



Protecting, Maintaining and Improving the Health of All Minnesotans

*****PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE (LSC) SURVEYS ARE BEING PROCESSED IN SEPARATE ENFORCEMENT CYCLES. THIS CYCLE INCLUDES EVENT IDs: 1AJ311, YJDL11, and 2DL611*****

Electronically delivered
October 23, 2023

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

RE: CCN: 245289
Cycle Start Date: April 18, 2023

Dear Administrator:

On May 4, 2023, we notified you a remedy was imposed. On July 25, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 14, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 18, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 26, 2023, 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 July 18, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 14, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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



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Electronically delivered

October 23, 2023

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

Re: Reinspection Results
Event ID: YJDL12 and 2DL612

Dear Administrator:

On June 8, 2023 and July 25, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on April 25, 2023 and May 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



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May 4, 2023

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

RE: CCN: 245289
Cycle Start Date: April 18, 2023

Dear Administrator:

On April 26, 2023, we informed you that we may impose enforcement remedies.

On April 25, 2023, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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 Region V Office for imposition. The CMS Region V Office 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 Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2023.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 \$11,292, 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 July 18, 2023, 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 July 18, 2023. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 October 18, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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

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

Nursing Home Informal Dispute Process

The Terrace At Crystal LLC

May 4, 2023

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

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



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May 4, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: YJDL11

Dear Administrator:

The above facility was surveyed on April 24, 2023 through April 25, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

The Terrace At Crystal LLC

May 4, 2023

Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

Please feel free to call me with any questions.



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

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

PRINTED: 10/23/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 4/24/23, through 4/25/23, 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: H52891703C (MN85017) H52891411C (MN92758, MN92791) with deficiencies issued at F553, F641, F684, and F725 H52892009C (MN92971) with deficiencies issued at F553, F725 H52891667C (MN83859) with deficiencies issued at F684, F685, F725 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to	F 553			5/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2023

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 553	Continued From page 1 be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents rights to participate in care planning were honored for 1 of 1 resident (R1) when R1 was denied use of a Purewick (external urinary catheter system) for urinary incontinence. Findings include: R1's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary incontinence,	F 553	1. R1 the affected resident was allowed to go over her care plan and offer up suggestions and guidance to the care she likes to receive. Doctors order was obtained, and the purewick was supplied for the resident. 2. All residents are potentially affected therefore the facility has revised the care conference procedure by allowing residents to go over their care plan during the care conference and give input and		

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F 553	Continued From page 2 depression, anxiety, chronic pain, and morbid obesity. R1's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated R1 was cognitively intact, had an external catheter for urinary incontinence, and required extensive assistance of two staff for bed mobility and toileting. On 4/24/23 at 1:02 p.m. R1 was interviewed and stated she was upset she could not longer have a Purewick system, and she wanted it back. R1 stated the Purewick was discontinued before her latest care conference, and then the care conference was delayed a week so she couldn't advocate for herself. R1 stated she did not agree with the decision to discontinue the Purewick, and wanted to talk to her provider privately about it, but the director of nursing (DON) was in the her room with the provider, and would not allow her to discuss it with her provider alone. R1 described how staff turned and repositioned her to change her incontinence briefs and pads many time a day, how it was horribly painful for staff to turn her and to wear the briefs with maxi pads inside, and stated when staff pulled the pads out of the briefs to change them, the nursing assistants (NA)s would, "Open one side of the brief, yank the old pad out, and stuff another one in under me, inside the brief. That's very painful." R1 stated she had pressure ulcers when she was admitted to the facility, and stated, "I don't want sores where they push and pull the pads out." R1 further stated when she had the Purewick, she was changed twice daily for urinary incontinence, but without it, almost every two hours. R1 stated the DON told her the Purewick was not medically necessary, but R1 stated for her comfort, and to prevent sores, she thought the Purewick was medically	F 553	guidance to the care they would like to receive. 3. The facility will conduct an IDT team education to reinforce to the IDT team that residents have the right to have an active say in their cares and care planning. Education will take place on or before 5/25/2023. 4. Facility will audit care plans during QAPI to ensure that the care plans are completed and that they have resident input. 5. Administrator and Social Services will oversee the education and completion of this plan of correction.		

