



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 12, 2022

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

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 19, 2022, we informed you of imposed enforcement remedies.

On September 29, 2022, the Minnesota Department of Health and Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F0550 -- S/S: D -- 483.10(a)(1)(2)(b)(1)(2) -- Resident Rights/exercise Of Rights
F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision
20555 -- MN Rule 4658.0405 Subp. 1 -- Comprehensive Plan Of Care; Development

In addition, at the time of this revisit, we identified the following deficiencies:

F0835 -- S/S: F -- 483.70 -- Administration
20130 -- MN Rule 4658.0050 Subp. 1 -- Licensee;general Duties

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 23, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 23, 2022. They will also notify the State Medicaid

Agency that they must also deny payment for new Medicaid admissions effective August 23, 2022.

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.

As we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 23, 2022. However, due to the extended survey the new NATCEP loss date is August 9, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 January 7, 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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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) 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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

**Nursing Home Informal Dispute Process
Minnesota Department of Health**

The Terrace At Crystal LLC

October 12, 2022

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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 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.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS
FOR NURSING HOMES

Electronically delivered

November 14, 2022

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

Re: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On September 29, 2022, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 25, 2022 with orders received by you electronically on August 8, 2022.

State licensing orders issued pursuant to the last survey completed on July 25, 2022, found not corrected at the time of this September 29, 2022 revisit and subject to penalty assessment are as follows:

20555 -- MN Rule 4658.0405 Subp. 1 -- Comprehensive Plan Of Care; Development \$300.00

The details of the violations noted at the time of this revisit completed on September 29, 2022 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of \$300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Nicole Osterloh, RN, Unit Supervisor

Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Program Assurance Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: Shellae.Dietrich@state.mn.us

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on September 29, 2022 additional violations were cited as follows:

20130 -- MN Rule 4658.0050 Subp. 1 -- Licensee;general Duties

They are delineated on the electronically delivered Minnesota Department of Health Statement of

The Terrace At Crystal LLC

November 14, 2022

Page 3

Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2022

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

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On October 29, 2022, we notified you a remedy was imposed. On November 16, 2022 the Minnesota Department 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 November 16, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 23, 2022 be discontinued as of November 16, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 9, 2022.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

November 23, 2022

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

RE: Project Number UILI13

Dear Administrator:

On November 14, 2022, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of \$300.00 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 November 16, 2022 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$600.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling \$319.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$919.00 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

The Terrace At Crystal LLC

November 23, 2022

Page 2

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

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 Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2022

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

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 19, 2022, we informed you that we may impose enforcement remedies.

On July 25, 2022, 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 23, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 23, 2022.

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 August 23, 2022, 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 August 23, 2022. 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 January 7, 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

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) 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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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:

The Terrace At Crystal LLC

August 8, 2022

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: U1LI11

Dear Administrator:

The above facility was surveyed on July 24, 2022 through July 25, 2022 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

The Terrace At Crystal LLC

August 8, 2022

Page 2

"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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/25/2022	
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 On 7/24/22-7/25/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52893429C (MN85293), with a deficiencies cited at (F550, F553 and F656) H52893439C (MN84561), with deficiency cited at (F550) The following complaint was found to be UNSUBSTANTIATED, however related deficiencies were cited. H52893324C (MN85202), with a deficiency cited at (F609) The following complaints were found to be UNSUBSTANTIATED: H52893270C (MN84963) H52893325C (MN85201) H52893487C (MN85289) H52893438C (MN85203 associated w/ MN85094) H52893440C (MN84985) H52893442C (MN85406) 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.			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2022

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	Continued From page 1	F 000			
F 550 SS=D	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. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550			8/18/22

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents needs were addressed in a respectful and dignified manner when residents used their call light to ask for assistance (R2 and R3) and when a sign, indicating date and time cares were performed was hung on the outside a resident's (R2) door. This affected 2 of 3 residents (R2 and R3) reviewed for dignity. Findings include: R2's admission Minimum Data Set (MDS) dated 6/16/22, indicated R2's speech was clear, he was able to make himself understood and was able to understand others. R2 had no cognitive impairment. R2 required physical assistance from two staff for transfers and toilet use, and physical assistance from one staff for dressing. R2 was continent of bladder and had occasional bowel incontinence. R2's face sheet printed 7/25/22, indicated he was responsible for himself. R2's diagnoses include diabetes mellitus, hypertension, cardiovascular disease and below the knee amputation on his right. R2's diagnosis did not include cognitive impairment or other diagnosis that would indicate he was unable to make decisions regarding his	F 550	F550 Resident rights/exercise of rights. 1. Nursing staff will be directed to not hang any information which may contain medical and private information regarding resident's care in any location that is visible to any other resident, staff or visitor. 2. All residents have the potential to be affected. 3. Nursing staff will be educated on dignity, resident rights and HIPA. 4. Social service or designee will conduct daily audits for four weeks, weekly audits for three weeks and then as needed. Any issues found will be brought to QAPI. 5. 8/18/2022		

