



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 28, 2026

Administrator

The Terrace at Crystal LLC
3245 VERA CRUZ AVENUE NORTH
CRYSTAL, MN 55422

RE: CCN: 245289

Cycle Start Date: March 5, 2026

Dear Administrator:

On April 7, 2026, we notified you a remedy was imposed. On May 18, 2026, 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 May 9, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 5, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 7, 2026, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 9, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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



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May 28, 2026

Administrator
The Terrace at Crystal LLC
3245 VERA CRUZ AVENUE NORTH
CRYSTAL, MN 55422

Re: Reinspection Results
Event ID: 1F2779-H2 and 22E61B-H2

Dear Administrator:

On April 7, 2026 and May 18, 2026 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 March 5, 2026 and April 16, 2026. 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 'Melissa Poepping', written in a cursive style.

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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March 16, 2026

Administrator

The Terrace at Crystal LLC
3245 VERA CRUZ AVENUE NORTH
CRYSTAL, MN 55422

RE: CCN: 245289

Cycle Start Date: March 5, 2026

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 March 5, 2026, 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:

**Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

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 June 5, 2026 (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 September 5, 2026 (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,



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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March 16, 2026

Administrator
The Terrace at Crystal LLC
3245 VERA CRUZ AVENUE NORTH
CRYSTAL, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 1F2779-H1

Dear Administrator:

The above facility survey was completed on March 5, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

**Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026
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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, Minnesota, 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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F0000	<p>INITIAL COMMENTS</p> <p>On 3/3/26 through 3/5/26, 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.</p> <p>The following complaints were reviewed: H52897315C (2789027)</p> <p>H52897681C (2792497) with a citation at F689 and F842</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 regulations has been attained.</p>	F0000		03/19/2026
F0689 SS = D	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with known</p>	F0689	<p>This Plan of Correction is submitted as a credible allegation of compliance and does not constitute an admission of guilt or agreement with the deficiency cited. The facility is committed to ensuring that each resident receives adequate supervision and assistance devices to prevent accidents, particularly for those with known cognitive impairments.</p> <p>Resident R3 has been discharged.</p> <p>The facility established a new process and policy to formally assess residents for safety when leaving the facility independently, ensuring that assessments consider cognitive ability (BIMS/SLUMS), mobility, and elopement risk.</p> <p>Licensed nursing staff, therapy staff, and receptionists will be re-educated on the requirements for independent community travel, including the</p>	03/31/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0689 SS = D	<p>Continued from page 1 cognitive impairment was comprehensively evaluated and had individualized interventions implemented to ensure safety when leaving the facility independently for 1 of 3 residents (R3) reviewed for safety.</p> <p>Findings include:</p> <p>R3's diagnoses list dated 3/5/26 included stroke, hypertension (high blood pressure), repeated falls, and cognitive communication deficit.</p> <p>R3's hospital discharge transfer orders dated 12/3/25 indicated R3 needed ongoing supervision due to continued need for help with moving, thinking, safety, and eating.</p> <p>R3's elopement risk assessments dated 12/3/25 indicated R3 was low risk for elopement.</p> <p>R3's admission Minimum Data Set (MDS) dated 12/9/26 indicated moderately impaired cognition R3 required maximum assist from staff for transfers, was dependent of staff for wheelchair mobility, and ambulation was not attempted due to medical condition or safety concerns.</p> <p>R3's care plan dated 12/3/25 included a focus of impaired cognitive function/dementia or impaired thought process related to cerebral infarction and communication deficits with interventions including but not limited to cue, reorient and supervise as needed. The care plan also informed that R3 required assistance from 1 staff member for dressing, personal hygiene, transfers, and locomotion with a manual wheelchair. R3 ambulated with a front wheeled walker and supervision from staff and required reminders to use the walker. R3 was at risk for falls with interventions including but not limited to education on how to sit properly in a wheelchair and encourage R3 to use a manual wheelchair when off the unit. R3's discharge focus indicated R3 wanted to discharge to a skilled nursing facility in a different city to be closer to family with an intervention of social service will coordinate services for discharge.</p> <p>R3's St. Louis University Mental Status assessment (SLUMS)(examination for detecting mild cognitive impairment and dementia) dated 12/12/25 identified a score of 15/30 which indicated dementia.</p> <p>R3's nursing notes dated 2/4/26 identified around 3:30 am, R3 told LPN-A she was leaving the facility. LPN-A tried to convince R3 to stay until morning but R3 refused. R3 signed out of the facility and left. The</p>	F0689	<p>Continued from page 1 necessity of a formal safety assessment and individualized interventions for residents with cognitive impairments.</p> <p>Expectations for timely and accurate documentation of safety assessments and the implementation of individualized interventions in the care plan were clarified with the interdisciplinary team.</p> <p>A facility-wide review will be conducted of all residents who currently leave the facility independently to ensure they have been appropriately assessed and that their care plans accurately reflect their supervision needs.</p> <p>The Director of Nursing or designee will complete weekly audits of independent travel assessments and care plans for four weeks, followed by monthly audits for two months to ensure ongoing compliance.</p> <p>Audit results will be reviewed through the QAPI process to monitor compliance, evaluate the effectiveness of the new assessment process, and determine the need for additional action.</p>	