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F 553	Continued From page 3 necessary. R1 further stated, "I am a [former]victim of sexual assault. It doesn't feel good when they do this and put their hands down there multiple times a day. It upsets me." On 4/24/23 at 3:30 p.m. during an interview licensed practical nurse (LPN)-B stated R1 previously had a Purewick, but it was discussed in a leadership team meeting, and the Purewick was discontinued. LPN-B further stated to qualify to use a Purewick, it had to be medically necessary which meant the resident was incontinent of urine, had skin breakdown in the perineal area, and required a provider order. LPN-B stated R1 had previous skin breakdown but none at this time, but acknowledged pulling pads out without opening the incontinence brief out could cause skin breakdown. On 4/24/23 at 3:56 p.m. during an interview and observation with R1, with LPN-A, NA- D, and NA-E present, LPN-A stated the process to change R1's pad in between incontinent brief changes was to un-tape the brief on both sides, carefully slide the used pad out, clean the perineal area, put barrier cream on, and slide the clean pad back in. All three staff helped change R1's incontinent brief at this time, cleaned her perineal area, and turned R1 to accommodate removing the brief. LPN-A stated it normally required two staff for the process. When R1 was turned, changed and cleaned, R1 was crying and yelled, " Oh God, oh please." R1 moaned, and then yelled again, "Oh please." LPN-A instructed R1 to take a deep breath as staff was turning her, and R1 said, "Owie, owie, owie, oh God. That's hurting me. Give me strength God so I can help the girls." R1 continued to moan and had facial grimacing when staff was cleaning her perineal	F 553			

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F 553	Continued From page 4 area with wet wipes. R1 said, "Owie. Owie. As the pad is pushed under, it scrapes and hurts. The plastic on it hurts. They open one side and pull it out. Sometimes they don't get all the way down when they clean me, just near the top. When we had the Purewick, we only had to change the brief twice a day. Now it's more." NA-A and NA-B acknowledges sometimes the pad was changed opening only one side of the brief. On 4/25/23 at 10:41 a.m. the occupational therapist (OT)-A and physical therapist (PT)-A were interviewed. OT-A stated R1 had not been out of bed since the summer of 2022, and R1 was bed bound and not safe to transfer out of bed. OT-A stated, "We tried to allow her time to pray, sing, deep breathe, and she couldn't do it. " OT-A further stated it was R1's right to refuse to get out of bed and to use the Purewick, and stated R1 was terrified to use the Hoyer (mechanical) lift. PT-A stated it was not realistic for R1 to use a Hoyer lift to go to the commode and stated R1 was bed bound. On 4/25/23 at 12:32 p.m. during an interview the DON stated residents have the right to participate in their care plan and to talk to their providers privately. The DON stated R1 wanted to talk to the provider about a Purewick system, and the provider had already had a conversation with R1 about it, had discontinued it, and there was no need to discuss it again at that time. Additionally, the DON stated the plan was for staff to get R1 out of bed with the Hoyer lift to use the commode instead of using the Purewick. The Resident Rights policy dated February 2021, directed a resident had a right to self-determination, to communicate with and	F 553			

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F 553	Continued From page 5	F 553			
F 641 SS=D	access to people and services both inside and outside the facility, and participate in the care planning process. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the mobility of 1 of 2 residents (R1) reviewed. Findings include: R1's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary incontinence, depression, anxiety, chronic pain, and morbid obesity. R1's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated R1 was cognitively intact, required extensive assistance of two staff for bed mobility and toileting. Additionally, the MDS indicated R1 required two staff to transfer out of bed, one staff for locomotion around her room and off the unit, and had performed locomotion around her room and off the unit once or twice in the 7-day assessment look-back period. On 4/25/23 at 10:41 a.m. during an interview occupational therapist (OT)-A stated R1 had not been out of bed since the summer of 2022, R1 was bed bound, and was not safe to transfer out of bed.	F 641	1. R1's lift mobility status assessment was redone to reflect the true nature of her mobility. 2. This has the potential to affect all residents so lift mobility status assessments were checked by DON and therapy. 3. The facility will conduct training on completion and thoroughness of completing assessments with all adequate staff. Training will take place on or before 05/25/2023. 4. MDS will audit assessments to make sure all assessments are completed in a timely manner. 5. Audits will be 3 times a week x4 weeks. 6. DON, MDS Coordinator or designee will be responsible for the completion of this plan of correction.		5/26/23

