



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2024

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

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

Dear Administrator:

On August 14, 2024, we notified you a remedy was imposed. On August 22, 2024 the Minnesota Department of Health 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 August 22, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 29, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 14, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 6, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 30, 2024

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

Re: Reinspection Results
Event ID: 79Y612

Dear Administrator:

On August 22, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue 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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August 14, 2024

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

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

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.

Dear Administrator:

On August 6, 2024, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 6, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 29, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new

The Terrace At Crystal LLC

August 14, 2024

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admissions is effective August 29, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 29, 2024, (42 CFR 488.417 (b)).

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.

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 6, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Crystal Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 6, 2024. This

The Terrace At Crystal LLC

August 14, 2024

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prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 their respective deficiencies (if any) is acceptable.

The Terrace At Crystal LLC

August 14, 2024

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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 February 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 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies.

The Terrace At Crystal LLC

August 14, 2024

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All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

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
August 14, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 79Y611

Dear Administrator:

The above facility was surveyed on July 31, 2024 through August 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

The Terrace At Crystal LLC

August 14, 2024

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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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2024

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

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

Dear Administrator:

On August 14, 2024, we notified you a remedy was imposed. On August 22, 2024 the Minnesota Department of Health 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 August 22, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 29, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 14, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 6, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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August 30, 2024

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

Re: Reinspection Results
Event ID: 79Y612

Dear Administrator:

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Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue 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

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

PRINTED: 09/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/06/2024
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NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>On 7/31/24, 8/1/24, 8/2/24 and 8/6/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.</p> <p>The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 7/24/24, when the facility sent R1 to an appointment without supervision, R1 did not come back to the facility, and the facility did not know his whereabouts until 20 hours after he left. The administrator, and director of nursing (DON) were notified of the IJ on 8/2/24 at 12:15 p.m. The IJ was removed on 8/6/24 at 2:00 p.m.</p> <p>The following complaint was reviewed: H52896290C (MN00105195) with a deficiency cited at F689.</p> <p>The above findings constituted Substandard Quality of Care and an extended survey was conducted on 8/2/24 and 8/6/24.</p> <p>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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2024
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 689 SS=J	<p>Continued From page 1 regulations has been attained.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision while out of the facility at an appointment for 1 of 3 residents (R1). This deficient practice resulted in an immediate jeopardy (IJ) for R1 when R1 went to an appointment without supervision and the facility did not know his whereabouts until 20 hours after he left.</p> <p>The immediate jeopardy began on 7/24/24 when the facility sent R1 to an appointment without supervision, R1 did not come back to the facility, and the facility did not know his whereabouts until 20 hours after he left. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 12:15 p.m. on 8/2/24. The IJ was removed on 8/6/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p>	F 000 F 689	<p>Submitted to: Terri Ament, Brenda Fischer, Becki Wegner</p> <p>Submitted by: Anil Ramnarayan, Kaleeca Bible</p> <p>Date Submitted: 8/20/2024</p> <p>In response to the 689.0 deficiency finding identified by the Minnesota Department of Health, this facility submits the following plan for review and approval. This plan does not constitute an admission of noncompliance with any requirement nor an agreement with any findings. This facility preserves our right to dispute these findings at any time and in any legal action. This facility may submit a separate request for informal dispute resolution or independent informal dispute resolution for certain findings and determinations.</p> <p>D-Tag* 689</p>	8/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2024
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 2</p> <p>R1's Diagnoses List dated 1/25/24 indicated R1 had dementia and type 2 diabetes.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 5/22/24, indicated R1 used a wheelchair as his primary mode of locomtion, transferred with supervision and did not ambulate.</p> <p>R1's care plan dated 6/6/24 indicated R1 had impaired cognition related to his dementia diagnosis.</p> <p>R1's Provider Orders dated 7/19/24 indicated R1 had a dental appointment on 7/24/24. R1's family member (FM)-A would be escorting R1 to the appointment with a transport company pick up time of 1:30 p.m. - 2:00 p.m.</p> <p>On 7/31/24 at 10:42 a.m., FM-A stated she had attempted to call the facility about 1:00 p.m. to inform them she was unable to escort R1 to the appointment, but no one answered the phone. In the past, when she had not arrived at the facility to escort R1, a staff member had called her to determine what was happening. She did not receive a call on 7/24/24, so she assumed the facility either had someone to send with R1, or they had rescheduled the appointment as had occurred previously. In the past, when R1's appointment was completed, she would call the facility so they could arrange for the transport company to pick them up from the appointment. The first phone call FM-A received on 7/24/24 was a call from a nurse about 10:00 p.m. to inform her R1 had not returned from his appointment.</p> <p>On 7/31/24 at 12:38 p.m. registered nurse (RN)-A stated family or a staff person needed to escort</p>	F 689	<p>Extent of Noncompliance (1# of Cases) *</p> <p>List the Serious Adverse Outcomes (or likelihood of Serious Adverse Outcomes) that Resulted from the Identified areas of Noncompliance*</p> <p>The facility failed to provide adequate supervision for residents when the facility sent resident to an appointment without supervision.</p> <p>(1) Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome because of the non-compliance.</p> <p>All residents requiring an escort to an appointment are at risk of harm</p> <p>(2) Specify the action(s) the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring.</p> <p>-The facility created a policy for appointments identifying residents at risk, and requiring staff escorts for resident's identified as at risk utilizing the BIMS assessment 08-02-2024.</p> <p>-The facility created a policy for appointments with family escorts to include a procedure to confirm family escorts in advance of the appointment on 08-02-2024.</p>	