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F0689 SS = D	<p>Continued from page 2 director of nursing and family were updated. Family was very upset that R3 was allowed to leave and called the police. The police filed a missing person report. At 7:20 pm a family member called to alert the facility R3 was at their home, and they would bring her back the next day. A nursing note dated 2/5/26 identified R3 had returned to the facility around 11:00 p.m.</p> <p>In review of R3's record between 12/3/25 through 2/4/26, the record did not include a comprehensive assessment that identified R3's level of supervision in the community with consideration of R3's documented cognitive deficits and/or R3's vulnerabilities or risks while independent community with applicable individualized interventions to ensure R3's safety in the community.</p> <p>R3's Brief Interview for Mental Status (BIMS) assessment dated 2/6/26 identified a score of 8 which indicated R3 had moderate cognitive impairment.</p> <p>R3's BIMS assessment dated 2/19/26 identified a score of 11 which indicated R3 had moderate cognitive impairment.</p> <p>R3's significant change Minimum Data Set (MDS) dated 2/19/26 indicated R3 had moderately impaired cognition and independence with mobility in a manual. wheelchair. Cognitive Loss/Dementia Care Area Assessment (CAA) indicated R3 had an actual problem of mild cognitive impairment related to a history of stroke. Cognitive loss would be addressed in the care plan with overall objectives to include avoid complications and minimize risks.</p> <p>R3's elopement risk assessments dated 2/19/26 indicated R3 was low risk for elopement.</p> <p>A police report dated 3/01/2026 identified at 7:04 a.m. on 3/1/26 an officer arrived at the facility regarding a missing person report. The officer spoke to staff who said R3 had signed out of the book. Staff did not see if R3 left on foot or in a car. Staff supplied the address of R3's family member (FM-A) where R3 was anticipated to be discharged. The officer contacted FM-B who was upset R3 had left the facility. FM-B did not think the facility supervised R3 enough. R3 was in a vulnerable state due to medical emergency, treatment, and ongoing recovery. R3 had recently moved back to Minnesota and did not have any other contacts in the area, and her phone did not have an active wireless plan. The officer received a phone call on 3/01/25 from the facility to inform him R3 had returned.</p>	F0689		