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F 641	Continued From page 6 On 4/25/23 at 12:32 p.m. the director of nursing (DON) acknowledged R1's quarterly MDS dated 1/20/23, was not accurate when it indicated R1 did not transfer out of bed, and had not moved around her room or down the hallway in the seven days prior to the 1/20/23, MDS assessment. The DON further stated R1 had not been out of bed since the summer of 2022. The DON also stated the Lift Mobility Status Assessment dated 4/19/23, contradicted the 1/20/23, MDS assessment, and inaccurately stated R1 could sit on the side of the bed. The Resident Assessment policy updated January 2023, indicated the interdisciplinary team conducted appropriate resident assessments and reviews.	F 641			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure weights were performed as ordered for 2 of 2 staff (R1, R2), and skin assessments were performed as ordered for 1 of 1 resident (R2) reviewed.	F 684	1. R1 and R2 weights were obtained. 2. R1 and R2 skin assessments were obtained. 3. These issues have the potential to affect all residents. 4. Education will be provided by 5/25/2023		5/26/23

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F 684	Continued From page 7 Findings include: R1's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary incontinence, depression, anxiety, chronic pain, and morbid obesity. R1's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated R1 was cognitively intact, had an external catheter for urinary incontinence, was incontinent of bowel, and required extensive assistance of two staff for bed mobility and toileting. R1's orders dated 9/2/22, indicated monthly weights. R1's weights document indicated weights on 4/13/23, and no others since 1/29/23. R1's progress notes lacked documentation of refused weights. On 4/24/23 at 1:02 p.m. R1 was interviewed and stated she did not like to get weighed on the Hoyer (mechanical) lift, but she allowed it. R2's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary retention, depression, kidney disease, cardiomyopathy (heart muscle disease), and morbid obesity. R2's annual MDS dated 3/20/23, indicated R2 was cognitively intact, required extensive assistance of two staff for bed mobility, transfers, and toileting, had an indwelling catheter, and was usually incontinent of bowel. R2's orders dated 11/17/22, indicated weekly skin	F 684	or sooner with aides and nurses on obtaining weights as ordered and doing skin assessments as ordered. 5. Skin reviews with baths will be audited by the facility 3x a week for 4 weeks during IDT morning meeting. 6. Weights audits will be completed 3x a week for 4 weeks during IDT morning meeting. 7. DON or designee will be responsible for education and completion of this plan of correction.		

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F 684	Continued From page 8 reviews with a bath on evening shift on Wednesdays. Chart all refusals. Orders dated 6/29/22, indicated weights on Mondays, Wednesdays, and Fridays. R2's April 2023, Treatment Administration Record (TAR) indicated weights were not performed for R2 on 4/4/23, 4/14/23, and 4/24/23, with no documented refusals. The TAR further indicated the weekly skin assessment dated 4/6/23, was not performed because R2 was hospitalized. The skin assessments on 4/12/23, and 4/19/23 were not completed and referred to the progress notes for details. The last weekly bath audit was documented on 3/23/23. R2's progress notes for 4/12/23, and 4/19/23, lacked mention of skin assessment. On 4/24/23 at 11:37 a.m. R2 stated he had not been weighed as often as he was supposed to. R2 also stated he didn't get skin assessments like he should with his current skin issues. On 4/25/23 at 12:32 p.m. the director of nursing (DON) stated the expectations was weights and skin assessments were performed as ordered, and documented if the resident refused. The DON acknowledged R1 and R2 did not have weights and skin assessments as ordered, which could cause staff to miss a decline in health. The facility Weighing and Measuring the Resident policy updated December 2022, directed residents' weights were utilized to provide a baseline and an ongoing record of body weight as an indicator of nutritional status and medical condition. The policy indicated documentation should include date, time, the name and title of	F 684			