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F 689	<p>Continued From page 3</p> <p>R1 to appointments. R1's order for the appointment on 7/24/24 indicated FM-A would be escorting R1. RN-A handed R1's appointment envelope to licensed practical nurse (LPN)-B when he assisted with taking R1 downstairs to the transportation pick-up area.</p> <p>On 7/31/24 at 11:12 a.m., transport company (TC)-A representative stated there was no note in their file indicating someone would be riding with R1 to the appointment. In the past, there had been an indication either family or a staff member would be riding with a resident. The pick-up driver did not receive an envelope from the facility. When he arrived at the appropriate address, he assisted R1 to the front desk of the building and requested information at the desk as to where in the building R1's appointment was. The driver assisted R1 to the correct office and was told the appointment would take about an hour. This information was placed in R1's notes with the transport company. A driver in the area about 75 minutes later stopped to see if R1 was ready to return to the facility because there had been no phone call for a return pick up. The pick-up driver was told that R1 had left the clinic approximately 45 minutes earlier. The driver searched the front area of the building and the surrounding outside area for R1, but did not see him. A call was placed to the facility around 3:45 p.m.- 4:00 p.m. to notify them R1 was not at the clinic but no one answered the phone.</p> <p>On 7/31/24 at 1:09 p.m., health unit coordinator (HUC)-A stated FM-A would be riding with R1 to his appointment, and she entered this information in R1's electronic health record (EHR) and wrote this on R1's appointment envelope. The envelope</p>	F 689	<p>-The facility has conducted BIMS assessments on all residents to determine cognition status on 08-05-2024.</p> <p>-the facility has created a list of all residents that require staff escort to appointments.</p> <p>-the facility updated resident's careplan and profile to include cognitive status</p> <p>-The facility provided education to the nursing staff regarding the emergency procedure for a missing resident and residents requiring supervision/escorts to appointments in the community-initated on 08-05-2024 and is ongoing.</p> <p>-Medical records will note if the resident requires an escort for an appointment.</p> <p>-Medical records will provide the front desk and all nursing stations with a copy of the appointment calendar to inform them of all appointments that require an escort.</p> <p>- A list of residents requiring escorts/supervision for appointments will be given to the front desk, each nurses station, and medical records.</p> <p>-Medical records will coordinate with staffing and nursing department for all resident's requiring escorts to appointments.</p> <p>The facility will draft a letter for all transportation companies used requesting</p>	

