



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 3, 2025

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

RE: CCN: 245289
Cycle Start Date: May 21, 2025

Dear Administrator:

On June 26, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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



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Electronically delivered

July 3, 2025

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

Re: Reinspection Results
Event ID: JNOS12

Dear Administrator:

On June 26, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



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June 4, 2025

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

RE: CCN: 245289
Cycle Start Date: May 21, 2025

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On May 21, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

verification.

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

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

If substantial compliance with the regulations is not verified by August 21, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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,

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

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



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Electronically delivered
June 4, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: JNOS11

Dear Administrator:

The above facility was surveyed on May 20, 2025 through May 21, 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/21/2025
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 5/20/25 - 5/21/25, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52895211C / MN113143 with a licensing orders issued at ST0685 & ST0690. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000			

Minnesota Department of Health

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2 000	Continued From page 2	2 000		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure appropriate discharge documentation was in the medical record for 3 of 3 residents (R1, R2, & R3). R1, R2 and R3's medical records were missing discharge summaries, a recapitulation of their stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication (both prescribed and over the counter medications). Findings include: R1's care plan dated 4/23/25 - 5/19/25 did not indicate any discharge focus, goals, or interventions. R1's list of assessment completed dated 4/23/25 - 5/6/25 did not include a discharge summary	2 685	The Terrace strives to have a safe discharge for all residents. 1.R1 is currently in the hospital. Resident R2 and R3 will be called for a follow-up wellness check. 2.All residents currently residing will be audited for appropriate discharge care plan. Discharge care plan updated as appropriate. Discharge report ran from 5/21/25-6/5/25 and reviewed for follow-up phone call to ensure services were met, if appropriate. 3.Facility will perform post discharge follow-up call with resident post discharge. Pending discharges will be discussed daily with IDT. UDA social services discharge summary will be opened and completed with IDT input. Education provided to managers/department heads on discharge	6/24/25

Minnesota Department of Health

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2 685	Continued From page 3 assessment. R1's admission Minimum Data Set (MDS) dated 4/29/25 did not include a Brief Inventory of Mental Status (BIMS) score to indicate his cognition level. R1 was dependent upon staff for toileting hygiene, bathing, and rolling in bed. He required maximum assistance with dressing lower body and minimal assistance dressing his upper body. R1's pertinent diagnoses were after care for surgical amputation, immunodeficiency (bodies inability to defend the body from foreign or abnormal cells), diabetes, obesity, absence of right leg above the knee. R1's provider Evaluation and Management note dated 5/1/25 indicated the provider ordered skilled nursing in the home to assess/instruct on medication management, provide complex wound care related to current conditions, assessment for complications or exacerbation of patients condition and administer/instruct intravenous (IV) therapy and wound care. Additional services needed were Occupation Therapy for durable medication equipment (DME) recommendations. R1 required assistance of 1-2 people to leave home, required the use of an assistive device. R1's altered mental status required supervision when leaving home, and psychiatric symptoms or severe anxiety interfered with ability to safely leave alone. A nursing progress note dated 5/6/25 at 11:41 indicated R1 was discharged and going home with a patient care assistant (PCA) and nursing services. He left via electric wheelchair accompanied by a family member (FM)-A. R1 refused wound care done at the facility and stated, "will have wound care done today when I get home." There were no more progress notes	2 685	policy and procedures. Nurses educated on discharge process and medication reconciliation process. 4.Administrator/DON/Designee will audit 100% of discharges for three months. Will bring to QAPI and follow recommendations. 5.Compliance date of 6/24/2025	

Minnesota Department of Health

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2 685	Continued From page 4 regarding R1's discharge documented. Upon interview on 5/20/25 R1 stated he did not recall any discharge planning at the facility. Upon discharge he was told his medications had been sent to his pharmacy and FM-A agreed to pick them up. He was not sent home with a discharge care plan. He was told he would be receiving home care services but was not given any information about the agency. R2's care plan dated 1/22/25 - 5/2/25 did not indicate any discharge focus, goals, or interventions. R2's quarterly MDS dated 1/26/25 indicated R2's BIMS score was a 6 indicating she was cognitively impaired. R2 was dependent upon staff for toileting hygiene and bathing. She required substantial assistance with dressing and rolling in bed. R2's pertinent diagnoses were aftercare for fracture of the humerus (upper arm from shoulder to the elbow), morbid obesity, a respiratory disorder. R2's provider discharge orders dated 4/25/25 indicated R2 was o.k. to discharge from the facility with the current care plan. R2 was to discharge with a 7-day supply of medications including controlled substances. Follow-up with community primary care provider within 7 days of discharge. Send R2's nurse practitioner (NP) and last note to R2's community provider. R2 required homecare services, physical therapy for weakness status post falls and recent arm fracture repair, congestive heart failure, obesity, and diabetes. Occupational therapy for gait instability and durable medication equipment review. Registered nurse for medication management review and care coordination and	2 685			

