light report)	F 550	the appropriate methods and times of call light response. Staff were educated on the call light policy during staff meetings and the policy was posted. The call light system is scheduled to be repaired by a third party vendor to provide full functionality and Nursing will check the call light board every 15 minutes to ensure call lights are responded to timely until the call light system can be fully functional. Random audits for call light response will be conducted weekly for 2 months and then monthly for 3 months and reported/reviewed at the quarterly QAPI meetings for 6 months. The call light system report, will be reviewed weekly by the Director of Nursing to monitor the overall call light response times. The Director of Nursing and/or their designee will responsible for the ongoing compliance.	

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F 550	Continued From page 3 dated 11/28/24 indicated R6's call light was pressed at 10:38 a.m. and answered at 1:26 p.m. totaling a 167-minute wait time. Upon interview on 1/13/25 at 2:20 p.m. R6 stated the staff leaves him waiting for hours on the call light therefor, he will sometimes sleep in his electric wheelchair. He stated that on 11/28/25, Thanksgiving day, R6 had made plans for his family to pick him up and take him out for the day. He stated he waited for two hours on his call light for staff assistance. He stated his family arrived at the facility around 1:00 p.m. to pick him up and he was still in bed. He stated his family left and brought him leftovers later during the day. Upon interview on 1/13/25, R6's family member (FM)-A was visiting and stated the family had Christmas at the facility so R6 could join in as the family feared the facility would not get R6 up and ready in time and she did not want him to miss two holidays. "He is lonely enough." In addition, Unidentified facility resident's device report activity dated 1/11 - 1/14/25 for the third floor indicated: -Readings on 1/10/25 of 64 minutes 49 seconds, a reading of 37 minutes 10 seconds for unidentified residents on the third floor. -Readings on 1/11/25 of 359 minutes 8 seconds, 36 minutes and 27 seconds, 60 minutes and 50 seconds, 49 minutes and 54 seconds, 65 minutes and 29 seconds, 76 minutes 34 seconds for unidentified residents on the third floor. -Readings on 1/12/25 of 46 minutes and 54 seconds, 38 minutes and 31 seconds, 43 minutes and 10 seconds, 62 minutes, and 43 seconds for unidentified residents on the third floor. -Readings on 1/13/24 of 77 minutes 14 seconds,	F 550		

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F 550	Continued From page 4 43 minutes 26 seconds, 49 minutes 36 seconds, 39 minutes 16 seconds, 40 minutes and 36 seconds, 118 minutes and 22 seconds, 40 minutes 36 seconds, 87 minutes 41 seconds, 45 minutes 11 seconds, 123 minutes, and 39 seconds for unidentified residents on the third floor. A call light policy was requested however none received.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		2/28/25

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F 656	Continued From page 5 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement care plans for 3 of 3 residents (R2, R3, and R4) reviewed when the residents did not receive care according to the comprehensive assessment. The residents were not turned and/or repositioned every two to three hours as indicated on the care plan. Findings include: R2's annual MDS dated 5/3/24 indicated R2 had a BIMS score of 00 indicating R2 had severe cognitive impairment. R2 was totally dependent upon staff for eating, dressing, grooming, bathing, toileting and transferring. R2 was always incontinent of bowel and bladder. R2's pertinent diagnoses were multiple sclerosis (a disease	F 656	The facility develops and maintains a comprehensive person-centered care plan for each resident, consistent with the resident rights. The Nursing Policy for Turning and Repositioning was reviewed and revised. Nursing and Rehab staff were educated on the policy for Turning and Repositioning of residents. A complete audit of each resident's care plan for repositioning was conducted to determine if the repositioning schedule was in place for each resident if applicable. An audit was conducted for all residents for the presence of any pressure relieving devices, wounds, and current mobility status. Care plans were updated to reflect any needed changes for repositioning. Ongoing audits on	

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F 656	Continued From page 6 where the immune system eats away at the protective covering of the nerves), muscle wasting, repeated falls, and adult failure to thrive. R2's care plan dated 9/30/24 indicated R2 was to be offered to be laid down following meals. R2's care plan with a revision dated of 10/27/24 indicated R2 was to be turned and repositioned every 2-3 hours due to actual skin impairments. Upon continuous observation of R2 on 1/13/25: -9:21 a.m. R2 was seated in a Geri-chair (a specialized wheelchair that reclines) in a reclined position in the commons area fully dressed and groomed following breakfast. -11:50 a.m. R2 was still in his Geri-chair wearing a restraining belt. R2 would sleep on and off in his chair. -12:24 p.m. R2, R3, and R4 were wheeled to the dining room without being repositioned or having their incontinent briefs changed. In addition, their hands were not sanitized before provided lunch. -12:49 R2, R3, and R4 ate lunch in the lunchroom without being repositioned. -1/13/25 at 12:49 R2, R3, and R4 ate lunch in the lunchroom without being repositioned. -Upon observation and interview on 1/13/25 at 1:48 p.m. R2 was still in his wheelchair facing his bed with his call light in place under the blanket. R3's MDS dated 10/17/24 did not indicate a BIMs score. R3 required maximum assistance with transferring and toileting. She required moderate assistance with dressing and grooming. R3's pertinent diagnoses were coronary artery disease, congestive heart failure, cerebral vascular incident (stroke) with hemiparesis and chronic pain.	F 656	residents that require repositioning will be conducted weekly for 4 weeks, then monthly for 3 months. Audit findings will be reviewed at the quarterly QAPI meetings for 6 months to monitor compliance. The Director of Nursing and/or their Designee will be responsible for ongoing compliance.	