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F 689	<p>Continued From page 4</p> <p>was placed in the appropriate area of the nurse's desk to send with R1. If FM-A was available, she would always ride with R1 in the transport vehicle. Around 6:00 p.m. she was notified by LPN-A R1 had not returned from his appointment. She called the transport company, but they were closed. She relayed this information to LPN-A. She did not notify anyone else because the LPN-A was handling the situation.</p> <p>On 7/31/24 at 2:12 p.m., LPN-B stated he brought R1 down the elevator to the transportation pick up area where R1 was placed in the transportation vehicle without an escort. LPN-B did not remember if R1 had his appointment envelope. He did not know FM-A was escorting R1 to the appointment.</p> <p>On 7/31/24 at 2:53 p.m., nursing assistant (NA)-A stated she first noticed R1 missing at 3:30 p.m. She notified LPN-A who suggested R1 might be at an activity. Later, NA-A was delivering trays for supper and R1 was not in his room. She told LPN-A who stated R1 was at an appointment with his niece. A search for R1 was not completed until residents were being assisted to bed. NA-A stated R1 did not self-propel forward in his wheelchair very quickly and would have struggled getting around by himself.</p> <p>On 7/31/24 at 3:45 p.m., RN-B stated at approximately 11:00 p.m. on 7/24/24 she received a call from LPN-A who stated R1 had not returned from his appointment. She added the director of nursing (DON) to the call. When she arrived at the facility the next morning between 7:30 a.m. to 8:00 a.m. R1 was still missing. She called the local hospitals and the dental clinic but R1 was not at any of those</p>	F 689	<p>that they do not leave without receiving paperwork for the resident's appointment and that the paperwork is given to the receiving entity with instructions that staff escort/supervision is required. This letter will be sent to all transportation companies on 8/5/2024, with a follow-up phone call to confirm receipt of the letter.</p> <p>All appropriate staff will be educated in the updated policies and procedures.</p> <p>8/22/2024</p> <p>Signatures: Anil Ramnarayan, LNHA</p> <p>Kaleeca Bible, DON</p>	

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F 689	<p>Continued From page 5</p> <p>locations. A team meeting was held approximately 8:00 a.m. to assign search areas. At approximately 10:00 a.m. she found R1 approximately 5 miles from the dental office. R1 was sent to the emergency room, and then back to the facility with no injuries.</p> <p>On 7/31/24 at 4:15 p.m., LPN-A stated she thought R1 was at an appointment with FM-A. She noticed R1 was not in his room before supper when she went to check his blood sugar. She asked HUC-A to see when R1 was returning. HUC-A told LPN-A she tried calling the transport company, but they were closed. She called FM-A who said she had not accompanied R1 to the appointment. LPN-A could not remember what time FM-A was called. She then called RN-B and DON who instructed staff to search the building.</p> <p>On 8/1/24 at 1:27 p.m., R1 confirmed he went to a dental appointment "last week." After the appointment, he took the bus to "the Salvation Army." R1 was unable to provide more details about the incident.</p> <p>On 8/1/2024 at 2:36 p.m., DON stated she received a call from RN-B and LPN-A at 11:22 p.m. on 7/24/24. She was told R1 had not returned from his dental appointment. She instructed staff to search the entire building. R1 was not found during this search. At approximately 11:45 p.m., DON instructed LPN-A to call all of R1's family members while she called the police to report R1 missing. The officer took the report, then stated he would go looking for R1. The DON went and searched the area around the dental clinic. R1 was not found. She went to the facility, then went home approximately 3:30 a.m. She returned to the building about 8:00</p>	F 689		

