DEPARTMENT OF HEALTH

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 Therefore, the NATCEP prohibition is rescinded.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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

May 28, 2026

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

RE: 1F529D-H3

Dear Administrator:

On May 20, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $500.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on May 14, 2026 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $500.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $104.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $604.40 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Department of Health
Health Regulation Division,
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

cc: Shellae Dietrich, Program Assurance Supervisor
Kami Fiske-Downing, Licensing and Certification Program
HRD Deposit Team

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 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 16, 2026, we informed you that we may impose enforcement remedies.

On April 7, 2026, we informed you of imposed enforcement remedies.

On April 24, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

F0658 - Services Provided Meet Professional Standards

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), June 5, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 5, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 5, 2026.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 5, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Terrace at Crystal LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@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 tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 7, 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 16, 2026, we informed you that we may impose enforcement remedies.

On March 19, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 5, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 5, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 5, 2026.

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.

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- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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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

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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

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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
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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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 7, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1F529D-H1

Dear Administrator:

The above facility survey was completed on March 19, 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 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	3245 VERA CRUZ AVENUE NORTH , CRYSTAL, Minnesota, 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
F0000	INITIAL COMMENTS On 3/18/26, and 3/19/26, 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. The following complaint was reviewed: H52898781C (2805756) with deficiencies issued at F658. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/08/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to administer long-acting insulin at consistent times according to the manufacturer's instructions for 2 of 3 residents (R2, R3) who were prescribed long-acting insulin. : Findings include: R2	F0658	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 all residents receive medications, specifically long-acting insulin, in accordance with professional standards of quality and manufacturer instructions to maintain clinical safety. The medication administration records (MAR) for Residents R2 and R3 were updated to include specific, fixed administration times for long-acting insulin to ensure consistency per manufacturer guidelines. A clinical review of Resident R2 and R3's blood glucose trends was conducted to confirm no adverse effects occurred from previous inconsistent administration times. An audit of all residents receiving long-acting insulin was conducted to ensure MARs contain specific times and reflect consistent delivery within a one-hour window. The facility medication administration policy was	04/10/2026

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

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 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	3245 VERA CRUZ AVENUE NORTH , CRYSTAL, Minnesota, 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
F0658 SS = D	Continued from page 1 R2's face sheet dated 3/19/26, identified diagnoses of type 2 diabetes with diabetic polyneuropathy (breakdown of nerves), and long-term use of insulin. R2's quarterly Minimum Data Set (MDS) dated 12/22/25, identified R2 had no cognitive issues. R2 had a therapeutic diet. R2 received insulin injections seven days a week. R2's care plan dated 9/23/25, identified R2 had diabetes mellitus with interventions which included but not limited to- administer diabetes medication as ordered by doctor. R2's physician order dated 9/23/25, identified Basaglar (long-acting) 62 units twice daily. R2's diabetic administration record dated March 2026, did not identify Basaglar order rather identified the physician order that was clinically equivalent. The administration record identified an order for Lantus 62 units twice daily however the times for administration were transcribed for 7:00 a.m.-11:00 a.m. and HS 19 (hour of sleep 7:00 p.m.). The manufacturer's package insert for Lantus under the section titled Patient Information included "You may take LANTUS at any time during the day but you must take it at the same time every day." R2's administration record identified the Lanus was administered at varying times for the evening scheduled dose and were not consistently given at the same time per the manufacturer's package insert. The following were examples from the record: -3/1/26-9:41 a.m. and 10:32 p.m. -3/2/26-9:17 a.m. and 9:43 p.m. -3/5/26-8:29 a.m. and 10:42 p.m. -3/6/26-9:04 a.m. and 8:27 p.m. R3 R3's face sheet dated 3/19/26, identified diagnoses of type 2 diabetes. R3's quarterly MDS dated 2/20/26, identified R3 had no cognitive issues. R3 was on a therapeutic diet. R3 had insulin injections seven days per week.	F0658	Continued from page 1 reviewed and updated to require specific, fixed administration times for all long-acting insulin orders. The medication transcription process now requires all long-acting insulin orders to be entered into the electronic MAR with a designated time instead of a broad "window." Licensed nursing staff (RNs and LPNs) were re-educated on professional standards for administering long-acting insulin and the clinical necessity of a small dosing window to avoid complications. The remaining internal and agency staff will be educated before their next shift. The Director of Nursing (DON) or designee will perform weekly audits of insulin administration records for four weeks, followed by monthly audits for two months. Audit findings will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly to evaluate the need for further systemic changes.	

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 03/19/2026

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F0658 SS = D	Continued from page 2 R3's care plan dated 6/2/25, identified R3 had diabetes mellitus with an interventions that included but not limited to diabetes medication as ordered by doctor. R3's physician order dated 5/29/25, included Lantus 20 units daily. The manufacturer's package insert for Lantus under the section titled Patient Information included "You may take LANTUS at any time during the day but you must take it at the same time every day." R3's diabetic administration record dated March 2026, included the physician order for Lantus 20 units in the morning with administration times of 7:00 a.m.-11:00 a.m. R3's administration record identified the Lanus was administered at varying times for the evening scheduled dose and were not consistently given at the same time per the manufacturer's package insert. The following were examples from the record: -3/1/26-8:27 a.m. -3/2/26-10:00 a.m. -3/4/26-8:52 a.m. -3/13/26-12:09 p.m. -3/14/26-7:58 a.m. During an interview on 3/18/26 at 2:40 p.m. licensed practical nurse (LPN)-C stated long-acting insulin should be given at the same time every day for it to work and do "what it is supposed to be doing". LPN-C administers long-acting insulin based on what the order in the medication administration record has for times to administer. During a phone interview on 3/19/26 at 10:43 a.m. registered nurse (RN)-A stated if the provider ordered long-acting insulin daily based on experience he would transcribe the order with a specific time so that it was given at the same time every day. During an interview on 3/19/26 at 7:49 a.m., RN nurse manager (NM)-B stated if long-acting insulin does not come with a specific time to administer, staff will transcribe the order with a "window where we can administer". "Lantus might be one where you want specific". NM-B stated it would be best to be given at	F0658		

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F0658 SS = D	Continued from page 3 a certain time every day. During an interview on 3/19/26 at 11:36 a.m., director of nursing (DON) stated some long-acting insulin orders are usually ordered once per day but do not always come with a specific time to be given. The provider would put a specific time in the order if they wanted a resident to have it at a specific time. During a phone interview on 3/19/26 at 10:13 a.m., pharmacist (P)-A stated long-acting insulin should be pretty specific with a very small window for the dose to be given. If the dose was given at different times daily the risk would be for the person to become hyperglycemic or hypoglycemic and could end up with ketoacidosis (potentially life threatening complication of high blood sugar levels) and that would not be good. The facility Insulin Administration policy dated 6/2022, identified characteristics and types of insulin: long-acting insulin: onset 1-2 hours, peak up to 8 hours, duration up to 24 hours.	F0658		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/18/26, and 3/19/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/08/2026

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

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20000	Continued from page 1 The following complaint was reviewed: H52898781C (2805756) with a licensing order issued at 21550. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to administer long-acting insulin at consistent times according the manufacturer's instructions for 2 of 3 residents (R2, R3) who were prescribed long-acting	21550	Corrected.	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

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21550	Continued from page 2 insulin. Findings include: R2 R2's face sheet dated 3/19/26, identified diagnoses of type 2 diabetes with diabetic polyneuropathy (breakdown of nerves), and long-term use of insulin. R2's quarterly Minimum Data Set (MDS) dated 12/22/25, identified R2 had no cognitive issues. R2 had a therapeutic diet. R2 received insulin injections seven days a week. R2's care plan dated 9/23/25, identified R2 had diabetes mellitus with interventions which included but not limited to- administer diabetes medication as ordered by doctor. R2's physician order dated 9/23/25, identified Basaglar (long-acting) 62 units twice daily. R2's diabetic administration record dated March 2026, did not identify Basaglar order rather identified the physician order that was clinically equivalent. The administration record identified an order for Lantus 62 units twice daily however the times for administration were transcribed for 7:00 a.m.-11:00 a.m. and HS 19 (hour of sleep 7:00 p.m.). The manufacturer's package insert for Lantus under the section titled Patient Information included "You may take LANTUS at any time during the day but you must take it at the same time every day." R2's administration record identified the Lanus was administered at varying times for the evening scheduled dose and were not consistently given at the same time per the manufacturer's package insert. The following were examples from the record: -3/1/26-9:41 a.m. and 10:32 p.m. -3/2/26-9:17 a.m. and 9:43 p.m. -3/5/26-8:29 a.m. and 10:42 p.m. -3/6/26-9:04 a.m. and 8:27 p.m. R3 R3's face sheet dated 3/19/26, identified diagnoses of	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