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F 550	Continued From page 3 care. R2's care plan printed 7/25/22, initiated date 6/21/22, failed to identify R2's needs specific to activities of daily living (ADLs), toileting, bowel incontinence and fall risk. On 7/24/22, at 1:59 p.m. R2 stated on 6/21/22 he put his call light on after an episode of bowel incontinence. R2 was not able to recall the exact time but stated it was during the day. R2 stated he waited approximately two hours for a staff member to come to his room to find out what he needed and before he got help. R2 stated it made him feel ashamed, like a child, "I am a grown man. This shouldn't happen." Since that incident, R2 stated he cleaned himself up after an incontinent episodes and called the staff when he is finished. R2 indicated he is worried the staff will not come when he calls, and he will have to sit in his bowel for a long period of time if he doesn't do it himself. R3's admission MDS dated 5/31/22, indicated R3's speech was clear, vision and hearing were adequate, and she could make herself understood. R3 required physical assistance from two staff for all ADLs. R3's quarterly review dated 7/19/22, indicated R3 was alert and oriented to person, place, time, and self. R3 was incontinent of both bowel and bladder. R3's care plan printed 7/25/22, initiated 5/27/22, indicated R3 wore incontinence products. R3 required physical assistance from staff to check and change incontinence products every two	F 550			

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F 550	Continued From page 4 hours and as needed. R3's face sheet, printed 7/25/22, indicated R3's diagnoses included major depressive disorder and general anxiety. On 7/24/22, at 4:00 p.m. lined sheets of paper were observed on the outside of R3's door. Information on this sheet included sections for staff to fill in date, time, staff name and to indicate yes or no if care was provided. Completed information noted 7/5/22-7/9/22 and 7/17/22-7/22/22. On 7/25/22, at 7:24 a.m. R3 stated she asked for assistance earlier to change her incontinence product but did not get it. R3 indicated this had happened several times. She requested surveyor to witness long wait times and turned the call light, on to requested help. R3 agreed for the surveyor to leave the room until the call light was answered. On 7/25/22, at 7:33 a.m. two staff were observed at the nursing desk. A message bar by the nursing desk showed R3's room number, indicating her call light was on. During this time, three staff walked past R3's room. At 7:35 a.m. one staff knocked on R3's door, opened it, did not talk with R3, immediately closed the door and walked away. At 7:55 a.m. NA-C knocked on R3's door and entered the room. NA-C turned off R3's call light, then changed R3's incontinent product as requested. On 7/25/22, at 7:59 a.m. NA-C left R3's room then returned with a sheet of lined paper with sections for staff to fill in date, time, staff name and to indicate yes or no if care was provided.	F 550			

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F 550	Continued From page 5 NA-C wrote her name, date, time and "yes" to indicate care was provided. NA-C stated the nurse manager gave direction to complete the form. It is used because R3 will put her light on to request the same care that has already been provided. NA-C stated she was aware R3's call light was on when she heard it on the pager she was wearing and because she saw it on the message board by the nursing desk. NA-C was not aware how long R3's light was on. On 7/25/22, at 8:02 a.m. R3 was not able to indicate how long her light is on for but stated it does take a long time for staff to answer it. R3 confirmed she puts her light on frequently, "I never know when they will actually come to check on me. I get anxious when they don't come in, so I put my light on again and again." R3 stated she did not know about the sheets of paper on the outside of her door, she did not know when it started or why they were there. R3 stated she was worried staff would write whatever they wanted on the paper to make it look like they had been in her room and helped her with care even though they did not. "I feel like they don't trust me, don't believe me when I call for help. It's just another reason to not put my light on. Why should I, if they aren't going to believe that I need help?" On 7/25/22, at 1:39 p.m. nurse manager (NM)-A confirmed he directed staff to use the sheet and hang it outside R3's door. NM-A stated the sheet was used to minimize the number of staff entering R3's door. NM-A confirmed, R3 did not have a medical reason to limit the number of staff who entered her room. NM-A stated he discussed the sheet with R3 and R3 signed a risk versus benefit regarding the sheet.	F 550			