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2 685	Continued From page 5 diabetic teaching. Home health aide for bathing assistance and social worker for community care coordination. R2's progress note dated 4/29/25 indicated R2's discharge was discussed with her family (FM)-B. FM-B was trained on transfers and unidentified nursing education for when R2 got home. Transportation was set-up. R2's progress note dated 5/2/25 indicated R2 would have homecare services for registered nurse, home health aide, physical therapy, occupation therapy and social worker. R2's note did not indicate involvement of the interdisciplinary team (IDT), resident goals of care and treatment preferences, interests in receiving information regarding return to the facility. There were no more additional progress notes regarding R2's discharge. A Social Services - Discharge Summary dated 5/2/25 at 9:21 a.m. was initiated by SW-A and then stopped in error. The summary indicated services to be initiated were RN (medication management, diabetic training), home health aide, physical therapy, occupation therapy and social worker. The reason for initiation of services indicated to assist with follow-up cares post discharge home. The recapitulation of stay indicated resident was admitted to the facility. No more documentation was completed on the summary. The summary did not indicate a discharge summary to include a full recapitulation of the residents stay including diagnosis, course of illness/treatment, pertinent lab, radiology, and consultation reports. A final summary of R2's status to include contact information of the practitioner responsible for the care of the resident was not included. Resident	2 685			

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2 685	Continued From page 6 representative information including contact information. Advance Directive information. All special instructions or precautions for ongoing care, as appropriate. Comprehensive care plan goals. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. There was no documentation of medication reconciliation completed with R2 or representative on the summary. Upon interview on 3/21/25 at 3:19 p.m. FM-B stated R2 left the facility with home care in place. R2 was told by her provider that she needed to follow-up with her community provider in a week or so. She did not receive any discharge care. She stated she did not recall a medication reconciliation taking place because she did not really understand what medication reconciliation was. She stated home care took over R2's medications immediate and to her knowledge they had the medication information. R3's care plan dated 1/21/25 - 4/22/25 did not indicate any discharge focus, goals, or interventions. R3's admission MDS dated 1/22/25 indicated R3's BIMS score was a 14 indicating she was cognitively intact. R3 was dependent for toileting hygiene, bathing, dressing, and rolling in bed. R3's pertinent diagnoses were osteomyelitis of the vertebrae (degenerative joint disease of the spine), chronic pain syndrome, cardiomyopathy (disease of the heart muscle), and respiratory failure. R3's providers Evaluation and Management visit documentation dated 4/22/25 indicated R3 was	2 685			

Minnesota Department of Health

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2 685	Continued From page 7 planning to discharge from the facility 4/22/25 with physical therapy, occupational therapy, registered nurse, and home health aide. R3's list of completed facility assessments dated 1/22/25 - 5/2/25 did not indicate a discharge summary was completed. R3's nursing progress note dated 4/21/25 at 2:50 p.m. indicated R3's discharge orders had been received. The facility spoke with R3's family member FM-C regarding scheduling appointments with her community provider. R3's discharge orders were faxed to her local primary care clinic. R3's nursing progress note dated 4/22/25 at 12:22 p.m. indicated R2 was discharged from the facility at 12:00 p.m. via wheelchair accompanied by a FM-D. All medications, paperwork, and personal belongings were sent with R2. Vital signs taken and body audit was completed. Daily wound was completed to a sacral wound. R3 did not return a call during the survey. Upon interview on 3/20/25 at 3:29 p.m. registered nurse (RN)-A stated a summary of residents discharge should be in progress notes during the discharge process and at discharge. Nursing and/or the facility social worker could perform discharges. She was not aware of a formal discharge summary at the facility. Upon interview on 5/21/25 at 11:12 a.m. social worker (SW)-A stated the nursing department, the social worker or the social workers assistant could work on discharges. There was not a specific stream-lined discharge process at the facility. SW-A stated she was certain what was	2 685			