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F 684	Continued From page 9 the person performing the weight, and how the resident tolerated the procedure. Additionally, the police indicated if the resident refused the procedure, staff would document the refusal with the reason why, the intervention taken, and notify the nursing supervisor.	F 684			
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide audiology services for 1 of 1 resident (R2) reviewed. Findings include: R2's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary retention, depression, kidney disease, cardiomyopathy (heart muscle disease), and morbid obesity. R2's annual MDS dated 3/20/23, indicated R2 was cognitively intact, and indicated R2 had hearing aids.	F 685			5/26/23
			1. R2's hearing aides were located and found to not be in working order, so the facility contacted audiology specialist to order new hearing aids. 2. This has the potential to affect all residents so facility did an audit to make sure all residents who have hearing aids have them and that they are in good working condition. 3. Education will be done with nursing staff on 5/25/2023 or sooner to ensure that they understand the importance of residents with hearing and or vision impairments having the proper devices in		

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F 685	Continued From page 10 R2's care plan dated 11/20/19, had a focus area for hearing deficit, but lacked mention of hearing aids. On 4/24/23 at 11:37 a.m. R2 stated he had difficulty hearing at the level of conversation. R2's TV was on and the volume was loud enough to hear it clearly from the hallway with the door closed. R2 stated he had given his hearing aids to staff "weeks ago," because his hearing aids were not working correctly, and R1 had not gotten them back. Staff brought R2's lunch tray in to the room, and asked R2 if he needed help with it. R2 asked several times for the staff to repeat questions because he could not hear her. On 4/24/23 at 3:30 p.m. licensed practical nurse (LPN)-B was interviewed and stated R2 told him his hearing aids worked sometimes, and sometimes did not because they sounded muffled when R1 heard his own voice. LPN-B acknowledged he did not know when audiology staff would come to repair the hearing aids. On 4/25/23 at 10:15 a.m. nursing assistant (NA)-C stated she didn't know where R2's hearing aids were, and she was unable to locate them. On 4/25/23 at 10:25 a.m. registered nurse (RN)-A was interviewed and stated the NA care sheets should indicate which residents had hearing aids, and acknowledged R2's care sheet did not. RN-B further stated he had been working on R2's floor for months, and did not know R2 had hearing aids. On 4/25/23 at 12:32 p.m. the director of nursing	F 685	working condition to aid them. 4. DON, Nurse Mangers, or designee are responsible for the completion of this plan of correction.		

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F 685	Continued From page 11 (DON) stated he did not know where R2's hearing aids were, but would try to find them, and either repair or replace them. The DON stated the expectation was R2's hearing aids would be present, in working condition, and stored properly. The DON stated if the hearing aids were not working, they would be repaired as soon as possible.	F 685			
F 725 SS=D	A hearing and vision policy was requested but not provided. Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725			5/26/23

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F 725	Continued From page 12 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available to respond to call lights timely to meet resident's medical, physical, and emotional needs for 2 of 2 residents reviewed for call light wait times. Findings include: R1's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary incontinence, depression, anxiety, chronic pain, and morbid obesity. R1's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated R1 was cognitively intact, had an external catheter for urinary incontinence, was incontinent of bowel, and required extensive assistance of two staff for bed mobility and toileting. R2's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary retention, depression, kidney disease, cardiomyopathy (heart muscle disease), and morbid obesity. R2's annual MDS dated 3/20/23, indicated R2 was cognitively intact, required extensive assistance of two staff for bed mobility, transfers, and toileting, had an indwelling catheter, was usually incontinent of bowel but was continent of bowel at least one time in the 7-day look back period.	F 725	1. R1 and R2's call lights were checked to make sure they are in good working order. 2. This has the potential to affect all residents, so all call lights were checked to ensure they are in good working order. 3. All staff were educated on the importance of answering call lights in a timely manner. Staff also educated that a call light is not to be turned off unless the cares were completed. Education and reeducation will take place on 05/25/2023 or before. 4. The administrator will audit the schedule 5x a week for 4 weeks to ensure that the facility has appropriate staffing levels to answer call lights and to meet the residents' needs. Call light audits (auditing answering times) will be completed 3x a week for 5 weeks to ensure that the answer times are within an acceptable range. IDT team will discuss the audits and educate and reeducate as necessary. 5. Administrator, Staffer, DON and Nurse Managers will be responsible for the completion of this plan of correction.		