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21550	Continued from page 3 type 2 diabetes. R3's quarterly MDS dated 2/20/26, identified R3 had no cognitive issues. R3 was on a therapeutic diet. R3 had insulin injections seven days per week. R3's care plan dated 6/2/25, identified R3 had diabetes mellitus with an interventions that included but not limited to diabetes medication as ordered by doctor. R3's physician order dated 5/29/25, included Lantus 20 units daily. The manufacturer's package insert for Lantus under the section titled Patient Information included "You may take LANTUS at any time during the day but you must take it at the same time every day." R3's diabetic administration record dated March 2026, included the physician order for Lantus 20 units in the morning with administration times of 7:00 a.m.-11:00 a.m. R3's administration record identified the Lanus was administered at varying times for the evening scheduled dose and were not consistently given at the same time per the manufacturer's package insert. The following were examples from the record: -3/1/26-8:27 a.m. -3/2/26-10:00 a.m. -3/4/26-8:52 a.m. -3/13/26-12:09 p.m. -3/14/26-7:58 a.m. During an interview on 3/18/26 at 2:40 p.m. licensed practical nurse (LPN)-C stated long-acting insulin should be given at the same time every day for it to work and do "what it is supposed to be doing". LPN-C administers long-acting insulin based on what the order in the medication administration record has for times to administer. During a phone interview on 3/19/26 at 10:43 a.m. registered nurse (RN)-A stated if the provider ordered long-acting insulin daily based on experience he would transcribe the order with a specific time so that it was given at the same time every day.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

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21550	Continued from page 4 During an interview on 3/19/26 at 7:49 a.m., RN nurse manager (NM)-B stated if long-acting insulin does not come with a specific time to administer, staff will transcribe the order with a "window where we can administer". "Lantus might be one where you want specific". NM-B stated it would be best to be given at a certain time every day. During an interview on 3/19/26 at 11:36 a.m., director of nursing (DON) stated some long-acting insulin orders are usually ordered once per day but do not always come with a specific time to be given. The provider would put a specific time in the order if they wanted a resident to have it at a specific time. During a phone interview on 3/19/26 at 10:13 a.m., pharmacist (P)-A stated long-acting insulin should be pretty specific with a very small window for the dose to be given. If the dose was given at different times daily the risk would be for the person to become hyperglycemic or hypoglycemic and could end up with ketoacidosis (potentially life threatening complication of high blood sugar levels) and that would not be good. The facility Insulin Administration policy dated 6/2022, identified characteristics and types of insulin: long-acting insulin: onset 1-2 hours, peak up to 8 hours, duration up to 24 hours. SUGGESTED METHOD OF CORRECTION: the DON or designee could review procedures for long and short-acting insulins with nurses to ensure all are educated and competent with diabetic management. The DON or designee could audit staff administration times, order input, and outcomes for diabetic residents. The DON or designee could review findings at Quality Assurance Performance Improvement (QAPI) meetings. TIME FRAME FOR CORRECTION: Twenty-one (21) days.	21550		

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 04/16/2026

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F0000	INITIAL COMMENTS On 4/15/26 and 4/16/26, 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. The following complaints were reviewed: H51891244C (2981559) and H51891353C (2792331). As a result of the investigation deficiencies were cited at F604, F627, and F628. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/06/2026
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12	F0604	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 all residents are free from unnecessary physical restraints and that any emergency intervention is performed only in accordance with regulatory requirements, including provider orders, documentation standards, and post-intervention assessments. The incident involving Resident R1 was reviewed. A facility-wide audit was completed on all behavioral incidents within the past 30 days to identify any use of physical holds or restraints, including emergency interventions.	05/06/2026

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

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 04/16/2026

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F0604 SS = D	Continued from page 1 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to obtain an order for restraint and perform an assessment following the restraint of 1 of 1 resident (R1) reviewed for physical restraint. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 3/30/26, indicated intact cognition, no behaviors, independence in activities of daily living and ambulation. R1's diagnoses included schizophrenia. R1’s care plan included: 10/9/24 substance abuse/dependence of alcohol and cocaine with interventions to monitor for signs and symptoms of intoxication and update provider as needed 7/23/25 resident did not wish to self-administer medications 8/20/25 resident wished to discharge to the community with interventions to arrange required community supports 11/6/25 potential to be physically aggressive to others and poor impulse control. Diagnoses included schizotypal disorder (a mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions), alcohol dependence, anxiety, depression, and bipolar disorder. Interventions included a room change,	F0604	Continued from page 1 Staff were re-educated on the definition of a physical restraint, including that any manual hold (e.g., “bear hug”) intended to restrict movement. Nursing staff were re-educated on obtaining provider order for emergency restraint use (including verbal/telephone orders when appropriate), timely provider notification, and completion of required post-restraint assessments addressing the resident’s physical, mental, and emotional status. Use of restraint policy reviewed. The Director of Nursing or designee will conduct weekly audits of all behavioral incidents and restraint-related documentation for 4 weeks, then monthly for 2 additional months. Audit findings will be reviewed through the QAPI Committee to ensure ongoing compliance and identify any additional training needs.	05/06/2026

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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
F0604 SS = D	Continued from page 2 separation of R1 from specific other residents, and 1:1 supervision starting 4/5/26, after an altercation 1/22/26 R1 was seeing a psychology provider for psychosocial support 3/26/26 R1 was able to go into the community independently R1’s care plan lacked indication restraint use for behavioral intervention. R1’s progress note dated 4/11/26 at 7:00 p.m., indicated R1 had an altercation with another resident, R2. R1 overpowered a staff, and was able to strike R2 on the face. Staff on second floor physically restrained R1. The police were called, and R1 was taken to jail. The progress notes lacked indication R1's provider was notified. R1's progress notes reviewed 4/11/26 through 4/12/26 lacked indication an order was obtained for the restraint noted in the 4/11/26 progress note, nor an assessment of R1 was completed after the use of physical restraint. During an interview on 4/15/26 at 12:39 p.m., nursing assistant (NA)-A stated they observed the incident on 4/11/26 between R1 and R2. NA-A observed licensed practical nurse (LPN)-A hold R1 in, "a bear hug from behind," to keep R1 away from the other resident. During an interview on 4/15/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated he was working on 4/11/26, when R1 and R2 were fighting. LPN-A had to, "hold him [R1] in a hug hold." to prevent R1 from getting to R2. LPN-A stated he did not get an order for the hold, nor did he know he needed an order. LPN-A stated he did update R1's provider about R1's aggression towards R2, through the provider online portal but LPN-A did not update R1's provider about the hold. During an interview on 4/15/26 at 2:49 p.m., LPN-B stated on 4/11/26 when LPN-B was working, he witnessed R1 become combative and confrontational when he was intoxicated. R1 overpowered the 1:1 staff who was assigned to R1 to get to R2 and LPN-A had to hold R1; R1 was restrained for safety. LPN-B stated staff did not get an order for the restraint, but should have. During an interview on 4/15/26 at 4:33 p.m., the social services designee (SSD)-A stated if a resident was restrained, the staff should obtain an order, and	F0604		05/06/2026