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F 550	Continued From page 6 On 7/25/22, at 2:06 p.m. Director of Nursing (DON) stated she expected all residents were treated with dignity. DON indicated staff were getting too comfortable with thinking they don't need to meet the resident where they are and care to the residents needed to be more person centered. DON stated she was not aware that R2 had his call light on for two hours after he was incontinent of bowel. She indicated it would likely make a resident feel depressed, sad, and mad. Further, DON was not aware of the sheets hanging outside R3's door until she worked the overnight shift on 7/24/22. DON expected a form like that was hung inside the door or inside the room on a clip board. DON stated not everyone needs to know what is happening in her room.	F 550			
F 553 SS=D	Facility form, risk versus benefit for the sign outside R3's door was request but was not received. Facility policy on dignity was requested but was not received. 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 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	F 553			8/18/22

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F 553	Continued From page 7 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 interview and document review the facility failed to ensure resident participation in the development and revision of care plans for 1 of 3 residents (R2) reviewed for care planning. Findings include: R2's admission Minimum Data Set (MDS) dated 6/16/22, indicated R2's speech was clear, he was able to make himself understood and was able to understand others. R2 had no cognitive impairment. R2's face sheet printed 7/25/22, indicated he was responsible for himself. R2's diagnosis did not include cognitive impairment or other diagnosis that would indicate he was unable to make	F 553	F553 Right to participate in care planning 1. R2 will be asked to actively participate in his care planning and notified in advance of revisions to his care plan. 2. All residents have the potential to be affected. 3. IDT will be re-educated on the importance of allowing residents to participate in their care planning. 4. Social services or designee to conduct weekly audits for four weeks then as needed. Any issues found will be brought to QAPI. 5. 8/18/2022		

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F 553	Continued From page 8 decisions regarding his care. R2's diagnoses include diabetes mellitus, hypertension and cardiovascular disease. R2's care plan printed 7/25/22, indicated R2's diet as no added salt, and 2000cc fluid restriction. R2's care plan indicated the diet was initiated 6/26/22. Facility document, Centennial Garden Nutrition Assessment dated 6/20/22, completed for R2 and signed by the facility Dietician, indicated a request would be made for R2's diet to be written as low concentrated sweets, no added salt, and 2000cc fluid restriction. On 7/24/22, at 3:59 p.m. R2 indicated he was not aware that his diet was changed after admission. R2 stated he found out about the fluid restriction when he asked for his water pitcher to be filled and staff told him he couldn't have more water due to the fluid restriction, he was allowed specified amounts at mealtime and between meals. R2 stated he asked for a reason for the diet change, but was not given one. R2 stated he preferred to manage his own fluids and did not understand why the change was necessary. On 7/25/22, at 11:29 a.m. the Dietician (D)-A confirmed she completed the nutrition assessment for R2 and made the recommendation for the diet change. D-A stated she made her recommendation based on hospital records and interviews with facility staff. D-A confirmed she did not talk with R2 regarding the diet change. D-A expected the Dietary Director (DD) notified R2 of changes to his diet. On 7/25/22, at 12:16 p.m. DD stated she was not	F 553			

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F 553	Continued From page 9 involved in diet changes but does talk with the residents about diet and food preferences. DD confirmed she did not talk with R2 about his diet or the change to it. On 7/25/22, at 1:10 p.m. the Director of Nursing (DON) confirmed R2's diet on his care plan included low concentrated sweets, no added salt and 2000cc fluid restriction. DON indicated she expected residents and their representatives were involved in care planning. DON stated R2 should have been made aware of the change to his diet and the reason for it. Facility policy, Care Planning- Interdisciplinary Team, undated, indicated the resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.	F 553			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609			8/18/22

