



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 27, 2023

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

RE: CCN: 245289
Cycle Start Date: July 17, 2023
Event ID: IMT312

Dear Administrator:

On October 3, 2023, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

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

On October 17, 2023, the Minnesota Department of Health 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:

21550 -- MN Rule 4658.1325 Subp. 1 -- Administration Of Medications; Pharmacy Serv.
F0755 -- S/S: D -- 483.45(a)(b)(1)-(3) -- Pharmacy Srvcs/procedures/pharmacist/records
F0838 -- S/S: F -- 483.70(e)(1)-(3) -- Facility Assessment

As a result of the revisit findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(b), effective October 17, 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 October 17, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 17, 2023.

An equal opportunity employer.

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 October 3, 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 August 17, 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 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 17, 2024 (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 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

The Terrace At Crystal LLC

October 27, 2023

Page 5

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.

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
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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

**NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES**

December 20, 2023

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

RE: Project Number IMT313

Dear Administrator:

On December 4, 2023, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of \$569.60 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 28, 2023 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$500. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling \$69.60, 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 \$569.60 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

December 20, 2023

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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

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 9, 2023

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

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

Dear Administrator:

On April 26, 2023, we informed you of imposed enforcement remedies.

On July 27, 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 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.

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

August 9, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

The Terrace At Crystal LLC

August 9, 2023

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

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

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

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

The Terrace At Crystal LLC

August 9, 2023

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

INFORMAL DISPUTE RESOLUTION/ 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: IMT311

Dear Administrator:

The above facility was surveyed on July 24, 2023 through July 27, 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.

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 07/27/2023
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 7/24/23-7/27/23, 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 complaint was reviewed: H52893756C (MN00095380) with deficiencies issued at F755, F838 & F919. 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 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		9/1/23	

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

Electronically Signed

TITLE

(X6) DATE
08/14/2023

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.

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 07/27/2023
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 755	Continued From page 1 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide pharmaceutical services to assure 2 of 3 residents (R1 & R2) received their physician ordered medications. Findings include: R1's admission Minimum Data Set (MDS) dated 6/19/23, noted R1 had moderately impaired cognition, no refusal of cares, and required the extensive assistance of 2 staff for bed mobility, transfers, dressing toileting and personal hygiene. R1's diagnoses included: wedge compression fracture of the 4th lumbar vertebra, repeated falls, hepatic (liver) failure, and hepatic encephalopathy (brain function affected). R1's electronic medical record (EMR) contained	F 755	1. Facility received medication for R1 and R2. 2. Facility will educate all TMA's and Nurses on the process to refill medications when they are empty. 3. Facility has put in place a new procedure to notify DON or designee when a residents meds are missing or out of stock. 4. DON or designee will keep a missing meds log and follow up on whether meds were ordered. 5. Facility will audit the missing meds log 3x a week for 4 weeks. 6. DON or designee is responsible for the completion of this plan of correction.		

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F 755	Continued From page 2 hospital discharge orders dated 7/10/23, with that included the medication rifaximin 550mg tab orally twice a day. R1's July 2023 medication administration record (MAR) noted rifaximin 550mg tablet twice a day for diarrhea to start on 7/10/23, at 4:00 p.m. and was coded 9. According to the MAR legend, 9 means "other/see progress notes". The order was discontinued and rewritten on 7/11/23, rifaximin 550mg by mouth twice a day for hepatic encephalopathy. The MAR noted a "9" for the dates 7/10/23-7/15/23, on 7/16/23-7/20/23 it was coded a 6, the legend noted a "6" meant the resident was hospitalized. Progress notes dated 7/11/23-7/15/23, noted the rifaximin was "on order" or "awaiting supply/delivery". There were no progress notes regarding follow up to obtain the medication from the pharmacy until 7/16/23. A progress note dated 7/16/23, noted R1 was verbally unresponsive did not receive her rifaximin and lactulose (medications for her hepatic failure), follow was made with the pharmacy, and they were still awaiting delivery. R1 was transferred to the hospital due to her change in condition. During an interview on 7/24/23, at 2:27 p.m. the pharmacy technician (PH) noted a prior authorization was sent to the facility on 7/10/23, for R1's rifaximin as it was an expensive medication, and they did not receive a response to the request for authorization. During an interview on 7/24/23, at 1:30 p.m. the director of nursing (DON) stated he was called	F 755			