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	245289	A. BUILDING _____ B. WING _____	C 01/17/2025

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F 656	Continued From page 7 R3's care plan dated 10/17/24 indicated R3 was to be turned and repositioned every 2-3 hours. Upon continuous observation of R3 on 1/13/25: -9:41 a.m. R3 was seated in a Geri-chair in a reclined position in the commons area fully dressed and groomed following breakfast. -11:48 a.m. R3 was seated in a Geri-chair. R3 stated her incontinent pad was wet. -12:24 p.m. R2, R3, and R4 were wheeled to the dining room without being repositioned or having their incontinent briefs changed. -12:49 R2, R3, and R4 ate lunch in the lunchroom without being repositioned. -12:50 p.m. R3 asked staff to go to her room. At 12:51 p.m. R3 was not taken her room she was taken to the same commons area she was in prior to lunch without being repositioned or her incontinent brief changed. -1:12 p.m. R3 was still seated in the commons area in her wheelchair. R4's MDS dated 10/14/24 did not indicate a BIMS score. R4 required moderate assistance with dressing, grooming, toileting and transferring. R4's pertinent diagnoses were diffuse traumatic brain injury (a type of brain injury that occurs when the brain is damaged in over a large area), cerebral infarction, adult failure to thrive and chronic pain. R4's care plan 10/27/24 indicated to offer repositioning every 2-3 hours. Upon continuous observation of R4 on 1/13/25: -9:41 a.m. R4 was seated in a regular wheelchair in the commons are following breakfast fully dressed and groomed.	F 656		

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F 656	Continued From page 8 -Upon continuous observation and interview on 1/13/25 at 11:49 a.m. R4 was still seated in her wheelchair. She stated she had back pain when she sits in her chair all day and stated her incontinent brief was wet. ' -12:24 p.m. R2, R3, and R4 were wheeled to the dining room without being repositioned or having their incontinent briefs changed. -12:49 R2, R3, and R4 ate lunch in the lunchroom without being repositioned. -12:53 p.m. R4 was taken to the same commons area she was in prior to lunch without being repositioned or her incontinent brief changed. -12:58 p.m. R4 was taken to his room left in his Geri-chair, a blanket was placed over him, and his call light was attached to the blanket. He was not repositioned, he was not checked and changed and not laid down after lunch as his care plan indicated. -1:04 p.m. R4 was taken to her room, toileted and laid down in bed. Upon interview on 1/13/25 at 1:15 p.m. nursing assistant (NA)-B stated R3 should have been repositioned, checked, and changed every 2-3 hours however the day was so busy that she forgot to reposition or change her. Upon interview on 1/13/25 at 1:50 p.m. NA-B stated she had not had time to check and change or lay R2 down because he required the assistance of two staff. She stated would perform his cares next. Upon interview on 1/14/25 at 11:14 a.m. the assistant director of nursing (ADON) stated the staff needed to follow the care plan and the facility was staffed enough to make sure the residents get checked, changed, and repositioned	F 656		

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F 656	Continued From page 9 as ordered even if the resident would require the assistance of two staff members. Upon interview on 1/17/25 at 2:20 p.m. the director or nursing stated the staff must follow the care plan. The facility policy titled Using the Care Plan, undated, indicated the care plan shall be used in developing the resident's daily care routines and will e available to staff who have responsibility for providing care or services to the resident. The nurse supervisor uses the care plan to complete the nursing assistants daily/weekly work assignment sheets or flow sheets. Documentation must be consistent with the resident's care plan.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		2/23/25

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F 692	Continued From page 10 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a systematic approach to assess and evaluate residents' fluid status to monitor the effectiveness of interventions for 2 of 2 residents (R1 and R8) reviewed. R1 and R8 were on a daily fluid restriction. The facility partially documented the fluid intake; however, the facility did not have a system in place to evaluate the total daily fluid intake to determine adequacy or if the provider required notification. Findings include: R1's care plan dated 7/22/21, indicated R1 required a fluid restriction of 2000 milliliters (ml) per day related to chronic kidney disease with fluid overload or potential for fluid overload. Staff was to monitor intake and output. R1's care plan dated 8/1/21 indicated the facility was to provide and serve a no added salt diet with a 2000 cubic centimeter (CC) daily fluid restriction as ordered with (double portions). Due to many allergens R1 can be resistive to eating facility meals, so wife brings in food. R1 prefers high protein/low carbohydrates, large entrée portions. The facility purchases sour dough bread per her request (provided at breakfast with butter pads), chicken breasts baked in olive oil, vegetarian burgers, and green beans. The facility was to document intake and output at each meal. Do not serve corn starch, dairy, (butter, American cheese and hard cheese are o.k.), egg whites were o.k. if cooked into something. No gluten,	F 692	The facility strives to maintain the Nutrition and Hydration status for each resident. The policy on fluid restrictions was reviewed and revised. Nursing and Dietary staff were educated on the policy for fluid restrictions. The fluid restrictions for each of the residents R1 & R8 were promptly reviewed and updated according to the resident's plan of care. All resident's care plans were reviewed to ensure that fluid restrictions and Physician Orders were addressed appropriately. Audits will be conducted on all new admissions and random audits of current residents will be conducted weekly for 3 months then monthly thereafter for 3 months to ensure that fluid restrictions are careplanned and followed. Audit findings will be reported to the QAPI committee for 6 months. The Director of Nursing and/or their designee will be responsible for compliance.	