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F 609	Continued From page 10 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation abuse to the State agency (SA) within two hours of being informed of the allegation for 1 of 1 residents (R1) reviewed for reports of abuse. Findings include: A Facility Reported Incident (FRI) submitted to the SA on 7/17/22, at 9:58 p.m. identified on 7/16/22 at approximately 12:30 p.m. R1 returned to the facility with documentation from the hospital that noted concerns included report of a facility nursing assistant "swatting or slapping" R1 which caused bruising to R1's body. On 7/17/22, R1 reported to the Dietary Director (DD) the nurse on the third floor beat her up and caused bruising. The FRI noted the date and time of the incident as 7/16/22, at 5:00 p.m. On 7/25/22, at 9:15 a.m. DD confirmed, during a meeting with R1 on 7/17/22, R1 reported the nurse working at the facility on the third floor hit her which caused bruising on both her arms. DD	F 609	F609 Reporting of alleged violations 1. Staff have been educated on the importance of reporting incidents in a timely manner. 2. All residents have the potential to be affected. 3. All IDT will be re-trained and have access to the OHFC process to be able to submit an incident. 4. The administrator and/or designee will be informed immediately when an incident has been identified to ensure the incident is reported in a timely manner. 5. The IDT will review the process at QAPI to identify potential barriers.		

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

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F 609	Continued From page 11 stated she immediately reported it to the Director of Nursing (DON). On 7/25/22, at 9:26 a.m. The DON confirmed the hospital document, "After Visit Summary" dated 7/16/22, indicated R1 reported an allegation of abuse from a facility staff member which resulted in bruising. The DON stated she expected the nurse to read the hospital report at the time R1 returned from the hospital. When it was noted R1 made an allegation of abuse against a facility staff, the DON expected the nurse to report the allegation to either the Administrator or the DON immediately so a report could be made to the SA according to facility policy. The DON stated she was not made aware of the allegation until 7/17/22 when the DD reported it to her. Facility policy, Abuse Investigation and Reporting, review date 12/6/21, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment will be reported to the State licensing/certification agency responsible for surveying/licensing the facility. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than two hours if alleged violation involves abuse or has resulted in serious bodily injury.	F 609			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657			8/18/22

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F 657	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan to include assessed and identified needs for 1 of 3 residents (R2) who's comprehensive care plans were reviewed. Findings include: R2's admission Minimum Data Set (MDS) dated 6/16/22, indicated R2's speech was clear, he was able to make himself understood and was able to understand others. R2 had no cognitive impairment. R2 required physical assistance from two staff for transfers and toilet use, and physical assistance from one staff for dressing. R2's face sheet printed 7/25/22, indicated he was	F 657	F657 Care plan timing and revisions 1. All residents care plans will be completed within 7 days of admission. 2. All residents have the potential to be affected. 3. IDT will be re-educated on the importance of completing care plans within the allotted timeframe. 4. Social services or designee to conduct weekly audits for four weeks then as needed. Any issues found will be brought to QAPI. 5. 8/18/2022		

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F 657	Continued From page 13 responsible for himself. R2's diagnoses include diabetes mellitus, hypertension, cardiovascular disease and right, below the knee amputation. R2's diagnoses did not include cognitive impairment or other diagnosis that would indicate he was unable to make decisions regarding his care. R2's care plan printed 7/25/22, initiated date 6/21/22, failed to identify R2's needs specific to; activities of daily living (ADLs), toileting, bowel incontinence and fall risk. On 7/25/22, at 11:13 a.m. nursing assistant (NA)-A indicated she was aware of residents' specific needs by looking at the care plan. NA-A reviewed R2's care plan and confirmed she was not able to determine R2's need for assist with ADLs or his fall risk. NA-A stated, because R2 was able to communicate his needs, she would ask him what he needed. On 7/25/22, at 2:06 p.m. the Director of Nursing (DON) confirmed R2's care plan was not completed. DON expected the comprehensive care plan was completed per facility policy. DON stated the care plan was required so the residents received the care they needed and desired in a manner that was consistent and appropriate. Facility policy, Care Planning- Interdisciplinary Team, undated, indicated a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).	F 657			

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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: On 9/27/22 through 9/29/22, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 7/25/22 by the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure and were found to be NOT to be corrected. The original licensing order	{2 000}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{2 000}	Continued From page 1 issued will remain in effect. Penalty assessment issued. The complaint H52893429C (MN85293), which was SUBSTANTIATED, with a licensing order previously issued at 0555 at the time of the survey and was found NOT to be corrected and remains OUT OF COMPLIANCE. 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 surveyors 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	{2 000}			

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{2 000}	Continued From page 2 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.	{2 000}			
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility. Refer to 0555.	2 130			