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F 725	Continued From page 13 On 4/24/23 at 11:37 a.m. during an interview and observation R2 stated he preferred to be as independent as possible but did use the call light occasionally. R2 stated he has waited up to three hours for staff response to the call light, had been without a working call light for a few days, but the call light was currently working. The Call Light Log indicated a wait time of 31 minutes on 4/20/23, and 49 minutes on 4/24/23. R2 stated he used his call light to get help from staff to the bathroom, to get help moving in bed, or when he didn't feel well. On 4/24/23 at 1:02 p.m. R1 stated during the previous night she activated her call light during the night for help as she had a bowel movement, and wanted her brief changed. R1 stated she waited for hours for help. The Call Light Log indicated the call light was activated at 4:31 a.m. and was on for 186 minutes. On 4/24/23 at 3:30 p.m. licensed practical nurse (LPN)-B stated the facility had enough staff to meet the staffing needs. On 4/24/23 at 3:56 p.m. R1 stated she activated her call light before 3:00 p.m. and a staff came and turned it off and left the room. The Call Light Log indicated the call light was activated at 2:42 p.m., turned off at 2:51 p.m., reactivated at 2:52 p.m., and was on for 63 minutes. Licensed practical nurse (LPN)-A was present in R1's room at this time and stated staff should not turn off the light unless care was completed. On 4/25/23 at 11:42 a.m. nursing assistant (NA)-A was interviewed and stated staff answered call lights as quickly as they could.	F 725			

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F 725	Continued From page 14 On 4/25/23 at 11:57 a.m. NA-B stated sometimes it took longer to answer call lights when there was only one aide on the floor, or if two staff were required to assist a resident and staff had to wait for a second staff to come help. Call light response times were reviewed for R2 from 4/2/23, to 4/24/23. R2 activated his call light 17 times and were as follows: 1 response time between 15 to 19 minutes 2 response times between 30 to 39 minutes 1 response time from 40-59 minutes 2 response times between 60-79 minutes 1 response time of 153 minutes On 4/24/23 at 1:02 p.m. R1 stated the previous night she activated her call light and waited for hours for someone to help her. The Call Light Log indicated the call light was activated at 12:13 a.m., and was on for 22 minutes, and the call light was activated again at 4:31 a.m., and was on for 186 minutes. Call light response times were reviewed for R1 from 4/10/23, to 4/25/23. Response times were as follows: 17 response times between 15 to 19 minutes 20 response times between 20 to 29 minutes 13 response times between 30 to 39 minutes 13 response times between 40 to 59 minutes 4 response times between 60 to 79 minutes 4 response time between 80 to 99 minutes 1 response time of 141 minutes 1 response times of 160 minutes 1 response time of 186 minutes 1 response time of 311 minutes On 4/25/23 at 12:32 p.m. the director of nursing (DON) was interviewed and stated the	F 725			

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F 725	Continued From page 15 expectation was to answer call lights in less than ten minutes, and acknowledged many call response times for R1 and R2 exceeded the 10-minute expectation. Further, the DON stated staff were expected to turn off the call light only if the required care was provided. The Answering Call Lights policy dated November 2022, directed staff to answer the call system immediately to ensure timely response to residents' requests and needs. The Facility Assessment Tool updated 8/1/22, directed to ensure each resident is provided care that allows the resident to maintain or attain the highest practicable physical, mental, and psychosocial well-being. At The Terrace at Crystal Lake, services and care offered are based on resident needs, including toileting programs, and responding to requests for assistance to the bathroom/ toilet promptly to maintain continence and promote resident dignity.	F 725			