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F 692	Continued From page 11 soy, or soybean oil to be used unless requested R1's quarterly Minimum Data Set (MDS) dated 12/23/24 indicated R1 had a Brief Inventory of Mental Status of 15 indicating R1 was cognitively intact. R1 required set-up and clean-up assistance with activities of daily living. R1's pertinent diagnoses were cardiac failure, renal insufficiency, morbid obesity, and borderline personality (a mental disorder displaying unstable moods). R1 required a therapeutic diet. R1's electronic treatment administration record (eTAR) dated 12/1/24 - 1/14/25 indicated R1's licensed nursing staff documented R1's fluid intake morning, evening, and night shifts. Documentation of fluid intake was omitted on the following dates: 12/1/24 morning shift 12/17/24 morning shift 12/27/24 morning shift 1/1/25 evening shift 1/3/25 morning shift 1/7/25 morning shift R1's Point of Care (POC) Response history (nursing assistant documentation) dated 12/15/24 - 1/12/25 indicated the nursing assistants were documenting R1's fluid intake on morning, evening, and night shifts. Documentation was omitted on the following dates: 12/15/24 morning and night shifts 12/16/24 morning, evening, and night shifts 12/17/24 morning, evening, and night shifts 12/18/24 morning and night shifts 12/19/24 morning and night shift 12/20/24 morning, evening, and night shifts 12/21/24 night shift 12/22/24 morning, evening, and night shifts	F 692		

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F 692	Continued From page 12 12/23/24 morning and night shifts 12/24/24 morning and night shifts 12/25/24 morning, evening, and night shift 12/26/24 morning and night shifts 12/27/24 morning, evening, and night shifts 12/28/24 morning shifts 12/29/24 morning and night shifts 12/30/24 morning, evening, and night shifts 12/31/24 morning and night shifts 1/1/25 morning and night shifts 1/2/25 morning and night shifts 1/3/25 morning and night shifts 1/4/25 morning shift 1/5/25 morning, evening, and night shifts 1/6/25 morning and night shifts 1/8/25 morning and night shifts 1/9/24 morning and night shift Upon interview on 1/13/25 at 9:50 a.m. R1 stated she has been on a fluid restriction since her admission in 2021. She stated was not aware if the facility was following it or how they were monitoring it. She stated she tried to keep track on her own. R8's dietary nutrition assessment dated 11/1/24 indicated R2's diet order was 2-gram sodium (NA+). R8 was on a fluid restriction of 2000 milliliters per day. Resident was to have regular portion sizes. R8's MDS dated 11/5/24 indicated R8 had a BIMs score of 15 indicating he was cognitively intact. R8 required moderate assistance with dressing, grooming, transferring and toileting. R8's pertinent diagnoses were congestive heart failure, diabetes mellitus, morbid obesity, and depression.	F 692		

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F 692	Continued From page 13 R8's (eTAR) dated 11/1/24 - 1/14/25 indicated the nursing staff had documented R8's fluid intake for the day, evening, and night shift. Documentation was omitted on: 11/2/24 morning shift 11/7/24 night shift 11/13/24 morning shift 11/22/24 morning shift 11/25/24 morning shift 11/27/24 morning shift 11/29/24 morning shift 12/15/24 morning and night shifts 12/16/24 morning shift 12/17/24 morning shift 12/23/24 night shift 12/25/25 morning and night shift 12/28/24 morning shift 12/30/24 morning shift and night shift 1/2/25 morning and evening shifts 1/3/24 morning shift 1/5/25 morning shift 1/7/24 morning shift 1/8/24 morning shift R8's POC response history (nursing assistant charting) dated 12/16/24 - 1/14/25 indicated the nursing assistants had documented R8's fluid intake morning, evening, and night. Documentation was omitted on the following dates: 12/16/24 morning and night shifts 12/17/24 morning, evening, and night shifts 12/18/24 morning and night shifts 12/19/24 morning and night shifts 12/21/24 morning and night shifts 12/22/24 morning and night shifts 12/24/24 morning and night shifts 12/25/24 morning and night shift 12/27/24 morning, evening, and night shift	F 692		

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F 692	Continued From page 14 12/31/24 morning and night shift 1/1/25 night shift 1/2/25 morning and night shift 1/3/25 morning and night shift 1/5/25 morning and night shift 1/6/25 morning and night shift 1/8/25 evening shift 1/9/25 morning and night shift 1/10/25 night shift 1/11/25 night shift Upon interview on 1/14/25 at 11:32 a.m. the facility dietician stated she thought the nurses kept track of the residents who had a fluid restriction and reported any concerns to her. Upon interview on 1/14/25 at 1:10 p.m. registered nurse (RN)-A, nurse manager stated the dietician looks at the fluid restriction results. She stated she "assumed" if the results were not correct the dietician would ask the nursing staff. RN-A stated she does not audit any of the fluid restrictions. Upon interview on 1/14/25 at 1:48 p.m. R8 stated having a fluid restriction was new to him and he tried to monitor it himself. He denied any education from the facility. Upon interview on 1/15/25 at 11:14 a.m. RN-B, the assistant director of nursing (ADON) stated when he worked on the floor, he would document the fluid intake in the residents' eTAR. He was uncertain how the nursing assistants tracked the fluid restrictions. He stated he thought the dietician was tracking all the fluids. "A dietician can only track what information is given." Upon interview on 1/17/25 at 2:20 p.m. the director of nursing (DON) stated fluid restrictions	F 692		