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2 130	Continued From page 3 Findings include: Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained. Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated, "No plans of correction have been done ...the past DON didn't complete anything ...no education ...nothing ...so we know you will have to recite them all and we are now going to get to work on it all." No policy or procedure on administrative oversight was provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The governing body and or medical director should review current policies and procedures, and industry standards for implementing appropriate changes for the quality, health, and safety of their resident population. The governing body and or medical director should complete audits of resident cares, resident satisfaction surveys, staffing patterns and staff competency. etc. to ensure resident needs are consistently met and deficient practice is corrected. The results of those measurable audits should be taken to the QAPI committee to determine ongoing compliance with oversight of facility operations. TIME PERIOD FOR CORRECTION: 21 days.	2 130			
{2 555}	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development	{2 555}			

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{2 555}	Continued From page 4 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to assess residents and develop a comprehensive care plan to include specific needs for 3 of 3 residents (R4, R5, and R6) who required assistance with Activities of Daily Living (ADL). Findings include: R4's admission Minimum Data Set (MDS) dated 9/21/22, included diagnoses of wedge compression fracture of T11-T12 vertebrae, post traumatic stress disorder (PTSD), chronic pain, spinal stenosis, urinary incontinence, and traumatic brain injury (TBI). If further included moderately impaired cognition and required limited assistance with bed mobility and toileting and was independent with all other ADL's. R4's care plan dated 9/19/22, lacked any indication R4 required assistance with ADL's.	{2 555}			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE TERRACE AT CRYSTAL LLC

**3245 VERA CRUZ AVENUE NORTH
CRYSTAL, MN 55422**

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{2 555}	Continued From page 5 R5's admission MDS dated 9/25/22, included diagnoses of syncope and collapse, low back pain, chronic obstructive pulmonary disease (COPD), depression, and malignant neoplasm of the prostate. If further included moderately impaired cognition and required extensive assistance with dressing, independent with eating, and limited assistance with all other ADL's. R5's progress noted dated 9/19/22, included "Resident eloped from hospital with use of a walker and made it home. Both family members requested that a [WanderGuard] WG be placed on Resident and Writer denied being able to do that with no presenting elopement behaviors but both agreeable to 30 minute safety checks while awake. R5's progress note dated 9/20/22, included "Resident is [alert and oriented] AO, understands and can be understood. Able to make needs known. slept all night. Continued with Q15 minutes check d/t risk of elopement." R5's care plan lacked any indication of R5 being an elopement risk. R6's progress note dated 9/21/22, included "Resident arrived at facility @ 1500 on a stretcher via ambulance and accompanied by two paramedics. Resident is left foot amputee. Resident is alert and oriented X4. Writer welcome resident to room and orient him on the call light. He as a condom catheter and Ostomy bag. Skin has discoloration on the back and have multiple wounds. Resident is assist X2, with wound cares and transfer. Diet is puree and take pills whole with apple sauce."	{2 555}		

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{2 555}	Continued From page 6 R6's care plan only contained activities and lacked any indication of the increased ADL care required for R6. During an interview on 9/28/22, at 11:20 a.m. licensed practical nurse (LPN)-A stated care plans were initiated by the director of nursing (DON). Once the care plans were created, any nurse could and should update them as needed as changes occurred. LPN-A verified R4, R5, and R6's care plans were lacking the above specifics for ADL cares which included ADL's, diet/nutrition, and risk for elopement. LPN-A would expect those areas to be included in the comprehensive care plan. Review of the undated, Facility policy, Care Planning- Interdisciplinary Team, indicated a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one	{2 555}			

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{2 555}	Continued From page 7 (21) days.	{2 555}			

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{F 000}	INITIAL COMMENTS Surveyor: 43007 On 9/27/22 through 9/29/22, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 7/25/22. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The complaint UNSUBSTANTIATED: H52893324C (MN85202), with a related deficiency previously cited at F609 was reviewed for compliance and was found to be CORRECTED. The complaints SUBSTANTIATED: H52893429C (MN85293), with deficiencies previously cited at F553 was found to be CORRECTED, however F657 was NOT corrected and remains OUT OF COMPLIANCE. H52893439C (MN84561), with deficiency previously cited at F550 and was also found NOT to be corrected and remains OUT OF COMPLIANCE. 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

10/20/2022

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

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{F 000}	Continued From page 1	{F 000}			
{F 550} SS=D	Surveyor: 43084 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	{F 550}			11/4/22