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 04/16/2026

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F0604 SS = D	Continued from page 3 the incident should be reported to the physician and documented. The SSD-A stated she did not find evidence in the medical record of of the restraint being documented, if an order for the restraint requested and/or received, and if the provider was notified, but would have expected the provider to be notified right away. During an interview on 4/16/26 at 4:19 p.m., the director of nursing (DON) stated, “We do not do restraints here.” DON stated, "a bear hug to hold a resident," was considered a restraint and required a provider's order, notification to the provider and a debriefing following the event which required the restraint be used. DON was unsure if there was an order, a debriefing, or if staff was trained regarding proper use of restraints. The Use of Restraints policy dated April 2017, indicated emergency use of restraint was permitted to prevent a resident from injuring himself or others. The DON had the authority to order the use of emergency restraint and the attending physician must be notified of such use and the reason for the order. The order may be received by telephone and signed by the physician within 48 hours. The order shall include the specific reason for the restraint, how the restraint will be used to benefit the resident’s medical symptom, the type of restraint, and period of time for the use of the restraint. Documentation regarding the use of the restraints shall include: Full documentation of the episode leading to the use of physical restraint that included the resident symptoms but also the conditions, circumstances, and environment associated with the episode A description of the resident’s medical symptoms that warranted the use of restraint How the restraint use benefit the resident by addressing medical symptoms The type of restraint used The length of effectiveness of the restraint time Observation, range of motion, and repositioning flow sheets	F0604		05/06/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)	F0627	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 all	05/06/2026

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F0627 SS = D	Continued from page 4 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the	F0627	Continued from page 4 involuntary discharges are conducted only after full interdisciplinary assessment, documentation of unmet needs, and demonstration of all reasonable efforts to meet resident needs in a safe and appropriate manner. Resident R1’s discharge process reviewed. Residents discharged within the past 30 days were reviewed to ensure compliance with reassessment requirements prior to discharge, especially following hospital or jail returns. Licensed nursing staff, social services, and administration were re-educated on completing a comprehensive reassessment prior to involuntary discharge or return from hospital or jail and on clearly identifying and documenting specific unmet needs the facility cannot meet. Discharge care plans were reviewed and updated as needed. The Director of Nursing and Social Services Director will jointly review all involuntary discharge cases weekly for 4 weeks, then monthly for 2 months. All findings will be reported to the QAPI Committee for ongoing monitoring and system improvement.	05/06/2026

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F0627 SS = D	Continued from page 5 facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services	F0627		05/06/2026

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F0627 SS = D	Continued from page 6 (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and	F0627		05/06/2026

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F0627 SS = D	Continued from page 7 treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s),	F0627		05/06/2026

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F0627 SS = D	Continued from page 8 which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to perform an appropriate discharge for 1 of 1 resident (R1) when R1 was discharged without a reassessment of the facility's ability to meet R1's needs when R1 returned from jail, and failed to identify the specific needs the facility could not meet nor the facility's efforts to meet those needs. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/30/26, indicated intact cognition, no behaviors, and independence in activities of daily living (ADLs). R1's diagnoses included schizophrenia. R1's care plan included the following: 10/9/24 substance abuse/dependence of alcohol and cocaine with interventions to monitor for signs and symptoms of intoxication and update provider as needed 7/23/25 resident did not wish to self-administer medications 8/20/25 resident wished to discharge to the community with interventions to arrange required community supports 11/6/25 indicated R1 had the potential to be physically aggressive to others and had poor impulse control. The care plan indicated R1 had diagnoses that included schizotypal disorder (a mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions), alcohol dependence, anxiety, depression, and bipolar disorder with interventions that included a room change, separation of R1 from specific other residents, and 1:1 supervision starting 4/5/26 after an altercation 1/22/26 resident was seeing a psychology provider for psychosocial support 3/26/26 resident was able to go into the community independently	F0627		05/06/2026

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F0627 SS = D	Continued from page 9 R1’s progress note dated 4/11/26 at 7:00 p.m., R1 had an altercation with R2. R1 overpowered a staff, and was able to strike R2 on the face. Staff on second floor restrained the resident. Police were called, and R1 was taken to jail. R1's medical record dated 4/11/26 through 4/12/26, lacked indication an order was obtained for the use of physical restraint, if the provider was informed of the use of physical restraint, and if an assessment of R1 was completed after the physical restraint. R1's Discharge Summary dated 4/13/26 at 4:52 p.m., indicated R1 discharged due to non-compliance with facility policy. Discharge summary failed to indicate which policy. The Discharge Summary indicated the facility was unable to meet R1’s needs, but failed to specify which of R1's needs the facility could not meet as well as the limitations R1 had in caring for himself. The Discharge Summary lacked indication of where R1 would reside when discharged. Additionally, the Discharge Summary also lacked mention if R1 had post-discharge appointments, medical or non-medical. R1’s provider order dated 4/13/26 at 5:40 p.m., indicated, “Okay to discharge resident to the community due to safety concerns for other residents.” The order lacked indication which of of R1’s needs the facility could not meet and the facility’s efforts to meet those needs. The order lacked indication to discharge R1 with medications. R1’s progress notes indicated the following: 4/13/26 at 6:15 p.m., R1 returned to the facility from jail and was given the notice to discharge due to the safety concerns for other residents. R1 was educated in the presence of the director of nursing (DON) on how to take his medications and R1 verbalized understanding. R1 left the facility at 6:00 p.m., via Uber with all his medications and some of his personal belongings. 4/14/26 at 8:12 a.m., when R1 returned from jail the administrator informed R1 he was discharged for the safety and welfare of the other residents. The facility paid for a motel room, provided the resident with fifty dollars, and offered to send food with R1, which he declined. The administrator provided business cards for himself and the DON and instructed R1 to call the facility if he needed information or food. 4/14/26 at 8:12 a.m., R1 discharged from the facility	F0627		05/06/2026

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F0627 SS = D	Continued from page 10 with written instructions on how to take his medications, face sheet, order summary, provider notes, discharge order, and motel reservation slip. R1's progress notes dated 4/13/26 through 4/14/26, failed to indicate what specific needs the facility could not meet as well as the efforts made to provide those needs. Progress notes also lacked indication an assessment was completed to determine R1's needs upon return to the facility on 4/13/26. During an interview on 4/15/26 at 10:55 a.m., the administrator stated R1 was no longer in the facility for the safety of the other residents. The administrator stated the facility did not perform assessments when R1 returned from the jail because R1 was discharged while he was in jail. The administrated stated R1's return from jail was not the time to complete new assessments. Facility staff instructed R1 in how to take his medications and provided the instructions in writing. R1 stated he understood how to take his medications as prescribed, but staff did not assess R1's ability nor request R1 provide a return demonstration. The administrator stated staff did not assess if R1 knew how to obtain medication refills but R1 could read and write and was alert and oriented. During an interview on 4/15/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated one of R1’s problems was alcohol dependence. R1 was a danger to others when he was drinking so the facility could not meet R1’s needs. The facility offered R1 treatment for alcoholism but R1 declined the intervention. During an interview on 4/16/26 at 10:53 a.m., relocation worker (RW)-A stated R1 was accepted to an assisted living facility but because R1 was discharged from the facility, the RW-A could no longer assist R1 with relocation assistance. RW-A stated R1 would benefit from going where there were activities and 24- hour care, and was concerned about R1 living in a motel due to R1's dependency on alcohol which could impede R1's ability to care for himself. R1's alcohol dependency may have been the cause of R1's recent behaviors. The RW-A further stated R1 had recent memory changes and was concerned these were progressing quickly. R1 was losing things and did not recall the details of their meetings. During an interview on 4/16/26 at 4:19 p.m., the DON stated when R1 was admitted, R1 required nursing care for medication assistance. R1 had	F0627		05/06/2026