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: From 4/24/23, through 4/25/23, 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	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

05/10/23

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52891703C (MN85017) H52892009C (MN92971) H52891411C (MN92758, MN92791) with licensing orders issued at 4658.0400 Subp 4, and 658.0510 Subp 1. H52891667C (MN83859) with a licensing order issued at 4658.0510 Subp 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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	2 000			

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2 000	Continued From page 2 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.	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the mobility of 1 of 2 residents (R1) reviewed. Findings include: R1's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary incontinence, depression, anxiety, chronic pain, and morbid obesity. R1's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated R1 was cognitively intact,	2 550	1. R1's lift mobility status assessment was redone to reflect the true nature of her mobility. 2. This has the potential to affect all residents so lift mobility status assessments were checked by DON and therapy. 3. The facility will conduct training on completion and thoroughness of completing assessments with all adequate staff. Training will take place on or before 05/25/2023. 4. MDS will audit assessments to make sure all assessments are completed in a		5/26/23

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2 550	Continued From page 3 required extensive assistance of two staff for bed mobility and toileting. Additionally, the MDS indicated R1 required two staff to transfer out of bed, one staff for locomotion around her room and off the unit, and had performed locomotion around her room and off the unit once or twice in the 7-day assessment look-back period. On 4/25/23 at 10:41 a.m. during an interview occupational therapist (OT)-A stated R1 had not been out of bed since the summer of 2022, R1 was bed bound, and was not safe to transfer out of bed. On 4/25/23 at 12:32 p.m. the director of nursing (DON) acknowledged R1's quarterly MDS dated 1/20/23, was not accurate when it indicated R1 did not transfer out of bed, and had not moved around her room or down the hallway in the seven days prior to the 1/20/23, MDS assessment. The DON further stated R1 had not been out of bed since the summer of 2022. The DON also stated the Lift Mobility Status Assessment dated 4/19/23, contradicted the 1/20/23, MDS assessment, and inaccurately stated R1 could sit on the side of the bed. The Resident Assessment policy updated January 2023, indicated the interdisciplinary team conducted appropriate resident assessments and reviews. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could assure weights, skin assessments, and assessments are completed according to provider orders. The DON could complete periodic audits to assure compliance of assessments/interventions.	2 550	timely manner. 5. Audits will be 3 times a week x4 weeks. 6. DON, MDS Coordinator or designee will be responsible for the completion of this plan of correction.		

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2 550	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available to respond to call lights timely to meet resident medical, physical, and emotional needs. This deficient practice had the potential to affect all 78 residents who resided in the facility. Findings include: R1's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary incontinence, depression, anxiety, chronic pain, and morbid obesity. R1's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated R1 was cognitively intact, had an external catheter for urinary incontinence, was incontinent of bowel, and required extensive assistance of two staff for bed mobility and toileting.	2 800	1. R1 and R2's call lights were checked to make sure they are in good working order. 2. This has the potential to affect all residents, so all call lights were checked to ensure they are in good working order. 3. All staff were educated on the importance of answering call lights in a timely manner. Staff also educated that a call light is not to be turned off unless the cares were completed. Education and reeducation will take place on 05/25/2023 or before. 4. The administrator will audit the schedule 5x a week for 4 weeks to ensure that the facility has appropriate staffing levels to answer call lights and to meet the residents' needs. Call light audits (auditing answering times) will be completed 3x a week for 5 weeks to ensure that the answer times are within an acceptable	5/26/23