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{F 550}	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 46885 Based on observation, interview and record review the facility failed to ensure residents needs were addressed in a respectful and dignified manner when residents used their call light to ask for assistance (R3). Findings include: R3's significant change Minimum Data Set (MDS) dated 7/20/22 indicated intact cognition, R3 required extensive assistance in toileting and was always incontinent of urine. R3's medical diagnoses list in point click care indicated R3 had the following diagnoses: other specified urinary incontinence, generalized anxiety disorder, type two diabetes with hyperglycemia, and chronic systolic congestive heart failure. R3's care plan revised 5/27/22, indicated R3 had	{F 550}	F550: 1. R3 call light placed within resident's reach 2. All residents call lights placed within reach 3. Staff educated on placing resident's call light within reach and timely response time 4. To ensure that the call lights are being answered in a timely manner the facility will change its current system to have group sheets for aides and nurses to have assigned rooms ensuring that the call lights are answered in a timely manner. 5. Groups will be audited individually for compliance to call light response time once a day. 6. All call lights will be checked weekly by maintenance to ensure that the call lights are operational. 7. Call light audits including timely response times will be conducted by DON or designee. Daily audits for 1 week on		

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{F 550}	Continued From page 3 urge and mixed bladder incontinence and required incontinence changes every two hours and as needed. R3's care plan revised 8/12/22, indicated R3 needed her call light within reach and R3 needed prompt response to all requests for assistance. R3's device activity log on 9/28/22, indicated an average response time of 26 minutes, 13 seconds for R3's call light to be answered. At 7:13 a.m., the log indicated R3 waited 90 minutes, 40 seconds for her call light to be answered. R3's medication administration record (MAR) for September 2022, indicated R3 was taking furosemide (a diuretic) 20 milligrams (mg) daily for heart failure. During interview and observation on 9/28/22, at 9:58 a.m. a sheet of paper was located on R3's door that stated, "Due to privacy, sign sheet has move [SIC] to the resident's closet." R3 stated at 10:00 a.m. that she was going to cry and stated the night nursing assistant (NA) changed her pad at 5:45, left at six and did not get her pad changed until 9:30 and stated she sat in a wet pad and stated she takes Lasix and needed to be changed frequently. R3 stated 10 to 15 minutes is a long enough time to wait for her call light to be answered. R3 stated she felt anxious and afraid because she did not know how long she would have to wait in a wet pad before someone answered her call light. During interview and observation on 9/28/22, at 10:05 a.m. R3 stated she had her light on for 20 minutes. The red button was on in R3's room. The sheet in R3's closet indicated a staff person	{F 550}	alternating shifts, then 3x per week for 2 weeks on alternating shifts, then 1x per week for 1 week on alternating shifts 8. All issues will be brought to QAPI		

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{F 550}	Continued From page 4 signed the sheet on 9/28/22, at 9:15 a.m. R3 stated that her skin burned from sitting in the pad and stated it was a chronic problem trying to get her pad changed. At 10:15 a.m. R3's light was still on and had not received help. R3 stated she felt afraid she would not be attended to timely if she couldn't breathe or if she was having a heart attack. At 10:19 a.m. R3's call light was still on. During observation on 9/28/22, at 10:28 am registered nurse (RN)-A came down the hall and asked R3 if she needed help. During interview and observation on 9/28/22, at 10:30 a.m. maintenance staff-A stated when a resident needs help, the room number will light up at the end of the hallway. At 10:31 a.m. R3's light was still on and RN-A left R3's room. During observation at 9/28/22, at 10:31 a.m. nursing assistant (NA)-A opened R3's door, went in room and left and stated she had to go to the bathroom and would be back and turned off R3's call light. At 10:36 a.m. NA-A returned to assist R3. During interview and observation on 9/28/22, at 10:47 a.m. NA-A stated R3 did not have the correct incontinent products and would inform the health unit coordinator. NA-A also stated R3 was supposed to have one to one assist and has staff with R3 for 16 hours, but stated the staff person called in sick. During interview on 9/28/22, at 11:03 a.m. RN-A stated when a resident turns on their call light, the light should remain on until the resident's needs are met. RN-A stated staff should not turn off the call light and tell a resident they will be back, they	{F 550}			

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{F 550}	Continued From page 5 need to sort it out and then turn off the call light. During interview on 9/28/22, at 12:45 p.m. licensed practical nurse (LPN)-A stated call lights should be answered as soon as possible within five minutes and stated R3 is usually one to one, but stated the aide was ill. Facility policy Resident Call Light System indicated all call lights should be answered promptly whether or not staff were assigned to the resident. It also indicated not to make a resident feel staff were too busy to provide assistance and indicated further assistance is offered before leaving the room.	{F 550}			
{F 657} SS=D	Surveyor: 43084 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	{F 657}			10/28/22