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F 692	Continued From page 15 should be monitored every shift by the nurses. She was not certain the role of the nursing assistants in the fluid restriction. She stated the responsibility is for the nurses to have a total of the day for the dietician to review. The DON was not certain the system the nurses were using to total the intakes daily on the residents. A facility policy titled Encouraging and Restricting Fluids with a revision date of 1/2024 indicated: Restricting Fluids: 1. Remove the resident's water pitcher and cup from the room. Store in designated area. If the resident refuses to have the water pitcher removed, notify the supervisor and in turn, the physician. 2. Wash and dry your hands thoroughly before serving the resident fluids. 3. Take the fluid container to the resident's room. 4. Inform the resident you have brought them a drink. Tell the resident what type of drink it is. 5. Encourage the resident to drink the fluid. Should the resident refuse, report such information to your supervisor. 6. Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in mLs. 7. Provide mouth care, as necessary. 8. Remove fluid container. 9. Wash and dry your hands thoroughly. Documentation The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. Any changes in the resident's condition.	F 692		

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F 692	Continued From page 16 4. Any problems or complaints made by the resident related to the procedure. 5. Any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin, etc. 6. The amount (in mLs) of fluids consumed by the resident during the shift. 7. The type of liquid consumed (i.e., tea, milk, coffee, soup, etc.). 8. If the resident refused the treatment, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.	F 692		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure food was served at the proper temperature to 3 of 3 residents (R1, R7, and R9) reviewed for residents during breakfast and lunch on the third floor of the building. This had the potential to affect all 37	F 804	The facility provides nutritive, palatable foods at the proper temperature. The policy on Food Temperature and Service was reviewed and revised. The Dietary Staff were educated on the proper way to temp food items prior to service and how	2/21/25

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F 804	Continued From page 17 residents who resided on the third floor. Findings Include: R1's quarterly Minimum Data Set (MDS) dated 12/23/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) of 15 indicating R1 was cognitively intact. R1 required set-up and clean-up assistance with activities of daily living. R1's pertinent diagnoses were cardiac failure, renal insufficiency, morbid obesity, and borderline personality (a mental disorder characterized by unstable moods. R1 required a therapeutic diet. R7's quarterly MDS dated 11/2/24 indicated R7's cognitions status was not completed. R7 used a wheelchair for mobility. Diagnosis included hypertension, seizure disorder, metabolic encephalopathy, malnutrition, anxiety, depression, and bipolar. R9's admission MDS was not completed at the time of the survey. R9 was admitted to the facility on 1/9/24. Upon interview on 1/13/25 at 9:50 a.m. R1 stated "more times than not the food is cold by the time it gets to me." R1 stated the temperature of the food is one of the many reasons she buys her own food. Upon interview on 1/13/25 at 11:30 a.m. R7 stated his family prepares and brings his food. He stated the food is either overcooked, undercooked, and always cold. Upon interview on 1/13/25 at 12:10 a.m. trained medication assistant (TMA) stated R7 refuses to eat at the facility. She stated to listen to what the	F 804	to ensure that the meal is properly delivered to maintain temperature. Daily temperature checks will occur at each meal by the cook and served to the resident within 10 minutes of plating. Random audits will be conducted to ensure that the meal delivered is at a regulatory safe and satisfiable temperature each day for 4 weeks and then weekly for 3 months thereafter. Resident satisfaction audits will be conducted weekly to allow input on menu choices and offerings. Audit Findings will be reported and monitored at the QAPI meeting for 6 months. The Dietary Manager and/or their designee will be responsible for ongoing compliance.	

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F 804	Continued From page 18 residents are saying about the food, their comments are not exaggerated. She stated she has seen cold food, undercooked food and food that looks like it had been half eaten before serving. Upon interview on 1/13/25 at 2:03 p.m. the director of food services stated he had heard a few complaints about cold food. He stated the food on the 2nd and 3rd floor of the building have steam tables the food goes on and if the staff do not deliver the food to the residents fast enough the nursing staff can heat it up. Upon interview on 1/14/25 at 12:38 p.m. the food service staff stated the nursing assistants heat-up a lot of the trays she sets-up from the steam table to be served. Upon observation on 1/14/25 at 12:45 p.m. the surveyor taste sampled the last food tray that had been set-up on the food cart right before getting served to the last resident being served in their room. The tray had a soft-shell taco with lettuce, chopped tomato and ground beef inside serviced with an ambrosia salad (fruit salad with marshmallows and whip cream) and milk. The ground beef was cold. The ambrosia salad and milk were room temperature. The resident was given a new tray. Upon observation on 1/15/25 at 8:02 a.m. yelling was hard coming from R9's room on the third floor. She was yelling "get in her, get in here now." Upon arrival of registered nurse (RN)-A and the surveyor, the resident stated she was soiled and her food that was just dropped off was cold again. R9 had RN-A touch a cheese filled omelet and RN-A verified the omelet was cold.	F 804		

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F 804	Continued From page 19 R9 also stuck her finger in the oatmeal and reported it was cold. R9 stated she wanted a new tray promptly because she had sent back trays before and stated the staff did not return the food for up to an hour. R9 was given a new tray at 8:20 a.m. which was warm. Upon interview on 1/17/25 at 2:20 the director of nursing stated she was aware of the complaints that the food was cold. She stated she had been working on a plan and was going to present it to the new Administrator about serving the food "assisted living style" she stated with her plan the resident would have meals served for a 2-hour time span and all the residents would come to the dining room on at the time they would choose. A facility policy titled Food Preparation and Service dated 11/2022 indicated the facility food and nutrition service employees prepare and serve food in a manner that complies with safe food handling practices.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 806	The facility accommodates resident	2/21/25

