



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2023

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

RE: CCN: 245289
Cycle Start Date: July 17, 2023

Dear Administrator:

On October 27, 2023, we notified you a remedy was imposed. On December 19, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 15, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 17, 2023 be discontinued as of December 15, 2023. (42 CFR 488.417 (b))

In our letter of , 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 October 17, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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



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December 20, 2023

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

Re: Reinspection Results
Event ID: L54I12

Dear Administrator:

On August 31, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 24, 2023

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

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

Dear Administrator:

On May 4, 2023, we informed you of imposed enforcement remedies.

On July 17, 2023, the Minnesota Department of Health completed a survey 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023, 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 July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2023.

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

As we notified you in our letter of April 26, 2023, 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 July 18, 2023.

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

An equal opportunity employer.

The Terrace At Crystal LLC

July 24, 2023

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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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to

The Terrace At Crystal LLC

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validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an

The Terrace At Crystal LLC

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appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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



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

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

PRINTED: 08/22/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/14/23 and 7/17/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52893703C (MN93667) H52893625C (MN95217) with deficiencies issued at F684, F725, and F842 H52893704C (MN95064) with a deficiency issued at F725 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684			8/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/31/2023

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

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F 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to administer insulin timely according to provider orders, failed to assess resident ability to use a Dexcom meter, perform accurate carbohydrate counts, and failed to obtain orders for skin care treatments for 1 of 1 resident (R1). Findings include: R1's significant change Minimum Data Set (MDS) dated 4/26/23 indicated intact cognition, no behaviors, assist of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene, and indicated insulin dependent diabetes. R1's orders dated 6/8/22 indicated Lispro Kwikpen (insulin) 2 units per 15 g [grams] of carbs [carbohydrates] with meals for diabetes. Orders dated 10/18/22 indicated Dexcom g6 (a device that uses a sensor inserted just under the skin, that measures glucose levels up to every five minutes and wirelessly transmits glucose readings to a receiver or compatible smart device) continuous blood glucose monitoring kit for insulin dependent type 2 diabetes and h/o [history of] hypoglycemia (low blood sugar). R1's Medication Administration Record (MAR) dated 7/14/23 indicated 18 units of Lispro (insulin) was administered at 11:30 a.m., but was actually administered at 2:18 p.m., more than one hour after lunch. R1's medical record lacked assessment for R1's ability to correctly use the Dexcom g6 or to count	F 684	1. The proper times R1's insulin administration will be documented. 2. This had the ability to affect all liked residents. All residents who receive insulin will have their administration times properly documented to reflect the time insulin was given. 3. R1 was educated on proper use of the Dexcom system. 4. Nursing staff were educated on the proper use of the Dexcom system. Education included reading the blood sugar on the Dexcom before administering insulin. 5. R1's care plan was updated to reflect that she receives instadry after her morning care. 6. Nurses were educated that they are supposed to apply the instadry. 7. Audits will be done 3x a week for 4 weeks of resident chart to ensure that blood sugars readings are taking place and being documented. 8. Audits will be done 3x a week for 4 weeks to ensure that instadry is being provided after morning cares by a nurse. 9. Audits will be bought to QAPI for review in order to maintain the system changes. 10. DON, Nurse managers will be responsible for the completion of this plan of correction.		

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F 684	Continued From page 2 carbohydrates in her diet to accurately report to nursing staff how much insulin R1 required with meals and lacked orders for use of InterDry (a fabric skin protectant for the management of skin folds and other skin-to-skin contact areas that utilizes antimicrobial silver complex on fabric to reduce odor and microbial colonization in the fabric). R1's care plan dated 11/17/22 indicated Dexcom g6 continuous blood sugar monitoring kit for insulin dependent type 2 diabetes. R1's care plan lacked mention of InterDry use as a moisture barrier to prevent skin breakdown. On 7/14/23 at 1:05 p.m., R1 was interviewed and stated her call light was activated at 12:50 p.m. because she was waiting for the Lispro insulin she needed after lunch R1 stated many staff quit recently, and since then she had to activate her call light to get her insulin during the day shift instead of the nurse bringing it as ordered. R1 further stated stated she was supposed to have InstaDry placed under her breasts and abdomen after morning cares, which were completed at approximately 9:30 a.m. and did not have it administered yet either. Further, R1 stated sometimes the nursing assistants place the InstaDry, even though a nurse is supposed to. On 7/14/23 at 2:18 p.m., during an observation and interview licensed practical nurse (LPN)-A entered R1's room and asked R1 how much insulin she needed. R1 advised LPN-A to administer 18 units. LPN- A did not ask R1 what she ate or read R1's Dexcom meter. LPN-A administered insulin dose as stated by R1, and LPN-A stated she would return to perform R1's treatments. LPN-A acknowledged she had not	F 684			