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F0689 SS = D	<p>Continued from page 3</p> <p>R3's nursing notes dated 3/1/26 identified on 2/28/26 around 7:30 pm, R3 had told the receptionist she was leaving the facility. R3 did not indicate where she was going or when she would be back. Around 5:00 a.m. on 3/1/26 R3 still had not returned to the facility so staff attempted to locate her at the facility then called her cell phone. When she could not be located, the police were called, and a missing person report was filed. R3 returned to the facility around 12:40 p.m. A skin check was completed with no new concerns. R3 Denied pain and shortness of breath. R3 was educated to sign out when leaving the facility and to call the facility when she cannot return to the facility the same day. R3 verbalized understanding.</p> <p>In review of R3's record between 2/4/26 through 3/3/26, the record did not include a comprehensive assessment that identified R3's level of supervision in the community with consideration of R3's documented cognitive deficits and/or R3's vulnerabilities or risks while independent community with applicable individualized interventions to ensure R3's safety in the community.</p> <p>During an interview on 3/3/2026 at 1:37 p.m., R3 stated she had moved back to Minnesota in October 2025. She went into the hospital a few days after arriving in Minnesota then was discharged to the facility. She had a cell phone, but it did not work for making calls. She needed to use the facility phone when she wanted to call someone. On February 4th, 2026, R3 told a staff member she was leaving to go to her cousin's house. Her cousin picked her up, R3 spent the night at the cousin's house, and her brother brought her back to the facility on February 5th, 2026. On February 28th, 2026, R3 called her cousin from the facility phone, who arranged for an Uber to pick R3 up at the facility and bring her back on March 1st, 2026. R3 indicated the facility had not provided her with any safety instructions while out in the community but would ask to borrow someone's phone if she had any trouble.</p> <p>During an interview on 3/3/2026 at 2:49 p.m., FM-A stated he was very upset R3 was allowed to leave the facility by herself. He was concerned R3 would make bad decisions while in the community because she "was not right in the head". FM-A could not define what bad decisions R3 might make. FM-A also stated R3's phone did not have cell service and could only be used when on a wi-fi network.</p> <p>During an interview on 3/3/2026 at 3:25 p.m., receptionist (R)-A stated a resident needed to sign out in the book with the time they were leaving and where</p>	F0689		

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F0689 SS = D	<p>Continued from page 4 they are going before leaving the facility. There was an elopement book with a list of residents who needed an escort to leave the facility. A resident could leave the facility independently if they were not listed in that book. R-A confirmed R3 was not on the list of residents who needed an escort to leave the facility.</p> <p>During a phone interview on 3/4/2026 at 2:43 p.m., the occupational therapy assistant (OTA) stated R3 scored 15/30 on a SLUMS examination completed on 12/12/25 which indicated R3 had dementia. OTA was not requested to assess R3 for safety in the community. OTA would have recommended R3 have supervision in the community due to memory problems and would need clear directions on coming and going to/from facility.</p> <p>During a phone interview on 3/5/2026 at 9:14 a.m., speech therapist (ST) stated a person with a SLUMS score of 15/30 would need supervision in the community because of memory issues. ST indicated there had not been a referral or request to do a screening or evaluation for community safety.</p> <p>During an interview on 3/4/2026 at 9:54 a.m., licensed practical nurse (LPN)-A stated a resident could leave the facility independently if they were alert and oriented, independent with mobility, were not an elopement risk, and could make their own decisions. The BIMS was used to determine a resident's cognitive ability.</p> <p>During an interview on 3/4/2026 at 11:41 a.m., the Nurse Manager (NM) stated a resident's ability to safely enter the community was based on cognition, mobility, elopement risk and a safety in the community assessment completed by therapy. NM asserted that while R3 would not have been capable of independent community travel upon admission, she had "improved enough" with her mobility to allow it, however no formal assessment had been completed to determine R3's level of improvement that would ensure R3 was safe or if R3 required interventions to ensure R3's safety.</p> <p>During an interview on 3/5/2026 at 11:56 a.m., director of nursing (DON) stated a resident's ability to safely go into the community independently was based on cognition and elopement risk. A resident with severely impaired cognition would not be deemed safe to leave independently. DON explained PT would complete an assessment for power chair mobility on facility grounds but she didn't know if therapy would do a safety in the community assessment. DON further indicated the facility did not have a process to assess residents for safety in the community.</p>	F0689		