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F0627 SS = D	Continued from page 11 verbal and physical aggression and had been intoxicated at times. When residents discharged, they had to have a place to go, be deemed safe to leave, a care conference had to occur to discuss the discharge plan, and required an order to discharge. DON stated R1 had all of those in place. DON stated R1 was safe to discharge to a motel because R1 was cognately intact, could verbalize understanding of how to take his medications, and could read the instructions. DON stated there were progress notes which indicated when R1 was intoxicated he didn't care for himself well. Additionally, DON acknowledged the facility did not do an assessment of R1 when he returned from the jail to assure the facility could no longer care for R1 safely, the jail did not send updated information regarding R1's care needs, and DON had not requested an update. DON stated she was not aware RW-A's referral to another facility and was not aware RW-A had found R1 an assisted living facility in which to reside. During a subsequent interview on 4/16/26 at 5:37 p.m., the administrator stated R1 was referred to another care facility because R1 was unable to find an independent apartment, not because he could not be in an independent living setting. The administrator stated when R1 returned from jail, the facility staff did not assess if R1's needs had changed to determine if the facility could continue to meet R1's needs. The administrator stated he was unsure what information the discharge orders were supposed to include for an unplanned discharge but acknowledged R1's discharge orders did not include the needs the facility could not meet, nor the facility's efforts to meet those needs. The Discharge Summary and Plan policy dated December 2016 indicated the discharge summary will include a recapitulation of stay and final summary of the resident's status at the time of the discharge to include: Current diagnoses Medical history Course of illness, treatment and/ or therapy since entering the facility Current laboratory, radiology, consultation, and diagnostic results Physical and mental functional status Ability to perform ADLs	F0627		05/06/2026

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F0627 SS = D	Continued from page 12 Sensory and physical impairments Nutritional status and requirements Special treatments or procedures Mental and psychosocial status Discharge potential Dental condition Activities potential Rehabilitation potential Cognitive status Medication therapy	F0627		05/06/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	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 all residents receive timely, accurate, and complete written discharge notices in accordance with federal regulations, including all required elements and documentation of delivery. Resident R1's discharge reviewed to identify missing information. All recent discharge notices (past 30 days) were audited to identify reason for discharge, effective date, location, appeal rights, and ombudsman contact information. Social Services and administrative staff were re-educated on the 30-day discharge notice requirement, bed-hold requirements, and allowable exceptions for shortened notice periods. Staff were re-educated on proper documentation of notice delivery, including date, recipient, and method of delivery. The facility reviewed the bed-hold policy and discharge notice policy.	05/06/2026

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 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	**3245 VERA CRUZ AVENUE NORTH , CRYSTAL, Minnesota, 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
F0628 SS = D	Continued from page 13 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F0628	Continued from page 13 The facility ensured inclusion of appropriate advocacy contact information, including the Long-Term Care Ombudsman Program, in all discharge notices. The Director of Social Services or designee will conduct weekly audits of discharge notices for 4 weeks, then monthly for 2 months. Audit results will be reviewed through the QAPI Committee to ensure sustained compliance and continuous improvement.	05/06/2026

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F0628 SS = D	Continued from page 14 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as	F0628		05/06/2026

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F0628 SS = D	Continued from page 15 the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both	F0628		05/06/2026

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F0628 SS = D	Continued from page 16 prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure appropriate discharge documentation was in the medical record for 1 of 1 resident (R1). reviewed for discharge. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 3/30/26, indicated intact cognition, no behaviors, and R1 was independent with activities of daily living (ADLs). R1's diagnoses included schizophrenia. R1's Discharge Summary dated 4/13/26 at 4:52 p.m., indicated R1 discharged due to non-compliance with facility policy and the facility's inability to meet R1’s needs. R1's discharge summary failed to indicate which facility policy R1 was non-compliant with, which of R1's needs the facility was unable to meet, the limitations R1 had in caring for himself at time of discharge, an indication of where R1 was discharging to, and if R1 had post-discharge appointments set-up, medical or non-medical. R1's medical record reviewed 4/11/26 through 4/15/26. R1 medical record failed to include a recapitulation of stay as well as reconciliation of all pre-discharge and post-discharge medications including prescribed medications as well as over-the-counter medications. During an interview on 4/15/26 at 2:49 p.m., licensed practical nurse (LPN)-B stated when a resident discharged, the plan had to be safe. LPN-B stated they heard administrative staff met R1 at the door with a discharge notice when R1 returned to the facility from jail. LPN-B stated with a typical discharge, the facility would find the resident a safe place with community supports. LPN-B did not feel R1 would have that in a motel. During an interview on 4/15/26 at 4:33 p.m., the social services designee (SSD)-A stated R1 had been looking for an apartment, and relocation services were trying to help R1. R1 was very specific about where he wanted to live and rejected a few apartments. SSD-A acknowledged she had not completed R1’s Discharge Summary so was unsure if it met the Discharge Summary criteria. During an interview on 4/16/26 at 4:19 p.m., the director of nursing (DON) stated R1's discharged	F0628		05/06/2026

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F0628 SS = D	Continued from page 17 was involuntary. For involuntary discharge, a resident needed a place to go. R1 was a danger to others in the building, understood how to take his medications, was independent in cares and mobility, and was his own decision-maker. During an interview on 4/16/26 at 5:37 p.m., the administrator stated he was unsure what the documentation requirements were for an unplanned discharge but acknowledged R1 did not receive the information required according to federal regulations. The Discharge Summary and Plan policy dated December 2016 indicated the discharge summary will include a recapitulation of stay and final summary of the resident's status at the time of the discharge to include: Current diagnoses Medical history Course of illness, treatment and/ or therapy since entering the facility Current laboratory, radiology, consultation, and diagnostic results Physical and mental functional status Ability to perform ADLs Sensory and physical impairments Nutritional status and requirements Special treatments or procedures Mental and psychosocial status Discharge potential Dental condition Activities potential Rehabilitation potential Cognitive status Medication therapy	F0628		05/06/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/15/26 and 4/16/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H51891244C (2981559) and H51891353C (2792331).	20000		05/06/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**

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20000	Continued from page 1 As a result of the investigation a licensing order was issued at 0520. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		05/06/2026
20520	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 3 B Subp. 3. Emergency use of restraint. B. If a restraint is needed, a physician's order must be obtained which specifies the duration and	20520	Corrected.	05/06/2026

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20520	Continued from page 2 circumstances under which the restraint is to be used. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to obtain an order for restraint and perform an assessment following the restraint of 1 of 1 resident (R1) reviewed for physical restraint. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 3/30/26, indicated intact cognition, no behaviors, independence in activities of daily living and ambulation. R1's diagnoses included schizophrenia. R1’s care plan included: 10/9/24 substance abuse/dependence of alcohol and cocaine with interventions to monitor for signs and symptoms of intoxication and update provider as needed 7/23/25 resident did not wish to self-administer medications 8/20/25 resident wished to discharge to the community with interventions to arrange required community supports 11/6/25 potential to be physically aggressive to others and poor impulse control. Diagnoses included schizotypal disorder (a mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions), alcohol dependence, anxiety, depression, and bipolar disorder. Interventions included a room change, separation of R1 from specific other residents, and 1:1 supervision starting 4/5/26, after an altercation 1/22/26 R1 was seeing a psychology provider for psychosocial support 3/26/26 R1 was able to go into the community independently R1’s care plan lacked indication restraint use for behavioral intervention. R1’s progress note dated 4/11/26 at 7:00 p.m., indicated R1 had an altercation with another resident, R2. R1 overpowered a staff, and was able to strike R2 on the face. Staff on second floor physically restrained R1. The police were called, and	20520		05/06/2026