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2 685	Continued From page 8 required per regulation in a discharge summary. Upon interview on 5/21/25 at 2:02 p.m. the director of nursing (DON) stated she had only been at the facility for about a week and was not certain of the entire discharge process. She stated the facility discussed discharges in the morning intradisciplinary team (IDT) meetings. The facility policy and procedure titled Discharge Summary and Plan, revised December 2016, indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: -current diagnosis; -medical history (including any history of mental disorders and intellectual disabilities); -course of illness, treatment, and/or therapy since entering the facility; - laboratory, radiology, consultation, and diagnostic test results; -physical and mental functional status; -ability to perform activities of daily living including: -bathing, dressing, and grooming, transferring, and ambulating, toilet use, eating, and using speech, language, and other communication systems;	2 685		

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2 685	Continued From page 9 -the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; and -the ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); Nutritional status and requirements: -weight and height, nutritional intake, and eating habits, preferences, and dietary restrictions. -special treatments or procedures (treatments and procedures that are not part of basic services provided); -mental and psychosocial status (ability to deal with life, interpersonal relationships, and goals, make health care decisions, and indicators of resident behavior and mood); -discharge potential (the expectation of discharging the resident from the facility within the next three months) Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); Activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); Rehabilitation potential (the ability to improve independence in functional status through restorative care programs); Cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and Medication therapy (all prescription and	2 685			

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2 685	Continued From page 10 over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented. Every resident will be evaluated for their discharge needs and will have an individualized post discharge plan. The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and their family and will include: -where the individual plans to reside; -arrangements that have been made for follow-up care and services; -a description of the resident's stated discharge goals; -the degree of caregiver/support person availability, capacity, and capability to perform required care. How the IDT will support the resident or representative in the transition to post-discharge care; What factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies	2 685			

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2 685	Continued From page 11 and support services that can assist in accommodating the resident's post-discharge preferences. 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.	2 685		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to sufficiently prepare, orientate, and understanding of discharge 1 of 3 residents (R1) reviewed for discharge. R1 was sent home without ordered home care services, which led to worsening of his wounds and an admission to the	2 690	The Terrace strives to have a safe discharge for all residents. 1 Phone calls were made to R2 and R3 identified during the survey period and to residents discharge from 5/21/2025-6/5/2025.	6/24/25

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2 690	Continued From page 12 hospital. Findings include: R1's care plan dated 4/23/25 - 5/19/25 did not indicate any discharge focus, goals, or interventions. R1's admission Minimum Data Set (MDS) dated 4/29/25 did not include a Brief Inventory of Mental Status (BIMS) score to indicate his cognition level. R1 was dependent upon staff for toileting hygiene, bathing, and rolling in bed. He required maximum assistance with dressing lower body and minimal assistance dressing his upper body. R1's pertinent diagnoses were after care for surgical amputation, immunodeficiency (bodies inability to defend the body from foreign or abnormal cells), diabetes, obesity, absence of right leg above the knee. R1 required application of nonsurgical dressing, applications of ointments/medications other than to feet, and application of dressing to feet. A Notice of Medicare Non-Coverage (NOMNOC) form dated 5/1/25 indicated beginning on 5/6/25 R1 may have to pay out of pocket for his skilled nursing care at the facility if he did not have other insurance to cover the costs. The estimated services would cost \$408.00 per day. Under the title Additional Information, a handwritten note indicated R1 requested discharge for 5/6/25. The form was signed by the facility social worker (SW)-A and R1 on 5/1/25. A provider Evaluation and Management note dated 5/1/25 indicated R1 the provider ordered skilled nursing in the home to assess/instruct on medication management, provide complex wound care related to current conditions, assessment for	2 690	2 All residents residing at The Terrace at Crystal have the potential to be affected. All current residents discharge care plan were audited, and discharge care plan updated as appropriate. 3 Facility will perform post discharge follow-up call with resident post discharge. Pending discharges will be discussed daily with IDT. UDA social services discharge summary will be opened and completed with IDT input. Education provided to managers/department heads on discharge policy and procedures. Nurses educated on discharge process and medication reconciliation process. 4 Administrator/DON/Designee will audit 100% of discharges for three months. Will bring to QAPI and follow recommendations. 5 Compliance date of 6/24/2025	