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2 800	Continued From page 5 R2's Admission Record printed 4/25/23, indicated diagnoses of heart failure, urinary retention, depression, kidney disease, cardiomyopathy (heart muscle disease), and morbid obesity. R2's annual MDS dated 3/20/23, indicated R2 was cognitively intact, required extensive assistance of two staff for bed mobility, transfers, and toileting, had an indwelling catheter, was usually incontinent of bowel but was continent of bowel at least one time in the 7-day look back period. On 4/24/23 at 11:37 a.m. during an interview and observation R2 stated he preferred to be as independent as possible but did use the call light occasionally. R2 stated he has waited up to three hours for staff response to the call light, had been without a working call light for a few days, but the call light was currently working. The Call Light Log indicated a wait time of 31 minutes on 4/20/23, and 49 minutes on 4/24/23. R2 stated he used his call light to get help from staff to the bathroom, to get help moving in bed, or when he didn't feel well. On 4/24/23 at 1:02 p.m. R1 stated during the previous night she activated her call light during the night for help as she had a bowel movement, and wanted her brief changed. R1 stated she waited for hours for help. The Call Light Log indicated the call light was activated at 4:31 a.m. and was on for 186 minutes. On 4/24/23 at 3:30 p.m. licensed practical nurse (LPN)-B stated the facility had enough staff to meet the staffing needs. On 4/24/23 at 3:56 p.m. R1 stated she activated	2 800	range. IDT team will discuss the audits and educate and reeducate as necessary. 5. Administrator, Staffer, DON and Nurse Managers will be responsible for the completion of this plan of correction.		

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2 800	Continued From page 6 her call light before 3:00 p.m. and a staff came and turned it off and left the room. The Call Light Log indicated the call light was activated at 2:42 p.m., turned off at 2:51 p.m., reactivated at 2:52 p.m., and was on for 63 minutes. Licensed practical nurse (LPN)-A was present in R1's room at this time and stated staff should not turn off the light unless care was completed. On 4/25/23 at 11:42 a.m. nursing assistant (NA)-A was interviewed and stated staff answered call lights as quickly as they could. On 4/25/23 at 11:57 a.m. NA-B stated sometimes it took longer to answer call lights when there was only one aide on the floor, or if two staff were required to assist a resident and staff had to wait for a second staff to come help. Call light response times were reviewed for R2 from 4/2/23, to 4/24/23. R2 activated his call light 17 times and were as follows: 1 response time between 15 to 19 minutes 2 response times between 30 to 39 minutes 1 response time from 40-59 minutes 2 response times between 60-79 minutes 1 response time of 153 minutes On 4/24/23 at 1:02 p.m. R1 stated the previous night she activated her call light and waited for hours for someone to help her. The Call Light Log indicated the call light was activated at 12:13 a.m., and was on for 22 minutes, and the call light was activated again at 4:31 a.m., and was on for 186 minutes. Call light response times were reviewed for R1 from 4/10/23, to 4/25/23. Response times were as follows: 17 response times between 15 to 19 minutes	2 800			

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2 800	Continued From page 7 20 response times between 20 to 29 minutes 13 response times between 30 to 39 minutes 13 response times between 40 to 59 minutes 4 response times between 60 to 79 minutes 4 response time between 80 to 99 minutes 1 response time of 141 minutes 1 response times of 160 minutes 1 response time of 186 minutes 1 response time of 311 minutes On 4/25/23 at 12:32 p.m. the director of nursing (DON) was interviewed and stated the expectation was to answer call lights in less than ten minutes, and acknowledged many call response times for R1 and R2 exceeded the 10-minute expectation. Further, the DON stated staff were expected to turn off the call light only if the required care was provided. The Answering Call Lights policy dated November 2022, directed staff to answer the call system immediately to ensure timely response to residents' requests and needs. The Facility Assessment Tool updated 8/1/22, directed to ensure each resident is provided care that allows the resident to maintain or attain the highest practicable physical, mental, and psychosocial well-being. At The Terrace at Crystal Lake, services and care offered are based on resident needs, including toileting programs, and responding to requests for assistance to the bathroom/ toilet promptly to maintain continence and promote resident dignity. SUGGESTED METHOD OF CORRECTION: The facility administrator or DON could review and revise policies and staffing schedules to assure adequate staff are available to assist residents in a timely manner and to meet all resident needs.	2 800			

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2 800	Continued From page 8 The administrator or DON could educate all staff on the policies and procedures. A designated staff could monitor the Call Light Logs to assure cares are being delivered and residents are supported to achieve and maintain their highest practicable physical, mental, and psychosocial well-being. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800			