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20520	Continued from page 3 R1 was taken to jail. The progress notes lacked indication R1's provider was notified. R1's progress notes reviewed 4/11/26 through 4/12/26 lacked indication an order was obtained for the restraint noted in the 4/11/26 progress note, nor an assessment of R1 was completed after the use of physical restraint. During an interview on 4/15/26 at 12:39 p.m., nursing assistant (NA)-A stated they observed the incident on 4/11/26 between R1 and R2. NA-A observed licensed practical nurse (LPN)-A hold R1 in, "a bear hug from behind," to keep R1 away from the other resident. During an interview on 4/15/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated he was working on 4/11/26, when R1 and R2 were fighting. LPN-A had to, "hold him [R1] in a hug hold." to prevent R1 from getting to R2. LPN-A stated he did not get an order for the hold, nor did he know he needed an order. LPN-A stated he did update R1's provider about R1's aggression towards R2, through the provider online portal but LPN-A did not update R1's provider about the hold. During an interview on 4/15/26 at 2:49 p.m., LPN-B stated on 4/11/26 when LPN-B was working, he witnessed R1 become combative and confrontational when he was intoxicated. R1 overpowered the 1:1 staff who was assigned to R1 to get to R2 and LPN-A had to hold R1; R1 was restrained for safety. LPN-B stated staff did not get an order for the restraint, but should have. During an interview on 4/15/26 at 4:33 p.m., the social services designee (SSD)-A stated if a resident was restrained, the staff should obtain an order, and the incident should be reported to the physician and documented. The SSD-A stated she did not find evidence in the medical record of of the restraint being documented, if an order for the restraint requested and/or received, and if the provider was notified, but would have expected the provider to be notified right away. During an interview on 4/16/26 at 4:19 p.m., the director of nursing (DON) stated, “We do not do restraints here.” DON stated, "a bear hug to hold a resident," was considered a restraint and required a provider's order, notification to the provider and a debriefing following the event which required the restraint be used. DON was unsure if there was an order, a debriefing, or if staff was trained regarding proper use of restraints.	20520		05/06/2026

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20520	Continued from page 4 The Use of Restraints policy dated April 2017, indicated emergency use of restraint was permitted to prevent a resident from injuring himself or others. The DON had the authority to order the use of emergency restraint and the attending physician must be notified of such use and the reason for the order. The order may be received by telephone and signed by the physician within 48 hours. The order shall include the specific reason for the restraint, how the restraint will be used to benefit the resident's medical symptom, the type of restraint, and period of time for the use of the restraint. Documentation regarding the use of the restraints shall include: Full documentation of the episode leading to the use of physical restraint that included the resident symptoms but also the conditions, circumstances, and environment associated with the episode A description of the resident's medical symptoms that warranted the use of restraint How the restraint use benefit the resident by addressing medical symptoms The type of restraint used The length of effectiveness of the restraint time Observation, range of motion, and repositioning flow sheets SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and/or revise policies to ensure restraints orders are obtained upon initiation, with the least restrictive restraint used, and incorporated into the plan of care. The DON or designee should review other residents at risk or who have restraints applied and ensure the physician order obtained for a physical or chemical restraint specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval, and ensure debriefings are held after each incident of restraint. The DON or designee should educate staff to policies and procedures and perform measurable audits for restraint use to ensure all measures are followed. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring.	20520		05/06/2026

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20520	Continued from page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20520		05/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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F0000	INITIAL COMMENTS On 5/6/26, an onsite revisit was conducted to follow up on deficiencies related to a recertification survey exited on 3/27/26. The facility was NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tag was recited: F686 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview,	F0686	F686 SS=D Affected Residents R6 treatment orders were received and have been implemented. R6 care plan has been reviewed and updated with appropriate and personalized interventions. Potentially Affected Residents All other residents with pressure ulcers have the potential to be affected. All other residents with pressure ulcers have been reviewed to ensure they have treatment orders or appropriate and personalized interventions implemented.	05/13/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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F0686 SS = D	Continued from page 1 the facility failed to ensure timely provider follow-up and implementation of treatment interventions for 1 of 3 resident's (R6) reviewed for pressure ulcers. After R6's Stage 2 pressure ulcer was identified, the facility failed to obtain timely treatment orders or ensure appropriate interventions were implemented to prevent worsening of the wound. Findings include: R6's admission minimum data set (MDS), dated 3/26/26, identified R6's cognition was moderately impaired and R6 was frequently incontinent of bowel. Diagnoses included cancer, age-related osteoporosis with pathological fracture of the vertebra, and weakness. The MDS further identified R6 was at risk for pressure ulcers and had moisture-associated skin damage (MASD). Skin treatments included pressure-reducing devices for the chair and bed and application of ointments/medications other than to the feet. R6's care area assessment (CAA), dated 3/26/26, identified R6 was at risk for pressure ulcers related to decreased mobility and transfers associated with fractures. The CAA identified a pressure-relieving bed and cushion were in place. Skin was noted to be intact on admission; however, a red coccyx related to moisture with ointment applied was identified on the 3/25/26 skin assessment. The CAA directed staff to proceed to care plan interventions to minimize risk of skin breakdown. R6's care plan focus, dated 5/4/26 (created 3/20/26 and revised 5/4/26), identified impaired skin integrity related to a Stage 2 pressure injury to the sacral area and left buttock. Interventions included: -3/20/26, inspect skin daily with cares and nursing assistant to report any concerns to the nurse. -4/1/26, pressure-reducing device for chair and weekly skin assessments by licensed nurses. -5/4/26, pressure-reducing air mattress applied, turn and reposition every two hours and as needed and weekly wound progress assessment/documentation by nursing. R6's New Skin Integrity Concern, dated 5/3/26 at 11:30 a.m., identified R6 complained of pain to the buttocks. A skin assessment revealed a skin tear to the left buttock measuring 4 centimeters (cm) x 2 cm and an open area on the coccyx measuring 1 cm x 3 cm, with mild redness noted in the surrounding area. Immediate actions included application of barrier	F0686	Continued from page 1 All other residents with pressure ulcers have had their care plans reviewed and updated to ensure appropriate and personalized interventions. Measures/Systemic Changes Residents with newly identified or worsening skin integrity concerns will be reviewed during morning stand-up until treatment orders and monitoring processes are in place. If provider response is delayed or not received within expected clinical timeframes, licensed nursing staff will escalate unresolved skin integrity concerns through facility chain of command up to and including medical director. Standing house wound care interventions initiated by licensed nurses will be entered into the electronic medical record/TAR to ensure ongoing treatment visibility, documentation, and monitoring pending provider evaluation. These orders will remain active until modified or replaced by the on-call provider, facility NP, or wound NP. The Morning Stand-Up form has been updated to document which residents need to be seen by the facility NP or other providers in the coming days, as well as which residents will be seen weekly by the wound NP. Reviewed and updated standing house orders. Medical director approved standing house orders. Licensed nurses will receive education on standing house orders and new process for addressing skin integrity concerns by implementing standing house orders. IDT team will receive education on the changes to the Morning Stand-Up Form and ensuring timely provider orders for treatment. Monitoring	05/13/2026

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F0686 SS = D	Continued from page 2 cream and Mepilex (border foam dressing). R6 was normally wheelchair bound and does not ambulate, was encouraged to sleep in bed to support repositioning and pressure relief, with a plan to reposition every two hours. R6's photograph of buttocks dated 5/3/26, was reviewed and the coccyx area shows a newly identified open skin injury in the midline of the sacral region. Visually, the skin appears partially disrupted with a shallow, moist-looking open area that was red/pink wound base consistent with superficial tissue loss. The surrounding skin appears irritated and fragile, with surrounding discoloration (redness). There is no visible deep tissue involvement, slough, or necrosis in the image provided. The wound presentation was most consistent with a Stage 2 pressure injury, given the partial-thickness skin loss with exposed dermal tissue and absence of deeper structural involvement. R6's progress note dated 5/3/26 at 1:04 p.m., indicated a new skin condition was identified at 11:30 a.m. R6 was assessed for injury, and the provider, family, and appropriate staff were notified. R6's Situation, Background, Assessment, Response (SBAR) nurse/provider communication form, dated 5/3/26 at 2:41 p.m., documented that the R6 complained of pain to the coccyx during a skin check. Assessment revealed open skin to the coccyx and a skin tear to the left gluteal area. Barrier cream and a Mepilex dressing were applied, and repositioning was planned. R6's skin issue note dated 5/3/26 at 6:46 p.m. identified a new pressure injury to the coccyx (midline). The wound was documented as a Stage 2 pressure ulcer/injury with partial-thickness skin loss and exposed dermis, acquired in-house. The wound measured 1.57 cm in length, 0.96 cm in width, with a total area of 1.16 cm² and no depth noted. There was no undermining or tunneling, and no odor after cleansing. Surrounding tissue was noted to be fragile, with no signs or symptoms of infection and no pain reported. R6's IDT post-investigation note dated 5/4/26 at 10:11 a.m., indicated that the interdisciplinary team reviewed R6's new skin condition incident. Following review of the investigation, the team identified the likely root cause as R6 sleeping in a recliner, as he had consistently refused to sleep in his bed. Facility fax dated 5/4/26 at 1:00 p.m., from nurse	F0686	Continued from page 2 The DON or designee will audit all residents documented to have pressure wounds to ensure standing house orders are in place and provider orders have been received and implemented timely for treatment and monitoring. DON or designee to complete audit weekly on new and existing pressure injuries for 4 weeks, then monthly for 3 months, or until substantial compliance has been achieved. Audit results will be reported to QAPI, and the need for further audits will be determined. Date of Alleged Compliance: 5.15.26	05/13/2026