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2 690	Continued From page 13 complications or exacerbation of patients condition and administer/instruct intravenous (IV) therapy and wound care. Additional services needed were Occupation Therapy for durable medication equipment (DME) recommendations. R1 required assistance of 1-2 people to leave home, required the use of an assistive device. R1's altered mental status required supervision when leaving home, and psychiatric symptoms or severe anxiety interfered with ability to safely leave alone. A nursing progress note dated 5/6/25 at 11:41 indicated R1 was discharged and going home with a patient care assistant (PCA) and nursing services. He left via electric wheelchair accompanied by a family member (FM)-A. R1 refused wound care done at the facility and stated, "I will have wound care done today when I get home." R1's hospital note dated 5/15/25 indicated he was admitted to the hospital with a concern of gluteal wound infection. Surgery was notified to evaluate for necrotizing fasciitis (bacterial skin infection which destroys tissues) for which they had low suspicion. R1 received debridement on 5/16/25 with no concerns for wound infection based on reports. R1 was afebrile (no fever) and had a normal white blood cell count (WBC) (lab result often used to detect inflammation or infection in the body). Upon interview on 5/20/25 at 2:45 p.m. R1 stated he was still in the hospital. He stated he was home for a few days following discharge and no home care agency had reached out to him to set-up cares. His wounds were becoming more painful. He reached out to FM-A and FM-A told him he needed to go to the hospital. He stated	2 690			

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2 690	Continued From page 14 chose to leave the facility because he was told he could end up paying over \$400 a day to be there. He was told by the facilities provider that she had ordered cares in his home. He was not told which home care agency. R1 was aware that his CADI waived had closed and that he would not have PCA services for a few weeks but was told he would have nurses for medications and wound cares. Upon interview on 5/20/25 at 3:29 p.m. registered nurse (RN)-A nursing manager stated R1 had open wounds upon his discharge. She believed FM-A would be completing wound care. SW-A sets up services, not nursing therefore RN-A was not certain of what resulted after R1 left the facility. Upon interview on 5/21/25 at 9:56 a.m. R1's provider stated she was aware of R1's discharge. R1 wanted to discharge, but he did not leave against medical advice. The provider completed a face-to-face visit with R1 and provided the facility with homecare orders. The provider was not aware that the facility did not get homecare services set-up for R1 prior to discharge. Upon interview on 5/21/25 at 11:12 a.m. SW-A stated R1 initiated his discharge on 5/1/25. She was aware he had discharge orders because SW-A notified the provider that R1 needed a face-to-face visit for upcoming discharge. R1 discharged on 5/6/25. SW-A works only part-time and did not return to work until 5/7/25 when she started searching for home care agencies. She received denials from six home care agencies. SW-A denied reaching out to R1 following his discharge. SW-A's process was to have residents sign the NOMNOC form when the facility believed Medicare would stop paying for services. She	2 690			

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2 690	Continued From page 15 believed R1 understood he had other insurance therefore would not be charged to stay at the facility. Upon interview on 5/21/25 at 1:48 p.m. RN-B stated she was the nurse who completed Ra's discharge on 5/6/25. She had never been "formally" trained on discharges. She used her knowledge from prior employment stating for she discharges the residents must have orders, vital signs, medications given, or prescriptions faxed and transportation. She believed SW-A had services in the home set-up as R1 and FM-A told her he would have the home care nurse change his dressing when he refused the dressing change treatment from her on the day of discharge. Upon interview on 5/21/25 at 2:02 p.m. the director of nursing (DON) stated she was not aware of R1's case specifically because she had only worked at the facility for a week. She stated her expectation was that homecare services be set-up and if there were difficulties the provider or leadership should have been notified. In addition, facility should have started searching for a homecare agency right when they were aware of the discharge. Upon interview on 5/21/25 at 3:35 p.m. R1's Minnesota Choice assessment worker stated she was aware of R1's discharge and completed his CADI assessment on 5/5/25. She stated she was clear with the facility that R1 would not have PCA services in the home until his CADI waiver was reinstated, but his skilled nursing and therapy needed to be started right away. She was aware that FM-A could assist with some of the PCA tasks such as food prep, taking R1 out of the house, minor personal cares, and homemaking.	2 690			

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2 690	Continued From page 16 The facility policy and procedure titled Discharge Summary and Plan, revised December 2016 indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and their family and will include: -where the individual plans to reside; -arrangements that have been made for follow-up care and services; - description of the resident's stated discharge goals; -the degree of caregiver/support person availability, capacity, and capability to perform required care; -how the IDT will support the resident or representative in the transition to post-discharge care. -what factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge	2 690			

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2 690	Continued From page 17 preferences. If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination. Residents transferring to another skilled nursing facility or who are discharged to a home health agency, long-term care hospital or inpatient rehabilitation facility will be assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences. Data used in helping the resident select an appropriate facility includes the receiving facility's: -standardized patient assessment data; -quality measure data; and -data on resource use. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed. A member of the IDT will review the final post-discharge plan with the resident and family at least twenty four (24) hours before the discharge is to take place. A copy of the following will be provided to the resident and receiving facility, and a copy will be filed in the resident's medical records: -An evaluation of the resident's discharge needs; -The post-discharge plan; and -The discharge summary 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:	2 690			