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{F 657}	Continued From page 6 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 42586 Based on interview and document review the facility failed to develop a comprehensive care plan to include assessed and identified needs for 3 of 3 residents (R4, R5, and R6) who required assistance with Activities of Daily Living (ADL). Findings include: R4's admission Minimum Data Set (MDS) dated 9/21/22, included diagnoses of wedge compression fracture of T11-T12 vertebrae, post traumatic stress disorder (PTSD), chronic pain, spinal stenosis, urinary incontinence, and traumatic brain injury (TBI). If further included moderately impaired cognition and required limited assistance with bed mobility and toileting and was independent with all other ADL's. R4's care plan dated 9/19/22, lacked any indication R4 required assistance with ADL's.	{F 657}	1. R4, R5, R6 care plan were updated to reflect correct care levels 2. All residents care plans were updated to reflect correct care levels 3. Nurse Managers educated on how to update care plan and care importance 4. IDT will address care plans as needed in morning meeting every day. Audits will be conducted 3x a week for 3 weeks by DON or designee. 5. All concerns will brought to QAPI		

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{F 657}	Continued From page 7 R5's admission MDS dated 9/25/22, included diagnoses of syncope and collapse, low back pain, chronic obstructive pulmonary disease (COPD), depression, and malignant neoplasm of the prostate. If further included moderately impaired cognition and required extensive assistance with dressing, independent with eating, and limited assistance with all other ADL's. R5's progress noted dated 9/19/22, included "Resident eloped from hospital with use of a walker and made it home. Both family members requested that a [WanderGuard] WG be placed on Resident and Writer denied being able to do that with no presenting elopement behaviors but both agreeable to 30 minute safety checks while awake. R5's progress note dated 9/20/22, included "Resident is [alert and oriented] AO, understands and can be understood. Able to make needs known. slept all night. Continued with Q15 minutes check d/t risk of elopement." R5's care plan lacked any indication of R5 being an elopement risk. R6's progress note dated 9/21/22, included "Resident arrived at facility @ 1500 on a stretcher via ambulance and accompanied by two paramedics. Resident is left foot amputee. Resident is alert and oriented X4. Writer welcome resident to room and orient him on the call light. He as a condom catheter and Ostomy bag. Skin has discoloration on the back and have multiple wounds. Resident is assist X2, with wound cares and transfer. Diet is puree and take pills whole with apple sauce."	{F 657}			

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{F 657}	Continued From page 8 R6's care plan only contained activities and lacked any indication of the increased ADL care required for R6. During an interview on 9/28/22, at 11:20 a.m. licensed practical nurse (LPN)-A stated care plans were initiated by the director of nursing (DON). Once the care plans were created, any nurse could and should update them as needed as changes occurred. LPN-A verified R4, R5, and R6's care plans were lacking the above specifics for ADL cares which included ADL's, diet/nutrition, and risk for elopement. LPN-A would expect those areas to be included in the comprehensive care plan. Review of the undated, Facility policy, Care Planning- Interdisciplinary Team, indicated a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). Surveyor: 43084 Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 657}			
F 835 SS=F		F 835			11/4/22

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F 835	Continued From page 9 Surveyor: 43007 Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility. Refer to F550 and F657 Findings include: Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained. Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated, "No plans of correction have been done ...the past DON didn't complete anything ...no education ...nothing ...so we know you will have to recite them all and we are now going to get to work on it all." No policy or procedure on administrative oversight was provided by the end of the survey.	F 835	1. Facility obtained a full time DON 2. Administrator reviewed policies and advised as necessary 3. Administrator education DON on the importance of correcting deficiencies 4. IDT sat and reviewed deficiencies and put together a plan of correction 5. IDT team will meet daily to ensure that all audits are being completed according to the schedules set for respective audits. 6. Administrator will meet with DON daily to ensure that audits are being done and plan of correction is being followed. 7. Administrator will meet with Regional Director of Operations weekly to update on status and progress of POC and other pertinent information regarding the facility.		