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F0686 SS = D	Continued from page 3 practitioner (NP-A) was reviewed and identified the provider requested additional information from the skilled nursing facility, specifically a detailed skin assessment of R6's coccyx wound and left gluteal fold skin tear. R6's provider orders, medication administration record (MAR), and treatment administration record (TAR) did not include any treatment orders and further record review noted no indication of daily monitoring from 5/3/26 through 5/5/26 for the newly identified Stage 2 pressure injury to the coccyx area. During an observation and interview on 5/6/26 at 10:42 a.m., R6 was observed lying in bed on his back with heels resting directly on the bed and not offloaded. An alternating pressure mattress was in use and set to cycle every 15 minutes at mid-level firmness. Wound certified nurse practitioner (WCNP)-A assessed both heels and stated they appeared intact. WCNP-A recommended podiatry follow-up for long, thick toenails. Interim registered nurse manager (IRNM)-A assisted with turning R6 onto his right side and lowered his sweatpants for assessment. No dressing was present to the buttocks or coccyx area. R6 was wearing underwear over a gray pull up brief. The left gluteal area was reddened with a small area of skin breakdown, which the WCNP-A identified as dermatitis related to friction and recommended barrier cream treatment. The coccyx wound contained a small open area with a pale gray/white/yellow wound bed. WCNP-A attempted cleansing the area and stated the slough was not easily removable and underlying tissue could not be visualized; therefore, the pressure ulcer was considered unstageable. WCNP-A recommended applying barrier cream to surrounding redness, applying a small amount of Iodosorb to the coccyx wound bed to assist with loosening slough, and covering the area with a foam border dressing to be changed three times weekly and as needed. During an interview on 5/6/26 at 11:10 a.m., registered nurse (RN)-A stated R6 required assistance with most activities of daily living, toileting hygiene, and spent a significant amount of time sitting in his chair. RN-A stated R6's buttocks were very red and macerated on 5/3/26 and he had a Stage 2 pressure injury to the coccyx with a pink wound bed and epithelial tissue present. RN-A stated an aide notified her on 5/3/26 that R6 complained of buttock pain, prompting the skin assessment. RN-A further stated the coccyx wound area that was previously pink was now gray/white in color.	F0686		05/13/2026

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F0686 SS = D	Continued from page 4 During an interview on 5/6/26 at 2:33 p.m., the director of nursing (DON) stated nurse practitioner (NP)-A had been notified by SBAR, either by email or fax, regarding R6's coccyx pressure injury identified on 5/3/26. The DON stated the nurse who identified the wound was RN-A; however, the DON was unsure what provider response had been received or what treatment had been implemented and stated the interim nurse manager might have additional information. During an interview on 5/6/26 at 2:45 p.m., nurse practitioner (NP)-A reviewed the medical record and stated she was notified on 5/4/26 regarding R6's coccyx wound, although the SBAR had been completed on 5/3/26. NP-A stated the nurse who sent the SBAR documented application of barrier cream and Mepilex dressing. NP-A further stated she had requested additional skin assessment information and had not yet provided treatment recommendations because the facility now had a contracted wound nurse practitioner for wound management. NP-A stated she would have expected the facility to follow standing house wound care orders until the resident could be visualized. During a follow-up interview on 5/6/26 at 2:52 p.m., the director of nursing (DON) stated RN-A identified R6's coccyx wound on 5/3/26, completed the assessment, applied barrier cream and Mepilex dressing per standing house orders, and faxed an SBAR to the provider for further direction. The DON stated confirmation showed the provider received the SBAR on 5/4/26 and requested additional information but did not provide treatment orders. The DON stated the coccyx wound was reassessed on 5/5/26 and identified as a Stage 2 pressure injury with epithelial tissue present, and the area was left open to air for healing. The DON stated the facility faxed an additional progress note to the provider on 5/5/26 but received no response. The DON further stated the facility could have followed standing house wound care recommendations for a Stage 2 pressure injury, including implementing a nursing order for daily monitoring and treatment until the resident could be seen by a provider. The DON verified no treatment orders or ongoing monitoring were in place from 5/4/26 until 5/6/26, when the wound was identified as unstageable. During a follow-up interview on 5/6/26 at 3:15 p.m., RN-A stated she assessed R6's coccyx wound on 5/3/26 after the resident complained of buttock pain. RN-A stated the wound had pink epithelial tissue with a small amount of drainage and the surrounding	F0686		05/13/2026

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F0686 SS = D	Continued from page 5 skin was red and macerated. RN-A stated she cleansed the area, applied barrier cream and a Mepilex dressing, and the SBAR was faxed to the provider for further direction. RN-A stated the facility follows standing house wound care recommendations; however, she verified she did not enter nursing orders for ongoing Mepilex dressing changes, daily monitoring, or treatment while awaiting provider response. During an interview on 5/6/26 at 3:46 p.m., IRNA-A stated R6's coccyx wound was reassessed on 5/4/26 and the Mepilex dressing previously applied had been removed and not replaced. IRNM-A stated the facility's standing house wound care recommendations for a Stage 2 pressure injury included application of a Mepilex dressing. IRNM-A stated additional information was faxed to the provider on 5/4/26 after the provider requested more information. IRNM-A further stated staff typically entered a nursing order when using standing house wound care recommendations so treatment would appear on the treatment administration record (TAR) for ongoing monitoring and care; however, no nursing order was entered while awaiting provider orders. IRNM-A stated if the order had been entered on the TAR, staff could have continued treatment and monitoring of the wound until R6 was seen by the wound provider. R6's wound provider order form dated 5/6/26, identified an initial evaluation of an unstageable pressure injury to the coccyx measuring 0.9 cm x 0.7 cm. The wound had no noted drainage and was documented as 100% slough. Treatment orders included removing the old dressing and assessing the wound and peri wound area, cleansing the peri wound with wound cleanser, and applying skin prep to the peri wound. Apply a small amount of Iodosorb to the wound bed and cover with a Mepilex or foam dressing. Dressing changes are to be completed three times per week and as needed for saturation or soiling. During an interview on 5/6/26 at 4:25 p.m., CWNP-A stated R6's coccyx pressure ulcer was classified as unstageable because the wound bed was covered with 100% slough and underlying tissue could not be visualized after attempted cleansing. CWNP-A stated the wound most likely progressed from a Stage 2 pressure injury to unstageable in a short period of time due to R6's immobility, need for staff assistance with activities of daily living, and lack of treatment in place. Facility Standing Orders for Skilled Nursing Facility	F0686		05/13/2026