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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, Minnesota, 55422	
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F0689 SS = D	Continued from page 5 During a phone interview on 3/5/2026 at 1:14 p.m., the medical director (MD) stated nursing should do an in-depth assessment when a resident requested to leave the facility independently. The assessment should include if the resident was safe, demonstrated insight and reasonable decision making as well as if the resident was physically able to navigate where they wanted to go. If a resident had moderately impaired cognition, they should not be allowed in the community independently unless the family was comfortable and the resident had been navigating the community for years. Facility policies did not address protocols and criteria for residents to leave the facility independently. The Elopement Prevention and Missing Resident policy dated 3/3/26 instructed the facility ensured the safety of residents by providing unsupervised departure (elopement) and responding promptly when a resident was missing.	F0689		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	This Plan of Correction is submitted as a credible allegation of compliance and does not constitute an admission of guilt or agreement with the deficiency cited. The facility is committed to maintaining medical records that are complete, accurately documented, readily accessible, and systematically organized. Resident R3 has been discharged. The "Documentation of Medication Administration" policy (dated 4/2007) and the "Charting and Documentation" policy (dated 7/2017) were reviewed to reinforce that all entries must be objective, complete, accurate, and documented only after a task is performed. Licensed nursing staff were re-educated on the requirement to document medication administration and vital signs immediately after they are given or taken, ensuring that documentation matches the resident's actual presence in the facility. Nursing staff will be retrained on the proper use of EHR progress note codes (e.g., "leave of absence" or "hospital") to accurately explain why a medication was not administered at the scheduled time rather than pre-dating. A facility-wide audit of Electronic Medication Administration Records (EMAR) was conducted for	03/31/2026

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F0842 SS = D	<p>Continued from page 6</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p>	F0842	<p>Continued from page 6</p> <p>residents who had recent leaves of absence to ensure there were no discrepancies between documented administration times and the residents' exit/entry logs.</p> <p>The Director of Nursing or designee will complete weekly audits of EMAR accuracy and nursing progress notes for four weeks, followed by monthly audits for two months.</p> <p>Audit results will be reviewed through the QAPI process to ensure that documentation standards are being sustained and to determine if further systemic changes are required.</p>	

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F0842 SS = D	<p>Continued from page 7</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 1 of 1 resident (R3) reviewed for accidents</p> <p>Findings include</p> <p>R3's diagnoses list dated 3/5/26 included stroke, hypertension (high blood pressure), repeated falls, and cognitive communication deficit.</p> <p>R3's provider order dated 1/15/26 instructed clonidine (a medication that lowers blood pressure) oral tablet 0.3 milligrams (MG). Give one tablet by mouth three times a day for hypertensive urgency. Hold if heart rate is less than 60 beats per minute or if systolic blood pressure is less than 100 millimeters of mercury (mmHg).</p> <p>R3's nursing notes dated 3/1/26 identified on 2/28/26 around 7:30 pm, R3 had told the receptionist she was leaving the facility. R3 did not indicate where she was going or when she would be back. Around 5am on 3/1/26 R3 still had not returned to the facility so staff attempted to locate her at the facility then called her cell phone. When she could not be located, the police were called, and a missing person report was filed. R3 returned to the facility on 3/1/26 around 12:40 pm.</p> <p>R3's medication administration audit report for February 2026 indicated a dose of clonidine was scheduled for 2/28/26 at 2200 was signed on 2/28/26 at 9:36 p.m. (even though R3 was not in the facility at the time the medication was documented as administered).</p> <p>R3's medication administration record for February 2026 indicated a dose of clonidine scheduled for 2/28/26 at 11:00 p.m. was administered with a blood pressure of 121/74 and a pulse of 72 by licensed practical nurse</p>	F0842		