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2 690	Continued From page 18 Twenty-One (21) days.	2 690			

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F 000	INITIAL COMMENTS On 5/20/25 - 5/21/25, 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 H52895211C / MN113143 with deficiencies issued at F627 & F628. 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 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 627			6/24/25

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

Electronically Signed

TITLE

(X6) DATE

06/09/2025

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 627	Continued From page 1 services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's	F 627			

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F 627	Continued From page 2 medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic	F 627			

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F 627	Continued From page 3 leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each	F 627			

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F 627	Continued From page 4 resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA,	F 627			

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F 627	Continued From page 5 IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 627			

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F 627	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to sufficiently prepare, orientate, and understanding of discharge 1 of 3 residents (R1) reviewed for discharge. R1 was sent home without ordered home care services, which led to worsening of his wounds and an admission to the hospital. Findings include: R1's care plan dated 4/23/25 - 5/19/25 did not indicate any discharge focus, goals, or interventions. R1's admission Minimum Data Set (MDS) dated 4/29/25 did not include a Brief Inventory of Mental Status (BIMS) score to indicate his cognition level. R1 was dependent upon staff for toileting hygiene, bathing, and rolling in bed. He required maximum assistance with dressing lower body and minimal assistance dressing his upper body. R1's pertinent diagnoses were after care for surgical amputation, immunodeficiency (bodies inability to defend the body from foreign or abnormal cells), diabetes, obesity, absence of right leg above the knee. R1 required application of nonsurgical dressing, applications of ointments/medications other than to feet, and application of dressing to feet. A Notice of Medicare Non-Coverage (NOMNOC) form dated 5/1/25 indicated beginning on 5/6/25 R1 may have to pay out of pocket for his skilled nursing care at the facility if he did not have other insurance to cover the costs. The estimated services would cost \$408.00 per day. Under the title Additional Information, a handwritten note	F 627	The Terrace strives to have a safe discharge for all residents. 1.R1 is currently in the hospital. Resident R2 and R3 will be called for a follow-up wellness check. 2.All residents currently residing will be audited for appropriate discharge care plan. Discharge care plan updated as appropriate. Discharge report ran from 5/21/25-6/5/25 and reviewed for follow-up phone call to ensure services were met, if appropriate. 3.Facility will perform post discharge follow-up call with resident post discharge. Pending discharges will be discussed daily with IDT. UDA social services discharge summary will be opened and completed with IDT input. Education provided to managers/department heads on discharge policy and procedures. Nurses educated on discharge process and medication reconciliation process. 4.Administrator/DON/Designee will audit 100% of discharges for three months. Will bring to QAPI and follow recommendations. 5.Compliance date of 6/24/2025		

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F 627	Continued From page 7 indicated R1 requested discharge for 5/6/25. The form was signed by the facility social worker (SW)-A and R1 on 5/1/25. A provider Evaluation and Management note dated 5/1/25 indicated R1 the provider ordered skilled nursing in the home to assess/instruct on medication management, provide complex wound care related to current conditions, assessment for complications or exacerbation of patients condition and administer/instruct intravenous (IV) therapy and wound care. Additional services needed were Occupation Therapy for durable medication equipment (DME) recommendations. R1 required assistance of 1-2 people to leave home, required the use of an assistive device. R1's altered mental status required supervision when leaving home, and psychiatric symptoms or severe anxiety interfered with ability to safely leave alone. A nursing progress note dated 5/6/25 at 11:41 indicated R1 was discharged and going home with a patient care assistant (PCA) and nursing services. He left via electric wheelchair accompanied by a family member (FM)-A. R1 refused wound care done at the facility and stated, "I will have wound care done today when I get home." R1's hospital note dated 5/15/25 indicated he was admitted to the hospital with a concern of gluteal wound infection. Surgery was notified to evaluate for necrotizing fasciitis (bacterial skin infection which destroys tissues) for which they had low suspicion. R1 received debridement on 5/16/25 with no concerns for wound infection based on reports. R1 was afebrile (no fever) and had a normal white blood cell count (WBC) (lab result	F 627			