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F0686 SS = D	Continued from page 6 form, signed 11/24/25, identified staff were to assess all wounds and dressings daily and complete weekly wound measurements unless otherwise ordered by the provider. The standing orders identified minor pressure injuries were to be cleansed with normal saline or non-cytotoxic wound cleanser and covered with a non-adherent dressing and appropriate cover dressing. For Stage 2 or 3 pressure injuries with moderate to heavy drainage, staff were to apply an adhesive foam dressing. For Stage 2 or 3 pressure injuries with minimal drainage, staff were to apply hydrogel to the wound bed and cover appropriately. The standing orders further identified staff may initiate skin sealant to intact peri wound skin, notify the provider by the next business day of a new wound or injury, change dressings every three days and as needed, and initiate a pressure reduction mattress as clinically indicated for residents at high risk for skin breakdown. Facility policy entitled, “Wound Treatment Management,” dated 1/21/26, identified residents with pressure injuries and other wounds were to receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent development of new wounds. The policy identified wound treatment and monitoring were to be individualized, consistent with the resident’s care plan, and monitored for effectiveness. The policy further identified in the absence of treatment orders; the licensed nurse was to notify the provider to obtain orders. Provider notification was required for newly identified wounds or skin breakdown, changes in wound condition, or wound deterioration. The policy identified if provider response was delayed, escalation procedures were to follow the facility chain of command until direction was received. The policy also identified routine wound treatments were to be documented on the treatment administration record (TAR) and ongoing wound effectiveness was to be monitored through continued assessment. Facility policy entitled, “Wound Management and Interdisciplinary Review,” dated 2/11/26, identified newly identified skin concerns, treatment interventions, and active wounds were to be reviewed through daily clinical review and weekly interdisciplinary wound review processes. The policy identified residents with active wounds were to have review of the date the wound was identified, date provider was notified, wound assessment, wound stage, treatment interventions and effectiveness, healing progress, care plan updates, and barriers to healing. The policy further identified wound evaluations, Braden Scale assessments,	F0686		05/13/2026

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F0686 SS = D	Continued from page 7 interdisciplinary progress notes, and care plan updates were to be documented in the electronic health record. Facility policy entitled, “Change of Condition Identification, Documentation, and Response,” dated 4/25/25, identified staff were expected to ensure timely identification, documentation, communication, and response to changes in resident condition using standardized tools and processes, including the E-Interact Change of Condition/SBAR process. The policy identified changes in skin condition, and new or worsening pain warranted immediate escalation and assessment by nursing staff. The policy further identified nursing staff were to notify the provider using the SBAR format, document all communication, orders, and responses in the medical record, implement treatment orders as directed, continue monitoring and reassessing the resident, and update the resident’s care plan with new interventions and monitoring instructions.	F0686		05/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/6/26, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 3/27/26 by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was issued. The complaint H562269020C (2808514 and 2807600) which was found to be out of compliance and issued at F686 at the time of the survey, remained out of compliance.	20000		

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20000	Continued from page 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 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. 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.	20000		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	20900	Corrected	05/13/2026

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20900	Continued from page 2 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure timely provider follow-up and implementation of treatment interventions for 1 of 3 resident's (R6) reviewed for pressure ulcers. After R6's Stage 2 pressure ulcer was identified, the facility failed to obtain timely treatment orders or ensure appropriate interventions were implemented to prevent worsening of the wound. Findings include: Findings include: R6's admission minimum data set (MDS), dated 3/26/26, identified R6's cognition was moderately impaired and R6 was frequently incontinent of bowel. Diagnoses included cancer, age-related osteoporosis with pathological fracture of the vertebra, and weakness. The MDS further identified R6 was at risk for pressure ulcers and had moisture-associated skin damage (MASD). Skin treatments included pressure-reducing devices for the chair and bed and application of ointments/medications other than to the feet. R6's care area assessment (CAA), dated 3/26/26, identified R6 was at risk for pressure ulcers related to decreased mobility and transfers associated with fractures. The CAA identified a pressure-relieving bed and cushion were in place. Skin was noted to be intact on admission; however, a red coccyx related to moisture with ointment applied was identified on the 3/25/26 skin assessment. The CAA directed staff to proceed to care plan interventions to minimize risk of skin breakdown. R6's care plan focus, dated 5/4/26 (created 3/20/26 and revised 5/4/26), identified impaired skin integrity related to a Stage 2 pressure injury to the sacral area and left buttock. Interventions included: -3/20/26, inspect skin daily with cares and nursing assistant to report any concerns to the nurse. -4/1/26, pressure-reducing device for chair and weekly skin assessments by licensed nurses.	20900		05/13/2026

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20900	Continued from page 3 -5/4/26, pressure-reducing air mattress applied, turn and reposition every two hours and as needed and weekly wound progress assessment/documentation by nursing. R6's New Skin Integrity Concern, dated 5/3/26 at 11:30 a.m., identified R6 complained of pain to the buttocks. A skin assessment revealed a skin tear to the left buttock measuring 4 centimeters (cm) x 2 cm and an open area on the coccyx measuring 1 cm x 3 cm, with mild redness noted in the surrounding area. Immediate actions included application of barrier cream and Mepilex (border foam dressing). R6 was normally wheelchair bound and does not ambulate, was encouraged to sleep in bed to support repositioning and pressure relief, with a plan to reposition every two hours. R6's photograph of buttocks dated 5/3/26, was reviewed and the coccyx area shows a newly identified open skin injury in the midline of the sacral region. Visually, the skin appears partially disrupted with a shallow, moist-looking open area that was red/pink wound base consistent with superficial tissue loss. The surrounding skin appears irritated and fragile, with surrounding discoloration (redness). There is no visible deep tissue involvement, slough, or necrosis in the image provided. The wound presentation was most consistent with a Stage 2 pressure injury, given the partial-thickness skin loss with exposed dermal tissue and absence of deeper structural involvement. R6's progress note dated 5/3/26 at 1:04 p.m., indicated a new skin condition was identified at 11:30 a.m. R6 was assessed for injury, and the provider, family, and appropriate staff were notified. R6's Situation, Background, Assessment, Response (SBAR) nurse/provider communication form, dated 5/3/26 at 2:41 p.m., documented that the R6 complained of pain to the coccyx during a skin check. Assessment revealed open skin to the coccyx and a skin tear to the left gluteal area. Barrier cream and a Mepilex dressing were applied, and repositioning was planned. R6's skin issue note dated 5/3/26 at 6:46 p.m. identified a new pressure injury to the coccyx (midline). The wound was documented as a Stage 2 pressure ulcer/injury with partial-thickness skin loss and exposed dermis, acquired in-house. The wound measured 1.57 cm in length, 0.96 cm in width, with a total area of 1.16 cm^2 and no depth noted. There was no undermining or tunneling, and no odor after cleansing. Surrounding tissue was noted to be	20900		05/13/2026

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20900	Continued from page 4 fragile, with no signs or symptoms of infection and no pain reported. R6's IDT post-investigation note dated 5/4/26 at 10:11 a.m., indicated that the interdisciplinary team reviewed R6's new skin condition incident. Following review of the investigation, the team identified the likely root cause as R6 sleeping in a recliner, as he had consistently refused to sleep in his bed. Facility fax dated 5/4/26 at 1:00 p.m., from nurse practitioner (NP-A) was reviewed and identified the provider requested additional information from the skilled nursing facility, specifically a detailed skin assessment of R6's coccyx wound and left gluteal fold skin tear. R6's provider orders, medication administration record (MAR), and treatment administration record (TAR) did not include any treatment orders and further record review noted no indication of daily monitoring from 5/3/26 through 5/5/26 for the newly identified Stage 2 pressure injury to the coccyx area. During an observation and interview on 5/6/26 at 10:42 a.m., R6 was observed lying in bed on his back with heels resting directly on the bed and not offloaded. An alternating pressure mattress was in use and set to cycle every 15 minutes at mid-level firmness. Wound certified nurse practitioner (WCNP)-A assessed both heels and stated they appeared intact. WCNP-A recommended podiatry follow-up for long, thick toenails. Interim registered nurse manager (IRNM)-A assisted with turning R6 onto his right side and lowered his sweatpants for assessment. No dressing was present to the buttocks or coccyx area. R6 was wearing underwear over a gray pull up brief. The left gluteal area was reddened with a small area of skin breakdown, which the WCNP-A identified as dermatitis related to friction and recommended barrier cream treatment. The coccyx wound contained a small open area with a pale gray/white/yellow wound bed. WCNP-A attempted cleansing the area and stated the slough was not easily removable and underlying tissue could not be visualized; therefore, the pressure ulcer was considered unstageable. WCNP-A recommended applying barrier cream to surrounding redness, applying a small amount of Iodosorb to the coccyx wound bed to assist with loosening slough, and covering the area with a foam border dressing to be changed three times weekly and as needed. During an interview on 5/6/26 at 11:10 a.m.,	20900		05/13/2026