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F0842 SS = D	<p>Continued from page 8 (LPN)-B (even though R3 was not in the facility at the time the medication was documented as administered).</p> <p>During an interview on 3/9/2026 at 10:07 a.m., LPN-B stated on 2/28/26 he administered all of R3's evening medications at the same time because she liked getting all of her pills together. If she was approached twice with medications and blood pressure checks, she would often refuse the second approach. He could not document the clonidine with the other medications because it was "too early". LPN-B subsequently entered the documentation at a later time to appear as though the medication was given as ordered. Furthermore, LPN-B could not provide a clinical explanation for the conflicting blood pressure readings documented at 6:22 p.m. and 9:36 p.m., as he had previously stated he only approached the resident once for all medications and vitals.</p> <p>During an interview on 3/5/2026 at 4:55 p.m. director of nursing (DON) stated medications could be administered up to one hour before or one hour after the scheduled administration time. If a resident was out of the building when a medication was due to be administered, the nurse should choose the code that applied to the situation (for example, at the hospital or leave of absence with medications). The nurse could also choose code 9 which prompts the nurse to write a note explaining why the medication was not administered. DON verified R3's 2/28/26 dose of clonidine and blood pressure check scheduled at 11:00 p.m. was documented as administered on 2/28/26 at 9:36 p.m. with corresponding blood pressure information. DON confirmed according to documentation, R3 was out of the building at the documented administration time. DON stated accuracy of documentation in the medical record was important.</p> <p>The Documentation of Medication Administration policy dated 4/2007 instructed administration of medication must be documented immediately after (never before) it is given.</p> <p>The Charting and Documentation policy dated 7/2017 instructed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>	F0842		

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>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:</p> <p>On 3/3/26 through 3/5/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	20000		03/19/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	<p>Continued from page 1</p> <p>The following complaints were reviewed:</p> <p>H52897315C (2789027)</p> <p>H52897681C (2792497)</p> <p>An incidental finding was cited at 0625 and 0830</p> <p>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/in_fobulletins/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.</p> <p>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.</p>	20000		
20625	<p>Clinical Record Contents; In General</p> <p>CFR(s): MN Rule 4658.0450 Subp. 1 A-P</p>	20625	Corrected.	03/31/2026

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20625	<p>Continued from page 2</p> <p>Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:</p> <p>A. the condition of the resident at the time of admission;</p> <p>B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520,</p> <p>subpart 2, item I;</p> <p>C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;</p> <p>D. the resident's general condition, actions, and attitudes;</p> <p>E. observations, assessments, and interventions provided by all disciplines responsible</p> <p>for care of the resident, with the exception of confidential communications with</p> <p>religious personnel;</p> <p>F. significant observations on, for example, behavior, orientation, adjustment to the</p> <p>nursing home, judgment, or moods;</p> <p>G. date, time, quantity of dosage, and method of administration of all medications, and</p> <p>the signature of the nurse or authorized persons who administered the medication;</p> <p>H. a report of a tuberculin test within the three months prior to admission, as described</p> <p>in part 4658.0810;</p> <p>I. reports of laboratory examinations;</p> <p>J. dates and times of all treatments and dressings;</p> <p>K. dates and times of visits by all licensed health care practitioners;</p> <p>L. visits to clinics or hospitals;</p> <p>M. any orders or instructions relative to the comprehensive plan of care;</p> <p>N. any change in the resident's sleeping habits or</p>	20625		

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20625	<p>Continued from page 3 appetite;</p> <p>O. pertinent factors regarding changes in the resident's general conditions; and</p> <p>P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 1 of 1 resident (R3) reviewed for accidents</p> <p>R3's diagnoses list dated 3/5/26 included stroke, hypertension (high blood pressure), repeated falls, and cognitive communication deficit.</p> <p>R3's provider order dated 1/15/26 instructed clonidine (a medication that lowers blood pressure) oral tablet 0.3 milligrams (MG). Give one tablet by mouth three times a day for hypertensive urgency. Hold if heart rate is less than 60 beats per minute or if systolic blood pressure is less than 100 millimeters of mercury (mmHg).</p> <p>R3's nursing notes dated 3/1/26 identified on 2/28/26 around 7:30 pm, R3 had told the receptionist she was leaving the facility. R3 did not indicate where she was going or when she would be back. Around 5am on 3/1/26 R3 still had not returned to the facility so staff attempted to locate her at the facility then called her cell phone. When she could not be located, the police were called, and a missing person report was filed. R3 returned to the facility on 3/1/26 around 12:40 pm.</p> <p>R3's medication administration audit report for February 2026 indicated a dose of clonidine was scheduled for 2/28/26 at 2200 was signed on 2/28/26 at 9:36 p.m. (even though R3 was not in the facility at the time the medication was documented as administered).</p> <p>R3's medication administration record for February 2026 indicated a dose of clonidine scheduled for 2/28/26 at</p>	20625		