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F 755	Continued From page 3 the pharmacy for R1's medication and had been told the medication was coming and then the medication was not in next the delivery. The DON stated he thought the nurses were also calling or faxing the pharmacy for medications and that there was no tracking of which medications were called in to be refilled. During an interview on 7/25/23, at 10:19 a.m. the nurse practitioner (NP) stated she was not notified of any difficulty in getting R1's rifaximin from the facility until 7/14/23, they were notified the medication required a prior authorization. During an interview with R1's physician on 7/26/23, at 3:09 p.m. he stated R1 has many comorbidities contributing the her hepatic encephalopathy and that R1 missing the medication administration of rifaximin would not cause her to be hospitalized.. R2's quarterly MDS dated 5/3/23, noted R2 had intact cognition, required the extensive assistance of 2 staff for transfers, bed mobility, dressing and toileting. R2's diagnoses included: morbid obesity, major depressive disorder, epilepsy. R2's May, June and July 2023, MAR noted an order for ropinirole HCl 0.25mg 1 tablet by mouth every 8 hours as needed for restless leg syndrome that began on 9/24/22, no doses had been administered to R2. During an interview on 7/24/23, at 10:16 a.m. R2 stated she had trouble with restless legs and ended up with her head over one side of the bed and her legs the other. R2 stated she was aware there was an order for ropinirole that was on her most recent discharge orders from the hospital	F 755			

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F 755	Continued From page 4 and that she had asked for the medication to help her restless legs but had been told that the facility did not have it and that it had not been ordered, even with continued follow up from R2. R2 stated she reminded a nurse the other day to order it and was told they would as there is a new pharmacy providing medications. There were no progress notes regarding contacting the pharmacy from 5/1/23-7/24/23 to order or refill R2's ropinirole. During an interview on 7/27/23, at 9:57 a.m. trained medication aide (TMA)-C noted she called the pharmacy for ordering and refilling resident medications, however, she documented in a notebook and would shred the sheets after receiving the medications. During an interview with licensed practical nurse (LPN)-B stated she would call the facility to request medication refills or new medications ordered as when she faxed and called to follow up, the pharmacy commonly stated they did not receive the fax. LPN-B stated the calls to the pharmacy were not documented anywhere or tracked. During an interview on 7/27/23, at 11:01 a.m. LPN-A stated he would call the pharmacy for refills or new orders, he would fax a request if there were 5 or more medications that he needed. LPN-A stated the calls and follow up were not documented. During an interview on 7/27/23, at 1:18 p.m. TMA-A stated she would look for R2's medication but knew it was not there as R2 asked for that medication that morning. The TMA-A went to a	F 755			

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F 755	Continued From page 5 computer and then to a box full of bubble packs of medications to look. R1's medication was not in the box and TMA-A stated she just ordered a refill now on the computer but wanted a nurse to verify she ordered the refill correctly. During an interview on 7/27/23, at 1:28 p.m. registered nurse (RN)-A stated the new pharmacy will not send PRN (as needed) medications unless they are specifically requested and that a phone call to the pharmacy is the quickest way to get the medication to the pharmacy. RN-A called the pharmacy to confirm the request to refill was submitted and requested R2's medication to be delivered this evening. The RN-A stated, R2 "asked me for it this morning when I went in to care for her wounds, she said it was for her restless legs". RN-A stated he had been busy with wound treatments, so he did not have the chance to request a refill that morning. A facility policy titled Pharmacy Services Overview last reviewed in November of 2022, noted residents have a sufficient supply of their prescribed medications and receive medications in a timely manner. Further, the policy noted nursing staff communicate prescriber ordered to the pharmacy and are responsible for contacting the pharmacy is a residents medication in not available for administration.	F 755			
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations	F 838			9/1/23