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F 689	<p>Continued From page 6</p> <p>a.m. on 7/25/24. A team meeting was held to formulate a plan. Staff members went out in teams of two to look for R1. Approximately 10:00 a.m. she received a call from RN-B that R1 had been located approximately 5 miles from the dental clinic. She stated staff should have known R1 needed an escort to the appointment, and should not have allowed transport to take him. Staff also should have informed her when R1 could not be found around supper time.</p> <p>The facility policy Safety and Supervision of Residents dated 7/17 directed an individualized, resident-centered approach to safety and accident hazards. Resident supervision is determined by the resident's assessed needs.</p> <p>The immediate jeopardy that began on 7/24/24, was removed on 8/6/24 when the facility reviewed and revised their current policy, and created new policies on the safety and supervision of residents with appointments with staff or family supervision, and missing persons. The facility implemented a new system for resident appointment, and provided information to all transportation companies utilized about new facility process for resident escorts. The facility completed audits on all residents to determine if they needed an escort to appointments. The facility educated staff on these policies and procedures. This was verified through observation, interview and document review.</p>	F 689		

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 7/31/24, 8/1/24, 8/2/24 and 8/6/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/26/24

Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed: H52896290C (MN00105195) with a licensing order issued at 4658.0520 Subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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</p>	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision while out of the facility at an appointment for 1 of 3 residents (R1). This deficient practice resulted in an immediate jeopardy (IJ) for R1 when R1 went to an appointment without supervision and the facility did not know his whereabouts until 20 hours after he left.</p> <p>The immediate jeopardy began on 7/24/24 when the facility sent R1 to an appointment without</p>	2 830	<p>Submitted to: Terri Ament, Brenda Fischer, Becki Wegner</p> <p>Submitted by: Anil Ramnarayan, Kaleeca Bible</p> <p>Date Submitted: 8/20/2024</p> <p>In response to the 689.0 deficiency finding identified by the Minnesota Department of Health, this facility submits the following</p>	8/22/24

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2 830	<p>Continued From page 3</p> <p>supervision, R1 did not come back to the facility, and the facility did not know his whereabouts until 20 hours after he left. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 12:15 p.m. on 8/2/24. The IJ was removed on 8/6/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's Diagnoses List dated 1/25/24 indicated R1 had dementia and type 2 diabetes.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 5/22/24, indicated R1 used a wheelchair as his primary mode of locomtion, transferred with supervision and did not ambulate.</p> <p>R1's care plan dated 6/6/24 indicated R1 had impaired cognition related to his dementia diagnosis.</p> <p>R1's Provider Orders dated 7/19/24 indicated R1 had a dental appointment on 7/24/24. R1's family member (FM)-A would be escorting R1 to the appointment with a transport company pick up time of 1:30 p.m. - 2:00 p.m.</p> <p>On 7/31/24 at 10:42 a.m., FM-A stated she had attempted to call the facility about 1:00 p.m. to inform them she was unable to escort R1 to the appointment, but no one answered the phone. In the past, when she had not arrived at the facility to escort R1, a staff member had called her to determine what was happening. She did not receive a call on 7/24/24, so she assumed the facility either had someone to send with R1, or</p>	2 830	<p>plan for review and approval. This plan does not constitute an admission of noncompliance with any requirement nor an agreement with any findings. This facility preserves our right to dispute these findings at any time and in any legal action. This facility may submit a separate request for informal dispute resolution or independent informal dispute resolution for certain findings and determinations.</p> <p>D-Tag* 689</p> <p>Extent of Noncompliance (1# of Cases) *</p> <p>List the Serious Adverse Outcomes (or likelihood of Serious Adverse Outcomes) that Resulted from the Identified areas of Noncompliance*</p> <p>The facility failed to provide adequate supervision for residents when the facility sent resident to an appointment without supervision.</p> <p>(1) Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome because of the non-compliance.</p> <p>All residents requiring an escort to an appointment are at risk of harm</p> <p>(2) Specify the action(s) the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring.</p>	