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F 627	Continued From page 8 often used to detect inflammation or infection in the body). Upon interview on 5/20/25 at 2:45 p.m. R1 stated he was still in the hospital. He stated he was home for a few days following discharge and no home care agency had reached out to him to set-up cares. His wounds were becoming more painful. He reached out to FM-A and FM-A told him he needed to go to the hospital. He stated chose to leave the facility because he was told he could end up paying over \$400 a day to be there. He was told by the facilities provider that she had ordered cares in his home. He was not told which home care agency. R1 was aware that his CADI waived had closed and that he would not have PCA services for a few weeks but was told he would have nurses for medications and wound cares. Upon interview on 5/20/25 at 3:29 p.m. registered nurse (RN)-A nursing manager stated R1 had open wounds upon his discharge. She believed FM-A would be completing wound care. SW-A sets up services, not nursing therefore RN-A was not certain of what resulted after R1 left the facility. Upon interview on 5/21/25 at 9:56 a.m. R1's provider stated she was aware of R1's discharge. R1 wanted to discharge, but he did not leave against medical advice. The provider completed a face-to-face visit with R1 and provided the facility with homecare orders. The provider was not aware that the facility did not get homecare services set-up for R1 prior to discharge. Upon interview on 5/21/25 at 11:12 a.m. SW-A stated R1 initiated his discharge on 5/1/25. She	F 627			

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F 627	Continued From page 9 was aware he had discharge orders because SW-A notified the provider that R1 needed a face-to-face visit for upcoming discharge. R1 discharged on 5/6/25. SW-A works only part-time and did not return to work until 5/7/25 when she started searching for home care agencies. She received denials from six home care agencies. SW-A denied reaching out to R1 following his discharge. SW-A's process was to have residents sign the NOMNOC form when the facility believed Medicare would stop paying for services. She believed R1 understood he had other insurance therefore would not be charged to stay at the facility. Upon interview on 5/21/25 at 1:48 p.m. RN-B stated she was the nurse who completed Ra's discharge on 5/6/25. She had never been "formally" trained on discharges. She used her knowledge from prior employment stating for she discharges the residents must have orders, vital signs, medications given, or prescriptions faxed and transportation. She believed SW-A had services in the home set-up as R1 and FM-A told her he would have the home care nurse change his dressing when he refused the dressing change treatment from her on the day of discharge. Upon interview on 5/21/25 at 2:02 p.m. the director of nursing (DON) stated she was not aware of R1's case specifically because she had only worked at the facility for a week. She stated her expectation was that homecare services be set-up and if there were difficulties the provider or leadership should have been notified. In addition, facility should have started searching for a homecare agency right when they were aware of the discharge.	F 627			

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F 627	Continued From page 10 Upon interview on 5/21/25 at 3:35 p.m. R1's Minnesota Choice assessment worker stated she was aware of R1's discharge and completed his CADi assessment on 5/5/25. She stated she was clear with the facility that R1 would not have PCA services in the home until his CADi waiver was reinstated, but his skilled nursing and therapy needed to be started right away. She was aware that FM-A could assist with some of the PCA tasks such as food prep, taking R1 out of the house, minor personal cares, and homemaking. The facility policy and procedure titled Discharge Summary and Plan, revised December 2016 indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and their family and will include: -where the individual plans to reside; -arrangements that have been made for follow-up care and services; - description of the resident's stated discharge goals; -the degree of caregiver/support person availability, capacity, and capability to perform required care; -how the IDT will support the resident or representative in the transition to post-discharge care. -what factors may make the resident vulnerable to preventable readmission; and how those	F 627			

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F 627	Continued From page 11 factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences. If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination. Residents transferring to another skilled nursing facility or who are discharged to a home health agency, long-term care hospital or inpatient rehabilitation facility will be assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences. Data used in helping the resident select an appropriate facility includes the receiving facility's: -standardized patient assessment data; -quality measure data; and -data on resource use. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed. A member of the IDT will review the final post-discharge plan with the resident and family at least twenty four (24) hours before the discharge is to take place. A copy of the following will be provided to the	F 627			

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F 627	Continued From page 12	F 627			
F 628 SS=D	resident and receiving facility, and a copy will be filed in the resident's medical records: -An evaluation of the resident's discharge needs; -The post-discharge plan; and -The discharge summary Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 628			6/24/25

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F 628	Continued From page 13 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 628			

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F 628	Continued From page 14 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information	F 628			

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F 628	Continued From page 15 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 628			

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F 628	Continued From page 16 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure appropriate discharge documentation was in the medical record for 3 of 3 residents (R1, R2, & R3). R1, R2 and R3's medical records were missing discharge summaries, a recapitulation of their stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication (both prescribed and over the counter medications). Findings include: R1's care plan dated 4/23/25 - 5/19/25 did not indicate any discharge focus, goals, or	F 628	The Terrace strives to have a safe discharge for all residents. 1 Phone calls were made to R2 and R3 identified during the survey period and to residents discharge from 5/21/2025-6/5/2025. 2 All residents residing at The Terrace at Crystal have the potential to be affected. All current residents discharge care plan were audited, and discharge care plan updated as appropriate. 3 Facility will perform post discharge follow-up call with resident post discharge. Pending discharges will be discussed daily with IDT. UDA social services		