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F 838	Continued From page 6 and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under	F 838			

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F 838	Continued From page 7 contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to review and update the facility assessment to determine the resources necessary to care for its residents competently both during day-to-day operations when it laid off eight direct care employees and emergencies when it did not ensure staff qualifications for cardiopulmonary resuscitation (CPR). Findings include: A Resident Listing Report, dated 7/25/23, identified 73 current residents, which 52 were identified as requesting cardiopulmonary resuscitation (CPR)/Full Code in the event of an unresponsive episode. A facility assessment dated 8/1/22, identified an average daily census of 60 residents with a capacity of 84 residents (18 short stays and 66 long term stays). -A section labeled Acuity described two wings:	F 838	1. Facility updated staffing pattern to match the facility assessment. 2. Facility updated the facility assessment on 07/28/2023. 3. Facility will audit the staffing pattern daily 5x a week for 4 weeks to ensure that facility is following staffing pattern in the facility assessment. 4. Staffing Coordinator will be educated on staffing based on the facility assessment. 5. Audits will be bought to QAPI for review 6. Administrator and Staffing coordinator are responsible for this plan of correction.		

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F 838	Continued From page 8 100 wing, dedicated for transitional care and a 200 wing, dedicated for long term care. 100 wing [first floor] was prepared to appropriately care for residents with complex wounds, complex medication regimes, multiple therapeutic treatments and intravenous (IV) therapy needs. 200 wing [second floor] was prepared to appropriately care for residents with complex wounds, complex medication regimes, multiple therapeutic treatments and IV therapy needs. -The Acuity section lacked identification of residents who resided on the 300 wing [third floor] or that the 200 wing was currently a secured memory/behavioral care unit. -In addition, the Acuity section lacked identification of appropriate care for complex behavioral and/or mental health needs for those residents. -A section labeled Staffing plan identified the number of sufficient staff to meet the needs of the residents at any given time. This indicated one full-time day's director of nursing (DON), one full-time assistant director of nursing (ADON), one registered nurse (RN) manager and one licensed practical nurse (LPN) health unit coordinator (HUC). -The plan indicated licensed nurses (RN and LPN) who provided direct care at the following ratios: 1:x14 ratio days and evenings (RN and LPN per shift) and 1:x28 ratio nights (RN and LPN per shift). Direct care staff: 1:x10 ratio days (total licensed or certified), 1:x10 ratio evenings, 1:x14 ratio nights. Other: one Minimum Data Set (MDS) coordinator and one social services director. -The facility assessment lacked information related to the direct care role and/or staffing ratio for trained medication aides (TMA - a nursing assistant who completed a course in medication	F 838			

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F 838	Continued From page 9 administration). -At the time of the survey, the facility did not employ an ADON or a director of social services. -The nursing scheduled for 7/24/23 identified two licensed nursing staff, two TMAs, and seven direct care staff (nursing assistants) for 71 residents. The staffing ratio on 7/24/23 was 1:x35.5 for licensed nursing staff and 1:x10 for direct care staff. -The facility assessment identified a section labeled Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. The section does not identify CPR needs or required certification. -A subsection of Part 3: Individual staff assignments, identified staff assignment coordination was based on consistent assignments and to ensure continuity of care in which census and acuity were used to determine staffing levels necessary to provide appropriate care. -A second subsection of Part 3 identified staff training/education and competencies which was provided through Relias Training (computerized). Clinical competencies were identified for all clinical staff and NAs; however, CPR certification was not listed. -The assessment lacked information on what the facility considered sufficient in terms of CPR certified staff scheduling in relation to the number of Full Code residents. Job Descriptions for RNs, LPN, and TMAs, undated, lacked information that identified CPR certification was a requirement of employment. During an interview on 7/24/23, at 11:50 a.m. the administrator stated the facility had received a	F 838			