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20900	Continued from page 5 registered nurse (RN)-A stated R6 required assistance with most activities of daily living, toileting hygiene, and spent a significant amount of time sitting in his chair. RN-A stated R6's buttocks were very red and macerated on 5/3/26 and he had a Stage 2 pressure injury to the coccyx with a pink wound bed and epithelial tissue present. RN-A stated an aide notified her on 5/3/26 that R6 complained of buttock pain, prompting the skin assessment. RN-A further stated the coccyx wound area that was previously pink was now gray/white in color. During an interview on 5/6/26 at 2:33 p.m., the director of nursing (DON) stated nurse practitioner (NP)-A had been notified by SBAR, either by email or fax, regarding R6's coccyx pressure injury identified on 5/3/26. The DON stated the nurse who identified the wound was RN-A; however, the DON was unsure what provider response had been received or what treatment had been implemented and stated the interim nurse manager might have additional information. During an interview on 5/6/26 at 2:45 p.m., nurse practitioner (NP)-A reviewed the medical record and stated she was notified on 5/4/26 regarding R6's coccyx wound, although the SBAR had been completed on 5/3/26. NP-A stated the nurse who sent the SBAR documented application of barrier cream and Mepilex dressing. NP-A further stated she had requested additional skin assessment information and had not yet provided treatment recommendations because the facility now had a contracted wound nurse practitioner for wound management. NP-A stated she would have expected the facility to follow standing house wound care orders until the resident could be visualized. During a follow-up interview on 5/6/26 at 2:52 p.m., the director of nursing (DON) stated RN-A identified R6's coccyx wound on 5/3/26, completed the assessment, applied barrier cream and Mepilex dressing per standing house orders, and faxed an SBAR to the provider for further direction. The DON stated confirmation showed the provider received the SBAR on 5/4/26 and requested additional information but did not provide treatment orders. The DON stated the coccyx wound was reassessed on 5/5/26 and identified as a Stage 2 pressure injury with epithelial tissue present, and the area was left open to air for healing. The DON stated the facility faxed an additional progress note to the provider on 5/5/26 but received no response. The DON further stated the facility could have followed standing house wound care recommendations for a	20900		05/13/2026

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20900	Continued from page 6 Stage 2 pressure injury, including implementing a nursing order for daily monitoring and treatment until the resident could be seen by a provider. The DON verified no treatment orders or ongoing monitoring were in place from 5/4/26 until 5/6/26, when the wound was identified as unstageable. During a follow-up interview on 5/6/26 at 3:15 p.m., RN-A stated she assessed R6's coccyx wound on 5/3/26 after the resident complained of buttock pain. RN-A stated the wound had pink epithelial tissue with a small amount of drainage and the surrounding skin was red and macerated. RN-A stated she cleansed the area, applied barrier cream and a Mepilex dressing, and the SBAR was faxed to the provider for further direction. RN-A stated the facility follows standing house wound care recommendations; however, she verified she did not enter nursing orders for ongoing Mepilex dressing changes, daily monitoring, or treatment while awaiting provider response. During an interview on 5/6/26 at 3:46 p.m., IRNA-A stated R6's coccyx wound was reassessed on 5/4/26 and the Mepilex dressing previously applied had been removed and not replaced. IRNM-A stated the facility's standing house wound care recommendations for a Stage 2 pressure injury included application of a Mepilex dressing. IRNM-A stated additional information was faxed to the provider on 5/4/26 after the provider requested more information. IRNM-A further stated staff typically entered a nursing order when using standing house wound care recommendations so treatment would appear on the treatment administration record (TAR) for ongoing monitoring and care; however, no nursing order was entered while awaiting provider orders. IRNM-A stated if the order had been entered on the TAR, staff could have continued treatment and monitoring of the wound until R6 was seen by the wound provider. R6's wound provider order form dated 5/6/26, identified an initial evaluation of an unstageable pressure injury to the coccyx measuring 0.9 cm x 0.7 cm. The wound had no noted drainage and was documented as 100% slough. Treatment orders included removing the old dressing and assessing the wound and peri wound area, cleansing the peri wound with wound cleanser, and applying skin prep to the peri wound. Apply a small amount of Iodosorb to the wound bed and cover with a Mepilex or foam dressing. Dressing changes are to be completed three times per week and as needed for saturation or soiling.	20900		05/13/2026

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20900	Continued from page 7 During an interview on 5/6/26 at 4:25 p.m., CWNP-A stated R6's coccyx pressure ulcer was classified as unstageable because the wound bed was covered with 100% slough and underlying tissue could not be visualized after attempted cleansing. CWNP-A stated the wound most likely progressed from a Stage 2 pressure injury to unstageable in a short period of time due to R6's immobility, need for staff assistance with activities of daily living, and lack of treatment in place. Facility Standing Orders for Skilled Nursing Facility form, signed 11/24/25, identified staff were to assess all wounds and dressings daily and complete weekly wound measurements unless otherwise ordered by the provider. The standing orders identified minor pressure injuries were to be cleansed with normal saline or non-cytotoxic wound cleanser and covered with a non-adherent dressing and appropriate cover dressing. For Stage 2 or 3 pressure injuries with moderate to heavy drainage, staff were to apply an adhesive foam dressing. For Stage 2 or 3 pressure injuries with minimal drainage, staff were to apply hydrogel to the wound bed and cover appropriately. The standing orders further identified staff may initiate skin sealant to intact peri wound skin, notify the provider by the next business day of a new wound or injury, change dressings every three days and as needed, and initiate a pressure reduction mattress as clinically indicated for residents at high risk for skin breakdown. Facility policy entitled, "Wound Treatment Management," dated 1/21/26, identified residents with pressure injuries and other wounds were to receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent development of new wounds. The policy identified wound treatment and monitoring were to be individualized, consistent with the resident's care plan, and monitored for effectiveness. The policy further identified in the absence of treatment orders; the licensed nurse was to notify the provider to obtain orders. Provider notification was required for newly identified wounds or skin breakdown, changes in wound condition, or wound deterioration. The policy identified if provider response was delayed, escalation procedures were to follow the facility chain of command until direction was received. The policy also identified routine wound treatments were to be documented on the treatment administration record (TAR) and ongoing wound effectiveness was to be monitored through continued assessment. Facility policy entitled, "Wound Management and	20900		05/13/2026

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20900	Continued from page 8 Interdisciplinary Review," dated 2/11/26, identified newly identified skin concerns, treatment interventions, and active wounds were to be reviewed through daily clinical review and weekly interdisciplinary wound review processes. The policy identified residents with active wounds were to have review of the date the wound was identified, date provider was notified, wound assessment, wound stage, treatment interventions and effectiveness, healing progress, care plan updates, and barriers to healing. The policy further identified wound evaluations, Braden Scale assessments, interdisciplinary progress notes, and care plan updates were to be documented in the electronic health record. Facility policy entitled, "Change of Condition Identification, Documentation, and Response," dated 4/25/25, identified staff were expected to ensure timely identification, documentation, communication, and response to changes in resident condition using standardized tools and processes, including the E-Interact Change of Condition/SBAR process. The policy identified changes in skin condition, and new or worsening pain warranted immediate escalation and assessment by nursing staff. The policy further identified nursing staff were to notify the provider using the SBAR format, document all communication, orders, and responses in the medical record, implement treatment orders as directed, continue monitoring and reassessing the resident, and update the resident's care plan with new interventions and monitoring instructions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and/or revise policies and procedures related to pressure injury identification, treatment, provider notification, and follow-up to ensure timely implementation of treatment orders and appropriate escalation when provider response is delayed. The director of nursing or designee should educate licensed nursing staff on provider notification and follow-up expectations, initiation of interim wound care interventions while awaiting orders, and proper documentation of wound changes and communication. The facility should develop a monitoring system, such as measurable audits of new and existing pressure injuries, to ensure timely provider follow-up, initiation of ordered treatments, and prevention of wound deterioration. The results of these audits should be reviewed through the QAPI process to determine compliance and identify the need for ongoing monitoring or additional corrective action.	20900		05/13/2026

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20900	Continued from page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		05/13/2026