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F 684	Continued From page 3 administered R1's InterDry and stated R1 would not allow InterDry placement until after the nursing assistants perform morning cares (cleaning, bed bath, or peri cares), and LPN-A stated she was not informed R1's morning cares were completed. LPN-A stated she would return to place the InterDry. On 7/14/23 at 2:32 p.m., during observation and interview R1's call light was answered by trained mediation aide (TMA)-B, who stated she was not sure why the InterDry was not in place, but should have been after morning cares. On 7/17/23 at 11:15 a.m. LPN-A was interviewed and acknowledged R1's insulin was administered late on 7/14/23, without checking R1's Dexcom or asking what she ate, and administered the amount of Lispro insulin R1 told her to administer. LPN-A stated she did not know if R1 had an assessment to ensure she could accurately use the Dexcom or perform carbohydrate counts. LPN-A further acknowledged R1's treatments (InterDy administration) was late on 7/14/23. On 7/17/23 at 1:14 p.m., the director of nursing (DON) acknowledged that facility staff had not assessed R1's ability to use the Dexcom or perform carbohydrate counting, and would expect the nurses to check the Dexcom reading before administering insulin. The DON stated the expectation was for staff to administer medications in the prescribed time frame, document if they were not, and notify the provider and DON. The DON further stated he expected treatments like InterDry would have an order, and be on the care plan. A policy was requested and not provided.	F 684			

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available to respond to call lights timely to meet resident's medical, physical, and emotional needs for 17 of 35 residents on the third floor reviewed for call light times. Findings include:	F 725	1. The facility updated the staffing patterns on the units to reflect more appropriate levels, ensuring staffing on each unit is a minimum of 3 hours per patient day. 2. Facility will audit the staffing pattern daily 5x a week for 4 weeks to ensure that facility is following staffing pattern in the		8/18/23

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F 725	Continued From page 5 R1's significant change Minimum Data Set (MDS) dated 4/26/23 indicated intact cognition, no behaviors, and had insulin dependent diabetes. R1's orders dated 6/8/22 indicated Lispo Kwikpen (insulin administration pen) 2 units per 15 g [grams] of carbs [carbohydrates] with meals for diabetes. On 7/14/23 at 1:05 p.m., during observation and interview R1 was lying in bed with her meal tray on her bedside table. R1 stated she was done eating and was waiting for her morning treatments and her after-lunch insulin. R1 stated there used to be four nursing assistants (NAs) and two nurses on the third floor, but recently staffing changed and there were only three NAs and two nurses. R1 stated with the staffing changes her medications were often late and she had to activate her call light to remind nurses to administer her treatments and insulin. Further R1 stated her meals were often late, which she stated would affect her blood glucose levels. R1 stated she activated her call light at 12:50 p.m. and it had not been answered. At 2:02 p.m. R1 called the facility reception to request assistance as her insulin was late. The call light was answered at 2:10 p.m. On 7/14/23 at 2:18 p.m., licensed practical nurse (LPN) -A entered R1's room and administered R1's insulin that was due after lunch. LPN-A stated she did not know when R1 activated her call light. On 7/14/23 at 2:23 p.m., trained medication aide (TMA)-B stated she did not know why R1's morning treatments were not done yet, and	F 725	facility assessment. 3. Call light time audits will be completed 3x a week for 4 weeks. 4. All staff will be educated on answering call lights in a timely manner. 5. The Staffing Coordinator will be educated on staffing based on the facility assessment. 6. Audits will be bought to QAPI for review. 7. The administrator, staffing coordinator and DON are responsible for this plan of correction.		