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F 838	Continued From page 10 recent citation for sufficient staffing, the owner of the facility directed him to layoff eight direct care staff about three weeks ago and that the new staffing pattern put the residents at risk and that he believed it was a financially driven decision. During an interview on 7/24/23, at 1:30 p.m. the director of nursing (DON) stated staffing the facility was very difficult, they had adequate staffing until the owner directed the administrator to lay off staff. The DON was not involved in the decision to lay off staff and was not consulted about resident care from a clinical perspective. The DON stated there were 35 residents on the third floor and at least 20 of them are an assist of two for transfers, 17 of those require mechanical lifts and staffing that floor with three nursing assistants was not adequate to provide the necessary care to those residents. During an interview on 7/24/23, at 4:38 p.m. (TMA)-A stated she worked that day on the third floor and was required to pass medications to all 34 residents. TMA-A stated due to the staffing change, she was not able to pass 8:00 a.m. medications to some residents until nearly 2:00 p.m. The TMA-A stated she was not sure why there was a decrease in the direct care staff on the third floor as the resident census did not change there and that the facility continued to admit new residents. During an interview on 7/24/23, at 4:55 p.m. registered nurse (RN)-A stated he was aware the owner came in and had a meeting with the administrator as he received a call from the staffing coordinator. RN-A stated he believed the staffing cuts were financially driven as there was no notable changes to resident census.	F 838			

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F 838	Continued From page 11 During an interview on 7/25/23, at 8:54 a.m. TMA-B stated there were recent cuts to nursing staff, however, there were no notable changes to the resident census and the facility continued to accept new admissions. During an interview on 7/25/23, at 12:48 p.m. the human resources (HR) stated she was aware of the recent staff layoff and the owner of the facility came in and expressed frustration with finances. She stated the FO directed the layoff and that it was a financially driven decision. During an interview on 7/26/23 at 12:03 p.m., the director of nursing (DON) stated most residents on the TCU were full code and if CPR was required, he expected the TMA to notify a nurse and for that nurse to provide CPR to the resident. He explained because of the potential CPR needs on the TCU, the TCU should be staffed with a nurse to respond to emergent situations and not a TMA. The DON was unsure if the TMAs or the nursing assistants (NA)s were CPR certified. During an interview on 7/26/23, at 1:16 p.m. the facility owner (FO) stated that he was aware of the direct care staff that were laid off, however, he was unsure how many staff were laid off and that it was due reduced census. The FO stated that he and the chief financial officer (CFO) performed a facility review and that the facility was overstaffed, prior to the layoff the facility was staffed for 80 residents. The FO stated the changes were made using resident acuity based on a case mix index (CMI) report and their experience with acuity and census. The FO stated that payroll was too high due to the	F 838			

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F 838	Continued From page 12 overstaffing in many areas of the facility including other departments. The FO was unaware of what the facility assessment was and thus was not aware the last time it was reviewed and/or updated. The FO stated there was no typed out operating budget and the administrator did not play an active role in budgeting. The administrator was expected to assist with staff need decisions and he identified the administrator had not brought forth any budge or staffing concerns . When interviewed on 7/26/23 at 2:04 p.m. human resources manager (HRM) stated she did not maintain a list of current CPR certified staff and was unsure who within the facility was CPR certified. She explained all licensed staff were required to be CPR certified and they recently developed a new form and auditing system to ensure the newly hired staff were CPR certified; however, staff prior to this newer process were not yet audited for the certification. During a follow up interview on 7/26/23, at 3:24 p.m. the administrator and DON were interviewed together. The administrator stated he would review and update the facility assessment in August, he was unaware of the need to review and updated it other than yearly. The administrator stated he brought the facility assessment up to the owner due to concerns with staffing cuts but was still instructed to lay off staff , that the owner thought a TMA would be included with the count for licensed nursing staff despite the administrators understanding that they would be included in nursing assistant staffing. The administrator stated that he is not involved in any budgeting, had never received an operating budget and that the average daily resident census is 69. All nurses were required to be CPR	F 838			