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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: Surveyor: 43007 On 9/27/22 through 9/29/22, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 7/25/22 by the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with	{2 000}			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

10/20/22

Minnesota Department of Health

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{2 000}	Continued From page 1 the MN State Licensure and were found to be NOT to be corrected. The original licensing order issued will remain in effect. Penalty assessment issued. The complaint H52893429C (MN85293), which was SUBSTANTIATED, with a licensing order previously issued at 0555 at the time of the survey and was found NOT to be corrected and remains OUT OF COMPLIANCE. 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 surveyors 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	{2 000}		

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{2 000}	Continued From page 2 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.	{2 000}		
2 130	Surveyor: 43084 MN Rule 4658.0050 Subp. 1 Licensee; General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	2 130		10/28/22

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2 130	Continued From page 3 This MN Requirement is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility. Refer to 0555. Findings include: Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained. Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated, "No plans of correction have been done ...the past DON didn't complete anything ...no education ...nothing ...so we know you will have to recite them all and we are now going to get to work on it all." No policy or procedure on administrative oversight was provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The governing body and or medical director should review current policies and procedures, and industry standards for implementing	2 130	1. Facility obtained full time DON 2. Administrator educated DON on the importance of correcting deficiencies 3. IDT sat and reviewed deficient practices and put together plan of correction	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/29/2022
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
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2 130	Continued From page 4 appropriate changes for the quality, health, and safety of their resident population. The governing body and or medical director should complete audits of resident cares, resident satisfaction surveys, staffing patterns and staff competency. etc. to ensure resident needs are consistently met and deficient practice is corrected. The results of those measurable audits should be taken to the QAPI committee to determine ongoing compliance with oversight of facility operations. TIME PERIOD FOR CORRECTION: 21 days.	2 130			
{2 555}	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Surveyor: 43084 Based on interview and document review the facility failed to assess residents and develop a comprehensive care plan to include specific	{2 555}			10/28/22
			1. R4, R5, R6 care plan were updated to reflect correct care levels 2. All residents care plans were updated to reflect correct care levels 3. Nurse Managers educated on how to		

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{2 555}	Continued From page 5 needs for 3 of 3 residents (R4, R5, and R6) who required assistance with Activities of Daily Living (ADL). Findings include: R4's admission Minimum Data Set (MDS) dated 9/21/22, included diagnoses of wedge compression fracture of T11-T12 vertebrae, post traumatic stress disorder (PTSD), chronic pain, spinal stenosis, urinary incontinence, and traumatic brain injury (TBI). If further included moderately impaired cognition and required limited assistance with bed mobility and toileting and was independent with all other ADL's. R4's care plan dated 9/19/22, lacked any indication R4 required assistance with ADL's. R5's admission MDS dated 9/25/22, included diagnoses of syncope and collapse, low back pain, chronic obstructive pulmonary disease (COPD), depression, and malignant neoplasm of the prostate. If further included moderately impaired cognition and required extensive assistance with dressing, independent with eating, and limited assistance with all other ADL's. R5's progress noted dated 9/19/22, included "Resident eloped from hospital with use of a walker and made it home. Both family members requested that a [WanderGuard] WG be placed on Resident and Writer denied being able to do that with no presenting elopement behaviors but both agreeable to 30 minute safety checks while awake. R5's progress note dated 9/20/22, included "Resident is [alert and oriented] AO, understands	{2 555}	update care plan and care importance 4. IDT will address care plans as needed in morning meeting every day. Audits will be conducted 3x a week for 3 weeks by DON or designee. 5. All concerns will brought to QAPI	

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{2 555}	Continued From page 6 and can be understood. Able to make needs known. slept all night. Continued with Q15 minutes check d/t risk of elopement." R5's care plan lacked any indication of R5 being an elopement risk. R6's progress note dated 9/21/22, included "Resident arrived at facility @ 1500 on a stretcher via ambulance and accompanied by two paramedics. Resident is left foot amputee. Resident is alert and oriented X4. Writer welcome resident to room and orient him on the call light. He as a condom catheter and Ostomy bag. Skin has discoloration on the back and have multiple wounds. Resident is assist X2, with wound cares and transfer. Diet is puree and take pills whole with apple sauce." R6's care plan only contained activities and lacked any indication of the increased ADL care required for R6. During an interview on 9/28/22, at 11:20 a.m. licensed practical nurse (LPN)-A stated care plans were initiated by the director of nursing (DON). Once the care plans were created, any nurse could and should update them as needed as changes occurred. LPN-A verified R4, R5, and R6's care plans were lacking the above specifics for ADL cares which included ADL's, diet/nutrition, and risk for elopement. LPN-A would expect those areas to be included in the comprehensive care plan. Review of the undated, Facility policy, Care Planning- Interdisciplinary Team, indicated a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).	{2 555}			

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{2 555}	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{2 555}			