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2 830	<p>Continued From page 4</p> <p>they had rescheduled the appointment as had occurred previously. In the past, when R1's appointment was completed, she would call the facility so they could arrange for the transport company to pick them up from the appointment. The first phone call FM-A received on 7/24/24 was a call from a nurse about 10:00 p.m. to inform her R1 had not returned from his appointment.</p> <p>On 7/31/24 at 12:38 p.m. registered nurse (RN)-A stated family or a staff person needed to escort R1 to appointments. R1's order for the appointment on 7/24/24 indicated FM-A would be escorting R1. RN-A handed R1's appointment envelope to licensed practical nurse (LPN)-B when he assisted with taking R1 downstairs to the transportation pick-up area.</p> <p>On 7/31/24 at 11:12 a.m., transport company (TC)-A representative stated there was no note in their file indicating someone would be riding with R1 to the appointment. In the past, there had been an indication either family or a staff member would be riding with a resident. The pick-up driver did not receive an envelope from the facility. When he arrived at the appropriate address, he assisted R1 to the front desk of the building and requested information at the desk as to where in the building R1's appointment was. The driver assisted R1 to the correct office and was told the appointment would take about an hour. This information was placed in R1's notes with the transport company. A driver in the area about 75 minutes later stopped to see if R1 was ready to return to the facility because there had been no phone call for a return pick up. The pick-up driver was told that R1 had left the clinic approximately 45 minutes earlier. The driver searched the front</p>	2 830	<p>-The facility created a policy for appointments identifying residents at risk, and requiring staff escorts for resident's identified as at risk utilizing the BIMS assessment 08-02-2024.</p> <p>-The facility created a policy for appointments with family escorts to include a procedure to confirm family escorts in advance of the appointment on 08-02-2024.</p> <p>-The facility has conducted BIMS assessments on all residents to determine cognition status on 08-05-2024.</p> <p>-the facility has created a list of all residents that require staff escort to appointments.</p> <p>-the facility updated resident's careplan and profile to include cognitive status</p> <p>-The facility provided education to the nursing staff regarding the emergency procedure for a missing resident and residents requiring supervision/escorts to appointments in the community-initiated on 08-05-2024 and is ongoing.</p> <p>-Medical records will note if the resident requires an escort for an appointment.</p> <p>-Medical records will provide the front desk and all nursing stations with a copy of the appointment calendar to inform them of all appointments that require an escort.</p> <p>- A list of residents requiring</p>	

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2 830	<p>Continued From page 5</p> <p>area of the building and the surrounding outside area for R1, but did not see him. A call was placed to the facility around 3:45 p.m.- 4:00 p.m. to notify them R1 was not at the clinic but no one answered the phone.</p> <p>On 7/31/24 at 1:09 p.m., health unit coordinator (HUC)-A stated FM-A would be riding with R1 to his appointment, and she entered this information in R1's electronic health record (EHR) and wrote this on R1's appointment envelope. The envelope was placed in the appropriate area of the nurse's desk to send with R1. If FM-A was available, she would always ride with R1 in the transport vehicle. Around 6:00 p.m. she was notified by LPN-A R1 had not returned from his appointment. She called the transport company, but they were closed. She relayed this information to LPN-A. She did not notify anyone else because the LPN-A was handling the situation.</p> <p>On 7/31/24 at 2:12 p.m., LPN-B stated he brought R1 down the elevator to the transportation pick up area where R1 was placed in the transportation vehicle without an escort. LPN-B did not remember if R1 had his appointment envelope. He did not know FM-A was escorting R1 to the appointment.</p> <p>On 7/31/24 at 2:53 p.m., nursing assistant (NA)-A stated she first noticed R1 missing at 3:30 p.m. She notified LPN-A who suggested R1 might be at an activity. Later, NA-A was delivering trays for supper and R1 was not in his room. She told LPN-A who stated R1 was at an appointment with his niece. A search for R1 was not completed until residents were being assisted to bed. NA-A stated R1 did not self-propel forward in his wheelchair very quickly and would have struggled getting around by himself.</p>	2 830	<p>escorts/supervision for appointments will be given to the front desk, each nurses station, and medical records.</p> <p>-Medical records will coordinate with staffing and nursing department for all resident's requiring escorts to appointments.</p> <p>The facility will draft a letter for all transportation companies used requesting that they do not leave without receiving paperwork for the resident's appointment and that the paperwork is given to the receiving entity with instructions that staff escort/supervision is required. This letter will be sent to all transportation companies on 8/5/2024, with a follow-up phone call to confirm receipt of the letter.</p> <p>All appropriate staff will be educated in the updated policies and procedures.</p> <p>8/22/2024</p> <p>Signatures: Anil Ramnarayan, LNHA Kaleeca Bible, DON</p>	