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F 628	Continued From page 17 interventions. R1's list of assessment completed dated 4/23/25 - 5/6/25 did not include a discharge summary assessment. R1's admission Minimum Data Set (MDS) dated 4/29/25 did not include a Brief Inventory of Mental Status (BIMS) score to indicate his cognition level. R1 was dependent upon staff for toileting hygiene, bathing, and rolling in bed. He required maximum assistance with dressing lower body and minimal assistance dressing his upper body. R1's pertinent diagnoses were after care for surgical amputation, immunodeficiency (bodies inability to defend the body from foreign or abnormal cells), diabetes, obesity, absence of right leg above the knee. R1's provider Evaluation and Management note dated 5/1/25 indicated the provider ordered skilled nursing in the home to assess/instruct on medication management, provide complex wound care related to current conditions, assessment for complications or exacerbation of patients condition and administer/instruct intravenous (IV) therapy and wound care. Additional services needed were Occupation Therapy for durable medication equipment (DME) recommendations. R1 required assistance of 1-2 people to leave home, required the use of an assistive device. R1's altered mental status required supervision when leaving home, and psychiatric symptoms or severe anxiety interfered with ability to safely leave alone. A nursing progress note dated 5/6/25 at 11:41 indicated R1 was discharged and going home with a patient care assistant (PCA) and nursing	F 628	discharge summary will be opened and completed with IDT input. Education provided to managers/department heads on discharge policy and procedures. Nurses educated on discharge process and medication reconciliation process. 4 Administrator/DON/Designee will audit 100% of discharges for three months. Will bring to QAPI and follow recommendations. 5 Compliance date of 6/24/2025		

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F 628	Continued From page 18 services. He left via electric wheelchair accompanied by a family member (FM)-A. R1 refused wound care done at the facility and stated, "will have wound care done today when I get home." There were no more progress notes regarding R1's discharge documented. Upon interview on 5/20/25 R1 stated he did not recall any discharge planning at the facility. Upon discharge he was told his medications had been sent to his pharmacy and FM-A agreed to pick them up. He was not sent home with a discharge care plan. He was told he would be receiving home care services but was not given any information about the agency. R2's care plan dated 1/22/25 - 5/2/25 did not indicate any discharge focus, goals, or interventions. R2's quarterly MDS dated 1/26/25 indicated R2's BIMS score was a 6 indicating she was cognitively impaired. R2 was dependent upon staff for toileting hygiene and bathing. She required substantial assistance with dressing and rolling in bed. R2's pertinent diagnoses were aftercare for fracture of the humerus (upper arm from shoulder to the elbow), morbid obesity, a respiratory disorder. R2's provider discharge orders dated 4/25/25 indicated R2 was o.k. to discharge from the facility with the current care plan. R2 was to discharge with a 7-day supply of medications including controlled substances. Follow-up with community primary care provider within 7 days of discharge. Send R2's nurse practitioner (NP) and last note to R2's community provider. R2 required homecare services, physical therapy for	F 628			

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F 628	Continued From page 19 weakness status post falls and recent arm fracture repair, congestive heart failure, obesity, and diabetes. Occupational therapy for gait instability and durable medication equipment review. Registered nurse for medication management review and care coordination and diabetic teaching. Home health aide for bathing assistance and social worker for community care coordination. R2's progress note dated 4/29/25 indicated R2's discharge was discussed with her family (FM)-B. FM-B was trained on transfers and unidentified nursing education for when R2 got home. Transportation was set-up. R2's progress note dated 5/2/25 indicated R2 would have homecare services for registered nurse, home health aide, physical therapy, occupation therapy and social worker. R2's note did not indicate involvement of the interdisciplinary team (IDT), resident goals of care and treatment preferences, interests in receiving information regarding return to the facility. There were no more additional progress notes regarding R2's discharge. A Social Services - Discharge Summary dated 5/2/25 at 9:21 a.m. was initiated by SW-A and then stopped in error. The summary indicated services to be initiated were RN (medication management, diabetic training), home health aide, physical therapy, occupation therapy and social worker. The reason for initiation of services indicated to assist with follow-up cares post discharge home. The recapitulation of stay indicated resident was admitted to the facility. No more documentation was completed on the summary. The summary did not indicate a	F 628			