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F 838	Continued From page 13 certified; however, an audit was not conducted to verify this information. Currently the facility was unable to hire a CPR trainer to provide education to staff due to past financial payment concerns with a previous educator. The administrator stated CPR certification was not considered with the recent staffing layoff and the staffing coordinator would not have information related to who was CPR certified. During a follow-up interview on 7/26/23 at 4:56 p.m., the administrator stated he can only ensure at least one CPR certified staff was in the building seven days a week, 24 hours a day, by reviewing employee records to identify who had a CPR certification in their employee file. When interviewed on 7/26/23 at 5:00 p.m., staffing coordinator (SC) stated she was responsible for the daily nursing schedules. She explained she was not in charge of CPR and thus was unaware of which facility staff were CPR certified and who was not. When she scheduled staff, she did not ensure CPR certified staff were in the building as she was unaware, they were required to maintain such requirements. A Facility Assessment, dated 8/1/22, requirement indicated nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. "The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility.	F 838			

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F 838	Continued From page 14 Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require." The facility assessment directed the facility to review and update the assessment annually or whenever there was a need to modify any part of the assessment. In addition, the assessment was to serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions. Furthermore, a section labeled Other identified other pertinent facts or descriptions of the resident populations must be considered when determining staffing and resource needs i.e., residents' preferences with regard to daily schedules, walking, bathing, activities, naps, food, going to bed. This section identified long term care residents were mostly dependent with cares. The facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation dated 3/22, indicated personnel are to have completed training of CPR and BLS including defibrillation by obtaining and/or maintaining American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel. The facility's procedure for administering CPR shall incorporate the steps covered in the 2010	F 838			

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F 838	Continued From page 15 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material. Provide periodic mock codes (simulations of an actual cardiac arrest) for training purposes. The facility to select and identify a CPR team for each shift in the case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue effort and directing other team members during the rescue effort. The CPR team in this facility shall include at least one nurse, one LPN/LVN and two CNAs, all of whom have received training and certification in CPR/BLS.	F 838			
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light system was maintained and in functional order for the facility's first, second, and third residents housed floors. This had the potential to affect all 73 residents who resided within the facility. Findings include:	F 919			9/1/23

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F 919	Continued From page 16 On 7/24/23 at 9:56 a.m. and 10:12 a.m. electronic call light displays hung from the following location and identified the following first floor room and designated call light information: - Northeast hallway, end of hallway near kitchen: 106 BR, 107, 108, 113, 114, 121-2, and 122. When interviewed on 7/24/23 at 10:16 a.m. R2, who resided in room 108, stated her call light failed to work on 7/20/23 and she was required to wait five and a half hours for assistance "to be cleaned up." In addition, she explained that on 7/23/23 she was updated by staff her call light failed to work; however, the staff failed to provide her a bell as they provided to other residents. When interviewed on 7/24/23 at 1:31 p.m., the director of nursing (DON) stated the facility call light system was "inadequate." He explained call light programming was an issue as at times the call lights did not work or other times, they turned on but could not be turned off. Call light issues prompted the effected resident(s) to receive a bell to alert staff of their needs, and "rounding." The DON stated call light system concerns were related to prior history of non-payment to the call light company and the lack of that company's on-site follow-up after the bill was paid and tech support services were requested. The DON denied knowledge call light function audits were completed due to call light concerns and explained the maintenance department was responsible for call light audits. During interview on 7/25/23 at 2:23 p.m., with director of maintence (DM)-A and the maintenance assistant (MA)-A both stated their hire dates where respectively the middle and beginning of March in which they were alerted to	F 919	Administrator who will ensure that the call light system is functioning as it should and if needed reset the system to ensure that all call lights are working and in order. 5. Audits will be bought to QAPI for review. 6. Maintenance and administration will review the call light audits once a week to ensure that the audits are getting done and that all call lights are in good working order.		