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 08/06/2024
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NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422
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2 830	<p>Continued From page 6</p> <p>On 7/31/24 at 3:45 p.m., RN-B stated at approximately 11:00 p.m. on 7/24/24 she received a call from LPN-A who stated R1 had not returned from his appointment. She added the director of nursing (DON) to the call. When she arrived at the facility the next morning between 7:30 a.m. to 8:00 a.m. R1 was still missing. She called the local hospitals and the dental clinic but R1 was not at any of those locations. A team meeting was held approximately 8:00 a.m. to assign search areas. At approximately 10:00 a.m. she found R1 approximately 5 miles from the dental office. R1 was sent to the emergency room, and then back to the facility with no injuries.</p> <p>On 7/31/24 at 4:15 p.m., LPN-A stated she thought R1 was at an appointment with FM-A. She noticed R1 was not in his room before supper when she went to check his blood sugar. She asked HUC-A to see when R1 was returning. HUC-A told LPN-A she tried calling the transport company, but they were closed. She called FM-A who said she had not accompanied R1 to the appointment. LPN-A could not remember what time FM-A was called. She then called RN-B and DON who instructed staff to search the building.</p> <p>On 8/1/24 at 1:27 p.m., R1 confirmed he went to a dental appointment "last week." After the appointment, he took the bus to "the Salvation Army." R1 was unable to provide more details about the incident.</p> <p>On 8/1/2024 at 2:36 p.m., DON stated she received a call from RN-B and LPN-A at 11:22 p.m. on 7/24/24. She was told R1 had not returned from his dental appointment. She instructed staff to search the entire building. R1</p>	2 830		

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2 830	<p>Continued From page 7</p> <p>was not found during this search. At approximately 11:45 p.m., DON instructed LPN-A to call all of R1's family members while she called the police to report R1 missing. The officer took the report, then stated he would go looking for R1. The DON went and searched the area around the dental clinic. R1 was not found. She went to the facility, then went home approximately 3:30 a.m. She returned to the building about 8:00 a.m. on 7/25/24. A team meeting was held to formulate a plan. Staff members went out in teams of two to look for R1. Approximately 10:00 a.m. she received a call from RN-B that R1 had been located approximately 5 miles from the dental clinic. She stated staff should have known R1 needed an escort to the appointment, and should not have allowed transport to take him. Staff also should have informed her when R1 could not be found around supper time.</p> <p>The facility policy Safety and Supervision of Residents dated 7/17 directed an individualized, resident-centered approach to safety and accident hazards. Resident supervision is determined by the resident's assessed needs.</p> <p>The immediate jeopardy that began on 7/24/24, was removed on 8/6/24 when the facility reviewed and revised their current policy, and created new policies on the safety and supervision of residents with appointments with staff or family supervision, and missing persons. The facility implemented a new system for resident appointment, and provided information to all transportation companies utilized about new facility process for resident escorts. The facility completed audits on all residents to determine if they needed an escort to appointments. The facility educated staff on these policies and procedures. This was verified through observation, interview and</p>	2 830		

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2 830	<p>Continued From page 8</p> <p>document review.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee review and revise policy and procedures for resident escorts and missing residents. The DON or designee could educate all staff on policy and procedures for resident escorts and missing residents and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.</p> <p>Time Period for Correction: Twenty-one (21) days.</p>	2 830		