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F 806	Continued From page 20 review the facility failed to accommodate foods for resident allergies and/or intolerances for 1 of 3 residents (R1) reviewed. R1 had an allergy to gluten and was given gluten meals so often at the facility that R1 was buying her own food and stocking-up on foods from the facility kitchen to have when she was served a gluten meal. Findings include: R1's clinical allergy sheet dated 7/20/21 indicated R1 had allergies to soybean oil, gluten, ciprofloxacin (an antibiotic), adhesive tape, latex, and cornstarch. R1's care plan dated 8/1/21 indicated the facility was to provide and serve a no added salt diet with a 2000 cubic centimeter (CC) daily fluid restriction as ordered with (double portions). Due to many allergens R1 can be resistive to eating facility meals, so her wife brings in food. R1 prefers high protein/low carbohydrates, large entrée portions. The facility purchases sour dough bread per her request (provided at breakfast with butter pads), chicken breasts baked in olive oil, vegetarian burgers, and green beans. The facility was to document intake and output at each meal. Do not serve corn starch, dairy, (butter, American cheese and hard cheese are o.k.), egg whites o.k. if cooked into something. No gluten, soy, or soybean oil unless requested. R1's care plan dated 6/22/23 indicate R1 had an allergy to gluten (a protein found in wheat and other grains). R1's quarterly Minimum Data Set (MDS) dated 12/23/24 indicated R1 had a Brief Inventory of	F 806	allergies, intolerances and preferences and offers different meal choices. The policy on Special Diets and Preferences was reviewed and revised. R1's care plan was reviewed to ensure that correct preferences were inputted in the Dietary meal tracker system. The Dietician and Dietary Manager reviewed all Care Plans to ensure that the resident's allergies and preference were consistent with the Meal Track system. Education was provided for Dietary staff on the policy for Diets and Preferences. Resident meal satisfaction and allergies and/or intolerances noted in the care plan will be audited weekly for 3 months and monthly thereafter for 3 months for compliance. Audit findings will be reviewed by the QAPI committee for 6 months. The Dietary Manager and/or their Designee will be responsible for ongoing compliance.	

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F 806	Continued From page 21 Mental Status of 15 indicating R1 was cognitively intact. R1 required set-up and clean-up assistance with activities of daily living. R1's pertinent diagnoses were cardiac failure, renal insufficiency, morbid obesity, and borderline personality (a mental disorder characterized by unstable moods). R1 required a therapeutic diet. Upon observation on 1/13/25 at 8:33 a.m. R1 was served one slice of French toast, a sausage patty and two hard boiled eggs. Upon interview on 1/13/25 at 10:18 a.m. R1 stated there were only three or four meals a week she could eat at the facility that did not have some sort of gluten like bread, pasta, or mashed potatoes. She stated she spends "a lot" of money out of pocket each month to get her own food. R1 stated she orders hard-boiled eggs for breakfast to have in her refrigerator for when she would be served a meal with substantial gluten. R1 had over 300 photos of food served to her at the facility that contained gluten. She stated about a year-and-a-half ago she would meet with the dietician and would make-up a weekly meal plan for her. She stated since then the facility had gotten a new food vendor and a new dietician and that had not happened. Upon interview on 1/13/25 at 12:10 p.m. trained medication assistant (TMA)-A stated she was aware that R1 received many meals with gluten and was aware R1 would buy her own food. She stated she was aware that R1's care plan indicated she was allergic to gluten, but thought she had an intolerance, since she would eat gluten at times. Upon observation on 1/13/25 at 12:32 p.m. R1	F 806		

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F 806	Continued From page 22 was served a bratwurst on a white bun, green beans, and a brownie for lunch. She did remove the bun herself and ate the bratwurst meat. Upon interview on 1/13/25 at 1:20 p.m. a facility cook stated he was aware that R1 had a soy and gluten allergy. He stated the kitchen did not cook with soy. He verified that R1 does get gluten, and he is not certain if she eats it. Her meal ticket indicated "no gluten." The cook stated R1 was supposed to meet with the dietician to discuss meal options, but since he did not have any specific instructions from either the dietician or the food service director, he did not prepare any gluten free meals. Upon interview on 1/13/25 at 2:03 p.m. the director of food services stated he was not aware that R1 had a soy and gluten allergy. He stated if he were aware that someone in the facility had gluten free needs, he would have requested a special menu from the dietician or nursing staff. In addition, he would set-up a clean area in the kitchen for the least amount of risk of cross contamination to the gluten free food. Upon interview on 1/14/25 11:15 a.m. the dietician stated when she started her position in 6/2024 the previous dietician told her that R1 had a gluten intolerance not a true allergy. She stated that R1's meal ticket indicated a gluten free diet. The dietician believed the facility had a communication problem due to staff turnaround. She stated she had never been told to set-up a "gluten free" diet with R1. Upon interview on 1/17/24 at 2:20 p.m. the director of nursing (DON) stated the facility dietary department needed an overhaul. She was	F 806		

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F 806	Continued From page 23 unaware R1 was not receiving the diet her care plan indicated. The DON was not certain if R1 had an allergy or intolerance but stated either way the facility needed to follow the care plan. A facility policy titled Resident Food Preferences dated 7/2021 indicated: Upon the resident's admission (or within twenty-four (24) hours after their admission) the dietitian or nursing staff will identify a resident's food preferences. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. The dietitian and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations that might conflict with the resident's food preferences. The dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The physician and dietitian will communicate the risks and benefits of specialized therapeutic vs. liberalized diets. Therapeutic diets will be ordered only after the resident/representative agrees with and consents to such a diet. The resident has the right not to comply with therapeutic diets. If the resident refuses or is unhappy with their diet, the staff will create a care plan that the resident is satisfied with. Documenting that a resident is refusing meals due to "non-compliance" with diet orders is not appropriate. The food services department will offer a variety	F 806		