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20625	<p>Continued from page 4 11:00 p.m. was administered with a blood pressure of 121/74 and a pulse of 72 by licensed practical nurse (LPN)-B (even though R3 was not in the facility at the time the medication was documented as administered).</p> <p>During an interview on 3/9/2026 at 10:07 a.m., LPN-B stated on 2/28/26 he administered all of R3's evening medications at the same time because she liked getting all of her pills together. If she was approached twice with medications and blood pressure checks, she would often refuse the second approach. He could not document the clonidine with the other medications because it was "too early". LPN-B subsequently entered the documentation at a later time to appear as though the medication was given as ordered. Furthermore, LPN-B could not provide a clinical explanation for the conflicting blood pressure readings documented at 6:22 p.m. and 9:36 p.m., as he had previously stated he only approached the resident once for all medications and vitals.</p> <p>During an interview on 3/5/2026 at 4:55 p.m. director of nursing (DON) stated medications could be administered up to one hour before or one hour after the scheduled administration time. If a resident was out of the building when a medication was due to be administered, the nurse should choose the code that applied to the situation (for example, at the hospital or leave of absence with medications). The nurse could also choose code 9 which prompts the nurse to write a note explaining why the medication was not administered. DON verified R3's 2/28/26 dose of clonidine and blood pressure check scheduled at 11:00 p.m. was documented as administered on 2/28/26 at 9:36 p.m. with corresponding blood pressure information. DON confirmed according to documentation, R3 was out of the building at the documented administration time. DON stated accuracy of documentation in the medical record was important.</p> <p>The Documentation of Medication Administration policy dated 4/2007 instructed administration of medication must be documented immediately after (never before) it is given.</p> <p>The Charting and Documentation policy dated 7/2017 instructed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>	20625		

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20625	<p>Continued from page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to ensuring resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	20625		
20830	<p>Adequate and Proper Nursing Care; General</p> <p>CFR(s): MN Rule 4658.0520 Subp. 1</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 LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with known cognitive impairment was comprehensively evaluated and had individualized interventions implemented to ensure safety when leaving the facility independently for 1 of 3 residents (R3) reviewed for safety.</p> <p>Findings include:</p> <p>R3's diagnoses list dated 3/5/26 included stroke, hypertension (high blood pressure), repeated falls, and cognitive communication deficit.</p> <p>R3's hospital discharge transfer orders dated 12/3/25 indicated R3 needed ongoing supervision due to continued need for help with moving, thinking, safety, and eating.</p> <p>R3's elopement risk assessments dated 12/3/25 indicated R3 was low risk for elopement.</p> <p>R3's admission Minimum Data Set (MDS) dated 12/9/26 indicated moderately impaired cognition R3 required maximum assist from staff for transfers, was dependent of staff for wheelchair mobility, and ambulation was</p>	20830	Corrected.	03/31/2026