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F 725	Continued From page 6 further stated the floor should have four NAs, but only had three. TMA-B stated the TMAs could not administered treatments, and there was only one nurse for approximately thirty residents. On 7/14/23 at 4:33 p.m., receptionist (REC)-A stated R1 called for reception for assistance twice on 7/13/23 when staff didn't answer her call light, and then R1 called 911 for assistance with a low blood sugar and a late meal. Call light response times were reviewed for third floor from 7/7/23, to 7/13/23. Response times were as follows: 97 response times between 15 to 29 minutes, 61 response times between 30 to 49 minutes, 18 response times between 30 to 39 minutes, 13 response times between 50 to 74 minutes, 14 response times between 75 to 99 minutes, 10 response time between 100 to 149 minutes, 3 response times between 150 and 199 minutes, and 1 response time of 217 minutes. On 7/17/23 at 1:14 p.m., the director of nursing (DON) stated the expectation was to answer call lights in less than ten minutes, and acknowledged many call response times for third floor exceeded the 10-minute expectation and were unacceptable. The DON stated the staffing changes were implemented by the owner and acknowledged there were not enough staff on third floor to answer call lights timely or administer medications and treatments timely because many of the residents on third floor required the assistance of two staff for most activities of daily living. The Answering Call Lights policy dated November	F 725			

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

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OMB NO. 0938-0391

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F 725	Continued From page 7 2022, directed staff to answer the call system immediately to ensure timely response to residents' requests and needs. The Facility Assessment Tool updated 8/1/22, directed to ensure each resident is provided care that allows the resident to maintain or attain the highest practicable physical, mental, and psychosocial well-being. At The Terrace at Crystal Lake, services and care offered are based on resident needs, including toileting programs, and responding to requests for assistance to the bathroom/ toilet promptly to maintain continence and promote resident dignity.	F 725			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842			8/18/23

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F 842	Continued From page 8 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842			

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F 842	Continued From page 9 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain accurate medication administration records for 1 of 1 resident (R1) reviewed for insulin administration. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/26/23 indicated intact cognition, no behaviors, and a diagnosis of insulin dependent diabetes. R1's orders dated 6/8/22 indicated Lispo Kwikpen (insulin administration pen) 2 units per 15 g [grams] of carbs [carbohydrates] with meals for diabetes. R1's Medication Administration Record (MAR) dated 7/14/23 indicated 18 units of Lispro was administered at 11:30 a.m. with blood glucose of 234 milligrams/deciliter (mg/dl). R1's charting report printed 7/17/23 indicated LPN-A charted R1's 7:30 a.m. dose of Lispro was administered at 3:56 p.m. and the 11:30 a.m. dose of insulin was administered at 3:55 p.m. On 7/14/23 at 1:04 p.m., during interview and observation R1 stated her call light had been on since 12:50 p.m., so she could ask the nurse for Lispro insulin as she was done eating, and with recent staffing changes had to ask for her insulin after meals; the nurses didn't just bring it	F 842	1. R1's medication administration record will reflect the correct time medications were received. 2. This has the ability to affect all residents so all residents medication administration records will reflect the appropriate time that medications were given. 3. Nurses will educated on the importance of timely documentation of medication administration records. Nursing staff will also be educated on the importance of chartinf accurately and verifying information before charting it. 4. Facility will audit medication administration times 3x a week for 4 weeks. 5. Audits will be bought to QAPI to ensure that the systems stay in place. 6. DON and Nurse Managers are responsible for the completion of this plan of correction.		

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F 842	Continued From page 10 anymore. On 7/14/23 at 2:18 p.m., licensed practical nurse (LPN)-A entered R1's room, and asked R1 how much insulin to give, R1 stated she needed 18 units, and LPN-A administered the insulin. On 7/17/23 at 11:15 a.m., LPN-A was interviewed and stated R1 did not get the insulin doses back-to-back as it was charted, and acknowledged she did not enter the accurate times of insulin administration and did not look at the Dexcom. The charting indicated the blood glucose reading was 234 mg/dl, even though it was not observed by LPN-A. On 7/17/23 at 1:14 p.m., the director of nursing (DON) stated the expectation for insulin administration was within one hour of the prescribed time, and the administration time would be recorded accurately. The DON acknowledged R1's insulin was not administered on time on 7/14/23, and the time of administration was not documented accurately. Further, the DON stated if insulin administration times were not accurately documented, the resident was at risk of having the next dose administered too soon causing low blood sugars, or too late causing high blood sugars, both of which could affect R1's well-being. The Administering Medications policy dated 4/19 indicated medications were administered in accordance with provider orders, including any required time frame. Medications were administered within one hour of their prescribed time, unless otherwise specified, for example before and after meal orders. Further, the policy indicated if the drug is given at a time other than	F 842			