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F 806	Continued From page 24 of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. The facility's quality assessment and performance improvement (QAPI) committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide the prescribed diet to 2 of 3 residents (R6 and R8) reviewed for therapeutic diets. R6 and R8 were both prescribed a low sodium diet, and the facility was unable to demonstrate how they provided the specialized diet. Findings include: R6's admission minimum data set dated 11/14/24 indicted R6 had a Brief Inventory of Mental Status (BIMs) score of 15 indicated R6 was cognitively intact. R6 required maximum assistance with lower body dressing, toileting, transferring and	F 808	The facility provides Therapeutic Diets as prescribed by a Physician. The policy on Therapeutic Diets was reviewed and revised. Nursing and Dietary Staff were educated on the Therapeutic Diet policy. The Care Plans for all residents were reviewed to ensure that specialized diets were consistent with the Diet Tracker information. Weekly audits of the residents with specialized diets will be conducted for 3 months and then monthly for 3 months to ensure that specialized diets are consistent with the Diet Tracker information. Resident meal satisfaction audits will be conducted weekly to ensure	2/23/25

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F 808	Continued From page 25 bathing. R6's pertinent diagnoses were severe obesity with alveolar hypoventilation (a breathing disorder in which a person with obesity breathes too slowly, resulting in too much carbon dioxide and not enough oxygen in the blood), diabetes, thyroid disorder, chronic pain, and lymphedema (swelling in the body due to build-up of lymphatic fluid) and chronic pain. R6's weight summary dated 11/11/24 indicated R6 weighed 445.9 pounds (lbs.) R6's care plan dated 11/20/24 indicated he was to have a cardiac diet (a dietary plan that reduces sodium, fat, and cholesterol). R6's care plan dated 12/12/24 indicated R6 had been educated on appropriate diet options for diabetes. R6's nutritional assessment dated 11/12/24 indicated R6 was on a cardiac diet with no added salt. R6's body mass index (BMI) was 51.5 indicating morbid obesity. R6 was working toward gradual weight loss. Per hospital note dated 2000 kcals (food calories) per day was ideal for resident with a maximum of 2500 kcals per day. Recommendation or Prosource (nutritional drink supplement) 30 milliliters (ml.) three times a day to meet estimated protein needs to support preventing muscle wasting while resident was working towards gradual weight goals. R6's weight summary dated 1/13/25 indicated R6's weighed 472.0 lbs. Upon interview on 1/13/25 at 1:20 p.m. a facility cook stated the facility runs out of food by the end	F 808	that meal choices/preferences are noted in the Diet Tracker. Audit information will be reported to the QAPI committee for 6 months and ongoing as needed. The Dietary Manager, Director of Nursing and/or their designee will be responsible for monitoring ongoing compliance.	

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F 808	Continued From page 26 of the week almost every week. He stated the kitchen cannot follow therapeutic diets for that reason. He and other staff members have spent their own money buying items such as eggs or milk for the facility. He stated the kitchen has had to cut some residents meals in half to make sure others received a tray. He stated other times the kitchen had to serve whatever was left in the kitchen so all residents would get fed. Upon interview on 1/13/25 at 2:03 p.m. the director of food services stated he had heard complaints about the facility serving the same meals repetitively. He stated he had reached out to his corporate office about that with no response. He stated the facility had been short of food and he believed it was a communication problem between the facility and the kitchen. He stated it was in part to new admissions and the kitchen would not be informed of them. He stated the kitchen had always come up with food to feed all the residents and stated because of the shortage he could not confirm that all residents were getting their therapeutic diet. Upon interview on 1/13/25 at 2:20 p.m. R6 stated he was disappointed with the assessments of, and food served at the facility. He stated entered the hospital approximately one year ago at a weight of 675 lbs. and had gotten his weight down to 445 lbs. before entering the facility in 11/2024. He stated his weight as of 1/2025 had been 478 lbs. He stated the facility had not addressed his weight gain even though he had brought up the situation to the nursing staff that he is not getting the correct meals, weight had increased, and he noticed his ankle lymphedema was worse. He stated his only meeting with the dietician was on his admission. R6 stated he is getting depressed	F 808		

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F 808	Continued From page 27 because he is required to lose weight before he had had a knee surgery. R6 had hundreds of photos on his phone of the food. He stated one night he was served potato chips and cooked zucchini and nothing else. He stated he had been given meals with just water to drink. R6's meal ticket dated 1/14/25 lunch indicated R6 was on a 2 GM NA diet (a low sodium diet) was to receive hamburger steak 3 ounces (oz), low sodium brown gravy, buttered macaroni noodles one-half of a cup, tomatoes one-half of a cup, one rosemary dinner roll, one pad of margarin, ambrosia salad (a fruit-based salad with marshmallows and whipped cream) one-half of a cup coffee or tea 6 ounces. Upon observation on 1/14/25 at 12:50 p.m. R6 was serviced two soft shelled tacos filled with hamburger (about 1.5 cups), tomatoes and lettuce, ambrosia salad (approximately 1 cup), a 6 oz glass of milk and 1 cup of coffee. R8's MDS dated 11/5/24 indicated R8 had a BIMs score of 15 indicating he was cognitively intact. R8 required moderate assistance with dressing, grooming, transferring and toileting. R8's pertinent diagnoses were congestive heart failure, diabetes mellitus, morbid obesity, and depression. R8's care plan dated 11/1/24 indicated staff was to discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. R8's dietary nutrition assessment dated 11/5/24 indicated R2's diet order was 2-gram sodium (NA+). R8 was on a fluid restriction of 2000	F 808		