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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, Minnesota, 55422	
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20830	<p>Continued from page 6 not attempted due to medical condition or safety concerns.</p> <p>R3's care plan dated 12/3/25 included a focus of impaired cognitive function/dementia or impaired thought process related to cerebral infarction and communication deficits with interventions including but not limited to cue, reorient and supervise as needed. The care plan also informed that R3 required assistance from 1 staff member for dressing, personal hygiene, transfers, and locomotion with a manual wheelchair. R3 ambulated with a front wheeled walker and supervision from staff and required reminders to use the walker. R3 was at risk for falls with interventions including but not limited to education on how to sit properly in a wheelchair and encourage R3 to use a manual wheelchair when off the unit. R3's discharge focus indicated R3 wanted to discharge to a skilled nursing facility in a different city to be closer to family with an intervention of social service will coordinate services for discharge.</p> <p>R3's St. Louis University Mental Status assessment (SLUMS)(examination for detecting mild cognitive impairment and dementia) dated 12/12/25 identified a score of 15/30 which indicated dementia.</p> <p>R3's nursing notes dated 2/4/26 identified around 3:30 am, R3 told LPN-A she was leaving the facility. LPN-A tried to convince R3 to stay until morning but R3 refused. R3 signed out of the facility and left. The director of nursing and family were updated. Family was very upset that R3 was allowed to leave and called the police. The police filed a missing person report. At 7:20 pm a family member called to alert the facility R3 was at their home, and they would bring her back the next day. A nursing note dated 2/5/26 identified R3 had returned to the facility around 11:00 p.m.</p> <p>In review of R3's record between 12/3/25 through 2/4/26, the record did not include a comprehensive assessment that identified R3's level of supervision in the community with consideration of R3's documented cognitive deficits and/or R3's vulnerabilities or risks while independent community with applicable individualized interventions to ensure R3's safety in the community.</p> <p>R3's Brief Interview for Mental Status (BIMS) assessment dated 2/6/26 identified a score of 8 which indicated R3 had moderate cognitive impairment.</p> <p>R3's BIMS assessment dated 2/19/26 identified a score of 11 which indicated R3 had moderate cognitive</p>	20830		

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20830	<p>Continued from page 7 impairment.</p> <p>R3's significant change Minimum Data Set (MDS) dated 2/19/26 indicated R3 had moderately impaired cognition and independence with mobility in a manual. wheelchair. Cognitive Loss/Dementia Care Area Assessment (CAA) indicated R3 had an actual problem of mild cognitive impairment related to a history of stroke. Cognitive loss would be addressed in the care plan with overall objectives to include avoid complications and minimize risks.</p> <p>R3's elopement risk assessments dated 2/19/26 indicated R3 was low risk for elopement.</p> <p>A police report dated 3/01/2026 identified at 7:04 a.m. on 3/1/26 an officer arrived at the facility regarding a missing person report. The officer spoke to staff who said R3 had signed out of the book. Staff did not see if R3 left on foot or in a car. Staff supplied the address of R3's family member (FM-A) where R3 was anticipated to be discharged. The officer contacted FM-B who was upset R3 had left the facility. FM-B did not think the facility supervised R3 enough. R3 was in a vulnerable state due to medical emergency, treatment, and ongoing recovery. R3 had recently moved back to Minnesota and did not have any other contacts in the area, and her phone did not have an active wireless plan. The officer received a phone call on 3/01/25 from the facility to inform him R3 had returned.</p> <p>R3's nursing notes dated 3/1/26 identified on 2/28/26 around 7:30 pm, R3 had told the receptionist she was leaving the facility. R3 did not indicate where she was going or when she would be back. Around 5:00 a.m. on 3/1/26 R3 still had not returned to the facility so staff attempted to locate her at the facility then called her cell phone. When she could not be located, the police were called, and a missing person report was filed. R3 returned to the facility around 12:40 p.m. A skin check was completed with no new concerns. R3 Denied pain and shortness of breath. R3 was educated to sign out when leaving the facility and to call the facility when she cannot return to the facility the same day. R3 verbalized understanding.</p> <p>In review of R3's record between 2/4/26 through 3/3/26, the record did not include a comprehensive assessment that identified R3's level of supervision in the community with consideration of R3's documented cognitive deficits and/or R3's vulnerabilities or risks while independent community with applicable individualized interventions to ensure R3's safety in the community.</p>	20830		