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F 628	Continued From page 20 discharge summary to include a full recapitulation of the residents stay including diagnosis, course of illness/treatment, pertinent lab, radiology, and consultation reports. A final summary of R2's status to include contact information of the practitioner responsible for the care of the resident was not included. Resident representative information including contact information. Advance Directive information. All special instructions or precautions for ongoing care, as appropriate. Comprehensive care plan goals. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. There was no documentation of medication reconciliation completed with R2 or representative on the summary. Upon interview on 3/21/25 at 3:19 p.m. FM-B stated R2 left the facility with home care in place. R2 was told by her provider that she needed to follow-up with her community provider in a week or so. She did not receive any discharge care. She stated she did not recall a medication reconciliation taking place because she did not really understand what medication reconciliation was. She stated home care took over R2's medications immediate and to her knowledge they had the medication information. R3's care plan dated 1/21/25 - 4/22/25 did not indicate any discharge focus, goals, or interventions. R3's admission MDS dated 1/22/25 indicated R3's BIMS score was a 14 indicating she was cognitively intact. R3 was dependent for toileting hygiene, bathing, dressing, and rolling in bed.	F 628			

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F 628	Continued From page 21 R3's pertinent diagnoses were osteomyelitis of the vertebrae (degenerative joint disease of the spine), chronic pain syndrome, cardiomyopathy (disease of the heart muscle), and respiratory failure. R3's providers Evaluation and Management visit documentation dated 4/22/25 indicated R3 was planning to discharge from the facility 4/22/25 with physical therapy, occupational therapy, registered nurse, and home health aide. R3's list of completed facility assessments dated 1/22/25 - 5/2/25 did not indicate a discharge summary was completed. R3's nursing progress note dated 4/21/25 at 2:50 p.m. indicated R3's discharge orders had been received. The facility spoke with R3's family member FM-C regarding scheduling appointments with her community provider. R3's discharge orders were faxed to her local primary care clinic. R3's nursing progress note dated 4/22/25 at 12:22 p.m. indicated R2 was discharged from the facility at 12:00 p.m. via wheelchair accompanied by a FM-D. All medications, paperwork, and personal belongings were sent with R2. Vital signs taken and body audit was completed. Daily wound was completed to a sacral wound. R3 did not return a call during the survey. Upon interview on 3/20/25 at 3:29 p.m. registered nurse (RN)-A stated a summary of residents discharge should be in progress notes during the discharge process and at discharge. Nursing and/or the facility social worker could perform	F 628			

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F 628	Continued From page 22 discharges. She was not aware of a formal discharge summary at the facility. Upon interview on 5/21/25 at 11:12 a.m. social worker (SW)-A stated the nursing department, the social worker or the social workers assistant could work on discharges. There was not a specific stream-lined discharge process at the facility. SW-A stated she was certain what was required per regulation in a discharge summary. Upon interview on 5/21/25 at 2:02 p.m. the director of nursing (DON) stated she had only been at the facility for about a week and was not certain of the entire discharge process. She stated the facility discussed discharges in the morning intradisciplinary team (IDT) meetings. The facility policy and procedure titled Discharge Summary and Plan, revised December 2016, indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: -current diagnosis; -medical history (including any history of mental disorders and intellectual disabilities); -course of illness, treatment, and/or therapy since	F 628			

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F 628	Continued From page 23 entering the facility; - laboratory, radiology, consultation, and diagnostic test results; -physical and mental functional status; -ability to perform activities of daily living including: -bathing, dressing, and grooming, transferring, and ambulating, toilet use, eating, and using speech, language, and other communication systems; -the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; and -the ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); Nutritional status and requirements: -weight arid height, nutritional intake, and eating habits, preferences, and dietary restrictions. -special treatments or procedures (treatments and procedures that are not part of basic services provided); -mental and psychosocial status (ability to deal with life, interpersonal relationships, and goals, make health care decisions, and indicators of resident behavior and mood); -discharge potential (the expectation of discharging the resident from the facility within the next three months) Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental	F 628			

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F 628	Continued From page 24 appliances); Activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); Rehabilitation potential (the ability to improve independence in functional status through restorative care programs); Cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and Medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented. Every resident will be evaluated for their discharge needs and will have an individualized post discharge plan. The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and their family and will include: -where the individual plans to reside; -arrangements that have been made for follow-up care and services; -a description of the resident's stated discharge goals; -the degree of caregiver/support person availability, capacity, and capability to perform required care. How the IDT will support the resident or representative in the transition to post-discharge care; What factors may make the resident vulnerable	F 628			

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F 628	Continued From page 25 to preventable readmission; and how those factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences.	F 628			