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F 808	Continued From page 28 milliliters per day. Resident was to have regular portion sizes. R8's care plan dated 11/6/24 indicated staff was to provide and serve diet as ordered: diabetic diet, regular texture, and thin liquids. R8's care plan did not indicate a low NA+ diet. Upon interview on 1/14/25 at 11:32 a.m. the dietician stated the facility uses portion sizes to control diabetic and low sodium diets. She stated the proper portion sizes are on each resident's meal ticket. She stated she questioned if R6's weights were accurate because a lot of facility weights had been inaccurate, and she was going to look into it. She stated R6 had a 5.9% weight gain in two and a half months, but with morbid obesity that was not considered significant. She reviewed R6's chart and stated she needed to look at changing his diet. She stated she also needed to look at why some high sodium foods were not "populating" on the residents' tickets such as bacon which should not be served to residents on low sodium diets. She stated she believed R8 was coping fine with his diet as she had not heard anything different. Upon interview 1/14/25 at 12:38 p.m. a food server stated she believed diabetics get less sugar than other residents, such as no sugar sweeteners for coffee or unsweetened applesauce. She stated, "isn't a low sodium diet the same as not having sugar?" The food server stated she had never been educated on portion sizes for residents except that some residents will ask for double portions and she doubles the food on the plate when asked if there is enough food or asks the residents to stop back for seconds.	F 808		

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F 808	Continued From page 29 Upon interview on 1/14/25 at 1:10 p.m. RN-A stated she had heard many complaints about the food portions, getting half portions, and running out of food. She had not heard of staff buying the residents food. She stated the facility had run out of milk and eggs. She stated she could confirm a meal of just potato chips and cooked zucchini had been served. She had informed the former administrator multiple times about the food complaints and her concerns. Upon interview on 1/14/25 at 1:48 p.m. R8 stated he had been at the facility for two months and he had a problem with the food portions. He stated he was 550 lbs., and he needed to lose weight; however, the portions kept him hungry all the time. He stated he requested to meet with the dietician with no luck. He spoke with the dietary servers and asked for more food approximately one week ago and had been given extra food since then. He was not certain how the facility was tracking his low sodium diet. He stated a few weeks ago he noticed the facility did not have enough food for six newly admitted residents so he shared his tray with them and asked the kitchen for peanut sandwiches so nobody would go to bed hungry. Upon interview on 1/17/25 at 2:20 p.m. the director of nursing stated the entire dietary department needed an overhaul. She stated she was not certain how the servers were determining the portion sizes to accompany the diets ordered on the resident's food tickets or how staff serves the food when the menu changes. A facility policy titled Therapeutic Diets dated 10/2017 indicated Therapeutic diets are prescribed by the attending physician to support	F 808		

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F 808	Continued From page 30 the resident's treatment and plan of care and in accordance with their goals and preferences. Diet order should match the terminology used by the food and nutrition services department. A 'therapeutic diet'' is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: diabetic/calorie-controlled diet; low sodium diet; cardiac diet; and altered consistency diet.	F 808		

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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
E 000	Initial Comments On 1/13/25 - 1/17/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard abbreviation survey. The facility was NOT in compliance. The survey resulted in an Immediate Jeopardy (IJ) at E0015 when sewage leaked into the boiler room and was jetted out by the mechanical company and was confirmed on 1/15/25 there were three to four inches of sewage waste on the floor in the boiler room. The boiler room shares an internal door to the facility. The facility emergency preparedness plan dated 6/10/24 did not identify a plan to maintain the safety of residents, staff, and visitors from the environmental and health hazard exposure to sewage waste by way of contamination or gases. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 015 SS=L	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1)	E 015		2/28/25

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

Electronically Signed | 02/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See 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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E 015	Continued From page 1 [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies.	E 015		

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E 015	Continued From page 2 (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify emergency provisions and develop policies and procedures to maintain necessary services for sewage waste (feces and urine mixed in wastewater) ensuring safe disposal if there was a blockage from the city sewage system. This resulted in several inches of sewage backup onto the floor of the boiler room on multiple occasions over three months posing a risk of contamination and toxic gases to residents, staff, and visitors. In addition, the facility failed to have policies and procedures for handling, storage, and disposal of infectious waste in accordance with local and state laws. This has the potential to affect all 67 residents, staff, and visitors. The immediate jeopardy began on 1/13/25 when sewage leaked into the boiler room and was confirmed on 1/15/25 when there were three to four inches of sewage waste on the floor in the boiler room. The boiler room shares an internal door to the facility. The facility emergency preparedness plan dated 6/10/24, did not identify a plan to maintain the safety of residents, staff, and visitors from the environmental and health hazard exposure to sewage waste by way of contamination or gases. The regional manager,	E 015	The facility develops and implements emergency preparedness policies and procedures to ensure the safety of residents and staff. The Emergency Action Plan for The Terrace at Crystal was updated on 1/16/2025 to reference procedures in the event of a sewage backup. The Emergency Policy for Sewage Back up was reviewed and revised on 1/15/2025. Department Leadership staff were educated on 1/16/2025 on the Emergency Policy for Sewage Back up. The Terrace at Crystal staff were trained on the Emergency policy for sewage back up from 1/16-22/2025 and the policy posted for ongoing review. A schedule to have the drains monitored by staff every 30 minutes and jetted by an outside contractor every two days with the street manhole monitored every day with a camera was initiated on 1/16/2025, to prevent further back ups. The repair work for replacing the sewage pipesfrom the building to the city main will be initiated by a third party vendor beginning 2/7/25 with an estimated completion date of 2/28/2025. The QAPI committee will	