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20830	<p>Continued from page 8</p> <p>During an interview on 3/3/2026 at 1:37 p.m., R3 stated she had moved back to Minnesota in October 2025. She went into the hospital a few days after arriving in Minnesota then was discharged to the facility. She had a cell phone, but it did not work for making calls. She needed to use the facility phone when she wanted to call someone. On February 4th, 2026, R3 told a staff member she was leaving to go to her cousin's house. Her cousin picked her up, R3 spent the night at the cousin's house, and her brother brought her back to the facility on February 5th, 2026. On February 28th, 2026, R3 called her cousin from the facility phone, who arranged for an Uber to pick R3 up at the facility and bring her back on March 1st, 2026. R3 indicated the facility had not provided her with any safety instructions while out in the community but would ask to borrow someone's phone if she had any trouble.</p> <p>During an interview on 3/3/2026 at 2:49 p.m., FM-A stated he was very upset R3 was allowed to leave the facility by herself. He was concerned R3 would make bad decisions while in the community because she "was not right in the head". FM-A could not define what bad decisions R3 might make. FM-A also stated R3's phone did not have cell service and could only be used when on a wi-fi network.</p> <p>During an interview on 3/3/2026 at 3:25 p.m., receptionist (R)-A stated a resident needed to sign out in the book with the time they were leaving and where they are going before leaving the facility. There was an elopement book with a list of residents who needed an escort to leave the facility. A resident could leave the facility independently if they were not listed in that book. R-A confirmed R3 was not on the list of residents who needed an escort to leave the facility.</p> <p>During a phone interview on 3/4/2026 at 2:43 p.m., the occupational therapy assistant (OTA) stated R3 scored 15/30 on a SLUMS examination completed on 12/12/25 which indicated R3 had dementia. OTA was not requested to assess R3 for safety in the community. OTA would have recommended R3 have supervision in the community due to memory problems and would need clear directions on coming and going to/from facility.</p> <p>During a phone interview on 3/5/2026 at 9:14 a.m., speech therapist (ST) stated a person with a SLUMS score of 15/30 would need supervision in the community because of memory issues. ST indicated there had not been a referral or request to do a screening or evaluation for community safety.</p>	20830		

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20830	<p>Continued from page 9</p> <p>During an interview on 3/4/2026 at 9:54 a.m., licensed practical nurse (LPN)-A stated a resident could leave the facility independently if they were alert and oriented, independent with mobility, were not an elopement risk, and could make their own decisions. The BIMS was used to determine a resident's cognitive ability.</p> <p>During an interview on 3/4/2026 at 11:41 a.m., the Nurse Manager (NM) stated a resident's ability to safely enter the community was based on cognition, mobility, elopement risk and a safety in the community assessment completed by therapy. NM asserted that while R3 would not have been capable of independent community travel upon admission, she had "improved enough" with her mobility to allow it, however no formal assessment had been completed to determine R3's level of improvement that would ensure R3 was safe or if R3 required interventions to ensure R3's safety.</p> <p>During an interview on 3/5/2026 at 11:56 a.m., director of nursing (DON) stated a resident's ability to safely go into the community independently was based on cognition and elopement risk. A resident with severely impaired cognition would not be deemed safe to leave independently. DON explained PT would complete an assessment for power chair mobility on facility grounds but she didn't know if therapy would do a safety in the community assessment. DON further indicated the facility did not have a process to assess residents for safety in the community.</p> <p>During a phone interview on 3/5/2026 at 1:14 p.m., the medical director (MD) stated nursing should do an in-depth assessment when a resident requested to leave the facility independently. The assessment should include if the resident was safe, demonstrated insight and reasonable decision making as well as if the resident was physically able to navigate where they wanted to go. If a resident had moderately impaired cognition, they should not be allowed in the community independently unless the family was comfortable and the resident had been navigating the community for years.</p> <p>Facility policies did not address protocols and criteria for residents to leave the facility independently.</p> <p>The Elopement Prevention and Missing Resident policy dated 3/3/26 instructed the facility endured the safety of residents be providing unsupervised departure (elopement) and responding promptly when a resident was missing.</p>	20830		

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20830	Continued from page 10 Suggested Method of correction: DON/designee could develop policy/procedure for assessment that identifies residents ability to be independent in the community and care planning interventions. DON/designee provide education to staff on the implementation of the policy/procedure. DON/designee could then develop and implement an auditing system to determine compliance and any modifications if applicable. Time period for correction: 21 days	20830		