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F 842	Continued From page 11 the scheduled time, the individual administering the medication shall document in the resident's MAR for that drug and dose. The individual administering the medication records in the resident's medical record the date and time the medication was administered. On 7/17/23 at 1:21 p.m., RN-A stated when insulin is administered late, a nursing note should be written as to why it was given late. The physician should be updated on the late administration because the late administration might affect the resident's next dose of insulin. Insulin should be documented right after administration. Not documenting at the time of administration could affect blood sugar monitoring or cause confusion. The paper the information was written on could be lost. If the resident had a high blood sugar reading and the insulin administration was not documented, the resident might get an additional dose of insulin which could cause a critically low blood sugar.			F 842			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 24, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: L54I11

Dear Administrator:

The above facility was surveyed on July 14, 2023 through July 17, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

The Terrace At Crystal LLC

July 24, 2023

Page 2

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

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

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

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

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

Please feel free to call me with any questions.



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

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 07/17/2023
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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 7/14/23 and 7/17/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

07/31/23

Minnesota Department of Health

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed: H52893703C (MN93667) H52893625C (MN95217) with a licensing order issued at MN Rule 4658. 0450 Subp. 1 A-P and MN Rule 4658.0510 subp. 1 H52893704C (MN95064) with a licensing order issued at MN Rule 4658.0510 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized	2 625			8/18/23

Minnesota Department of Health

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2 625	Continued From page 3 persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain accurate medication administration records for 1 of 1 resident (R1) reviewed for insulin administration. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/26/23 indicated intact cognition, no behaviors, and a diagnosis of insulin dependent diabetes. R1's orders dated 6/8/22 indicated Lispo Kwikpen (insulin administration pen) 2 units per 15 g [grams] of carbs [carbohydrates] with meals for	2 625	CORRECTED		

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2 625	Continued From page 4 diabetes. R1's Medication Administration Record (MAR) dated 7/14/23 indicated 18 units of Lispro was administered at 11:30 a.m. with blood glucose of 234 milligrams/deciliter (mg/dl). R1's charting report printed 7/17/23 indicated LPN-A charted R1's 7:30 a.m. dose of Lispro was administered at 3:56 p.m. and the 11:30 a.m. dose of insulin was administered at 3:55 p.m. On 7/14/23 at 1:04 p.m., during interview and observation R1 stated her call light had been on since 12:50 p.m., so she could ask the nurse for Lispro insulin as she was done eating, and with recent staffing changes had to ask for her insulin after meals; the nurses didn't just bring it anymore. On 7/14/23 at 2:18 p.m., licensed practical nurse (LPN)-A entered R1's room, and asked R1 how much insulin to give, R1 stated she needed 18 units, and LPN-A administered the insulin. On 7/17/23 at 11:15 a.m., LPN-A was interviewed and stated R1 did not get the insulin doses back-to-back as it was charted, and acknowledged she did not enter the accurate times of insulin administration and did not look at the Dexcom. The charting indicated the blood glucose reading was 234 mg/dl, even though it was not observed by LPN-A. On 7/17/23 at 1:14 p.m., the director of nursing (DON) stated the expectation for insulin administration was within one hour of the prescribed time, and the administration time would be recorded accurately. The DON acknowledged R1's insulin was not administered	2 625			

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2 625	Continued From page 5 on time on 7/14/23, and the time of administration was not documented accurately. Further, the DON stated if insulin administration times were not accurately documented, the resident was at risk of having the next dose administered too soon causing low blood sugars, or too late causing high blood sugars, both of which could affect R1's well-being. The Administering Medications policy dated 4/19 indicated medications were administered in accordance with provider orders, including any required time frame. Medications were administered within one hour of their prescribed time, unless otherwise specified, for example before and after meal orders. Further, the policy indicated if the drug is given at a time other than the scheduled time, the individual administering the medication shall document in the resident's MAR for that drug and dose. The individual administering the medication records in the resident's medical record the date and time the medication was administered. On 7/17/23 at 1:21 p.m., RN-A stated when insulin is administered late, a nursing note should be written as to why it was given late. The physician should be updated on the late administration because the late administration might affect the resident's next dose of insulin. Insulin should be documented right after administration. Not documenting at the time of administration could affect blood sugar monitoring or cause confusion. The paper the information was written on could be lost. If the resident had a high blood sugar reading and the insulin administration was not documented, the resident might get an additional dose of insulin which could cause a critically low blood sugar.	2 625			