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E 015	Continued From page 3 director of nursing, and administrator were notified of the IJ on 1/15/25 at 5:45 p.m. and the immediacy was removed on 1/17/25 at 3:40 p.m. but remained at a scope and severity F. Findings include: The facility emergency preparedness plan dated 6/10/24 did not identify a plan to maintain the safety of residents, staff, and visitors from the environmental and health hazard exposure to sewage waste by way of contamination or gases. Email correspondence dated 1/15/25 at 7:41 p.m. from the contracted mechanical company to the regional operations manager, the facility administrator, and the maintenance director indicated the first sewer jetting (cleaning the pipes and drains using high pressure water jets to blast away debris and build-up) performed was on 11/19/24, the second sewer jetting performed was on 1/3/25, the third sewer jetting performed was on 1/7/25, the fourth sewer jetting performed was on 1/15/25. Upon interview on 1/13/25 at 2:20 p.m. an unidentified resident stated he heard the facility had a sewage problem with raw sewage in the boiler room and the ice on the road in the front of facility consisted of sewage from the facility. Upon observation and interview on 1/13/25 at 2:44 p.m. a city employee was observed in front of the facility's building on a city-maintained side street removing ice from the drain. He stated he was not certain if the ice build-up was clean water or sewage. The city had been watching this location, in front of the facility's building since November of 2024 due to an excess of water flow	E 015	review any audit findings related to sewer back ups on a monthly basis for 3 months. The Director of Maintenance, Administrator and/or their designee will be responsible for ongoing compliance.	

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E 015	Continued From page 4 outside the building onto the street from the north side of the building. He denied ever noticing an odor while removing the ice. He stated the last few days due to freezing temperatures the city had been removing ice from the street and drain daily. Upon observation and interview on 1/13/25 at 3:18 p.m. there was approximately one inch of water covering the entire floor of the facility boiler room. The wet area had a strong odor and sludgy material throughout. The room had poor lighting and the floor was grey. The boiler room had three steps leading down to the floor. On the stairs were rubber boots the staff had been wearing when entering the boiler room. The boiler room was on the lowest level of the facility where no residents resided. The boiler room was behind two sets of closed metal doors. The facilities maintenance assistant stated he had been aware of the water in the boiler room since the fall of 2024 because water had backed-up and the facility had jetted (cleaning the pipes and drains using high pressure water jets to blast away debris and build-up) the pipelines multiple times since fall. He stated he did not think the water was sewage and described the odor as the smell from longstanding water on the floor. Upon interview on 1/13/25 at 3:25 p.m. the regional operations director stated he was aware the facility had sewage back-up, and the facility had jetted the pipes multiple times and the staff would then clean the area when the clog was removed. He stated he had notified the city, however, was unable to provide any information on the notification. Upon interview on 1/13/25 at 5:07 p.m. the city	E 015		

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E 015	Continued From page 5 public works manager stated the street in front of the facility had been on the city's "radar" since November of 2024 when the city noticed excess water flow draining from the facility on the street. When the outdoor temperatures got colder ice began to build-up on the street and the drain. Upon interview on 1/15/25 at 10:32 a.m. the maintenance director stated the water in the boiler room was sewage and the concern was the sewage system. The pipes were jetted a "few" times in November and the former administrator had been notified. He stated in January of 2025 the pipes had been jetted three times and required it again on 1/15/25. The city was not notified of the sewage backup. Upon interview on 1/15/25 at 11:30 a.m. the public works manager stated a city official had reported to him that more than usual water as being drained from the facility, so the public work manager went to the facility to address the concerns. He observed the boiler room and stated the facility had an environmental hazard and he was required to report his findings to his supervisors and the sewage was running in the nearby storm reservoir. Upon observation on 1/15/25 at 11:45 a.m. there were three to four inches of sewage waste on the floor in the boiler room. The boiler room shares an internal door to the facility. The odor noticed was heavier than the days prior. The contracted mechanical team was onsite jetting the pipes. Upon interview on 1/15/25 at 2:13 p.m. the social worker designee (SW) stated she had been aware of the sewage problem at the facility since the fall of 2024 because there were discussions	E 015		

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E 015	Continued From page 6 regarding the sewage system and the heating system at the facilities daily morning meetings. On 1/16/25 at 8:30 a.m. a findings meeting was conducted at the facility with city public works staff, the facilities mechanical contract company, Minnesota department of health staff, the Fire Marshall, a neighboring communities environment protection staff the facility administrator and the facility regional operations manager. The topics discussed were: -A recap of findings since November 19th, 2024. - The sewage line from the facility to the city was no longer aligned creating a backflow of sewage to the boiler room. Facility staff collected the sewage in the sump pump, moving it outside to their parking lot, onto the city street and into the storm water collection across the street. -The facility water usage is approximately 600 gallons an hour, 14,000 gallons a day that is going down the sanitary sewer. -Verification that the concerns were risk for environmental disease contamination and mix of toxic and nontoxic gases related to improper ventilation associated with drainage of sewage waste from the facility. -Immediate jetting of the pipes again, professional cleaning and disinfection of the boiler room, and professional removal of the toxic ice build-up. -The city informed the facility further assessments and penalties. The requirement to mitigate the sewage for the interim and the requirement for a permanent plan solution for the safety of the residents, staff, and community for the building to functioning. On 1/17/25 at 3:40 p.m. the immediate jeopardy was removed when the facility:	E 015		

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E 015	Continued From page 7 -Updated the facility emergency procedure plan and educated leadership staff. -Assessed and had a monitoring plan for residents related to any type of sewage contamination. -Verified there was not a gas build-up from a sewage leak. -Obtained vendor proposals to fix the sewage, along with an interim plan to mitigate the sewage problem until it is permanently resolved. -The facility reported the sewage concerns to the Minnesota Pollution Control Agency (MPCA) A policy regarding sewage and maintenance was requested and the facility provided their facility policy titled Grounds dated 2008 indicated the facility grounds would be maintained in a safe and attractive manner.	E 015		