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 07/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
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2 625	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee person could review policies and procedures about documentation requirements. The DON or designee revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 625	CORRECTED		8/18/23
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available to respond to call lights timely to meet resident's medical, physical, and emotional needs for 17 of 35 residents on the third floor reviewed for call light times. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/26/23 indicated intact cognition, no behaviors, and had insulin dependent diabetes.	2 800			

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2 800	Continued From page 7 R1's orders dated 6/8/22 indicated Lispo Kwikpen (insulin administration pen) 2 units per 15 g [grams] of carbs [carbohydrates] with meals for diabetes. On 7/14/23 at 1:05 p.m., during observation and interview R1 was lying in bed with her meal tray on her bedside table. R1 stated she was done eating and was waiting for her morning treatments and her after-lunch insulin. R1 stated there used to be four nursing assistants (NAs) and two nurses on the third floor, but recently staffing changed and there were only three NAs and two nurses. R1 stated with the staffing changes her medications were often late and she had to activate her call light to remind nurses to administer her treatments and insulin. Further R1 stated her meals were often late, which she stated would affect her blood glucose levels. R1 stated she activated her call light at 12:50 p.m. and it had not been answered. At 2:02 p.m. R1 called the facility reception to request assistance as her insulin was late. The call light was answered at 2:10 p.m. On 7/14/23 at 2:18 p.m., licensed practical nurse (LPN) -A entered R1's room and administered R1's insulin that was due after lunch. LPN-A stated she did not know when R1 activated her call light. On 7/14/23 at 2:23 p.m., trained medication aide (TMA)-B stated she did not know why R1's morning treatments were not done yet, and further stated the floor should have four NAs, but only had three. TMA-B stated the TMAs could not administer treatments, and there was only one nurse for approximately thirty residents. On 7/14/23 at 4:33 p.m., receptionist (REC)-A	2 800			

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2 800	Continued From page 8 stated R1 called for reception for assistance twice on 7/13/23 when staff didn't answer her call light, and then R1 called 911 for assistance with a low blood sugar and a late meal. Call light response times were reviewed for third floor from 7/7/23, to 7/13/23. Response times were as follows: 97 response times between 15 to 29 minutes, 61 response times between 30 to 49 minutes, 18 response times between 30 to 39 minutes, 13 response times between 50 to 74 minutes, 14 response times between 75 to 99 minutes, 10 response time between 100 to 149 minutes, 3 response times between 150 and 199 minutes, and 1 response time of 217 minutes. On 7/17/23 at 1:14 p.m., the director of nursing (DON) stated the expectation was to answer call lights in less than ten minutes, and acknowledged many call response times for third floor exceeded the 10-minute expectation and were unacceptable. The DON stated the staffing changes were implemented by the owner and acknowledged there were not enough staff on third floor to answer call lights timely or administer medications and treatments timely because many of the residents on third floor required the assistance of two staff for most activities of daily living. The Answering Call Lights policy dated November 2022, directed staff to answer the call system immediately to ensure timely response to residents' requests and needs. The Facility Assessment Tool updated 8/1/22, directed to ensure each resident is provided care that allows the resident to maintain or attain the	2 800			

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2 800	Continued From page 9 highest practicable physical, mental, and psychosocial well-being. At The Terrace at Crystal Lake, services and care offered are based on resident needs, including toileting programs, and responding to requests for assistance to the bathroom/ toilet promptly to maintain continence and promote resident dignity. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing (DON) could review and revise policies and staffing schedules to assure adequate staff are available to assist residents in a timely manner and to meet all resident needs. The administrator or DON could educate all staff on the policies and procedures. The administrator or DON could monitor the Call Light Logs to assure cares are being delivered and residents are supported to achieve and maintain their highest practicable physical, mental, and psychosocial well-being. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800			