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F 919	Continued From page 17 call light concerns in April. They have worked on this concern since. Since hire, neither were educated on how to utilize the call light system, from a maintenance software standpoint, and they contacted the administrator for call light re-programming as he was the only one in the facility knowledgeable to perform that action. DM-A presented a call light that identified it to be an Arial model 54037. Neither were aware of any manufacturer guidelines for the use of and/or auditing of the Arial call light system. When a call light issue occurred, staff communicated this to them verbally and they attempted to fix the issue the best they could. Overall, they attempted battery replacement, call light swap out, or a system reboot (turned the system off and then back on). They denied new call lights were ordered since either started. "Global Tech," who was very hard to get in touch with, was contacted to send a service technician to the facility as the system required a whole system hard reset "to get it working right," and to educate both of them on the call light system; however, they denied a service technician had arrived since either started and were unaware of any confirmed reasons for the lack of technician assistance. It was explained the call lights often lost signal and when batteries were replaced the call light may work at that time but "later in the week" the call light button would be triggered and the hallway display would not alert as it was supposed to: "If you keep tapping on it, it will eventually come on" and thus there was a "glitch" in the system. MA-A stated there was an audit conducted in April. (this documentation was provided and dated 4/19/23). Around middle of May or June "the whole system went down" which required a "reset" which failed to fix all the issues and the concerns continued. In response, they changed all call light batteries	F 919			

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F 919	Continued From page 18 and tested all the call lights. The event and audit were not documented. In addition, another call light audit was conducted "around two weeks ago" in which "a few" call lights failed to work. The audit was not documented. On 7/26/23, four electronic call light displays hung from the first floor's northeast, northwest, southwest, and southeast hallways and identified the following room and designated call light information: -From 10:24 a.m. to 10:27 a.m.: 106 BR, 106 bed, 108 bed, 113 bed, 114 BR, 116 BR, 121-2 bed, and 122 bed. An alert was heard after each cycle of displayed room numbers and no changes to the cycle were identified. -From 10:29 a.m. to 10:30 a.m.: 106 BR, 106 bed, 108 bed, 113 bed, 114 BR, 116 BR, 121-2 bed, and 122 bed. During this time, staff walked out of room 116; however, the display continued to display the BR call light was on. -At 10:30 a.m.: the southwest hallway display remained blank. -At 10:41 a.m.: 106 BR, 106 bed, 108 bed, 113 bed, 114 BR, 116 BR, 121-2 bed, and 122 bed. On 7/26/23 at 10:50 a.m. room 121-2's call light was visualized. No one was in the room and the bed call light indicator light was not activated (lacked a red light). On 7/26/23 at 10:51 a.m., room 116's call light was visualized. No one was in the room and the BR call light indicator light was activated (red light was on). On 7/26/23 at 10:51 a.m., R4 confirmed call light concerns and explained call light response times were up to an hour. Both the BR and bed call	F 919			

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F 919	Continued From page 19 lights lacked an activated red indicator light. He declined assistance needs at that time and denied he placed on his call light recently. However, he asked to have staff called as he needed water due to increased coughing. This was observed during the interaction. The surveyor engaged the bed call light and the indicator light lite up red; however, when the hallway display was visualized it lacked identification of the call light activation. When the bed call light was re-checked, the indicator light was off. On 7/26/23 at 10:56 a.m. the DON walked into room 116 and inquired as to the resident's needs. The resident requested toilet paper. The DON exited 116 and the BR light no longer displayed on the hallway display. On 7/26/23 from 10:57 a.m. to 11:18 a.m., the DON was interviewed and, in conjunction with the surveyor, performed the following actions: -At 10:57 a.m., 114 was absent of its resident. The DON confirmed the hallway display indicated the room and confirmed the BR call light indicator was off. The DON tested the call light and the indicator light lit up. -Room 121 was absent of both its residents. The DON visualized all call lights in the room and confirmed the indicator lights were off. -The DON confirmed the southwest hallway display was blank. -At 11:12 a.m., 114 BR continued to scroll on the display. R4 was in his room and stated he had no idea why the call light did not work properly. The DON confirmed the call light indicators were off and informed R4 he would be supplied with a bell due to the call light concerns. - At 11:14 a.m., 108 was entered and R2 was	F 919			

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F 919	Continued From page 20 asked if she needed anything. She explained she waited for the trained medication aide (TMA) to bring her a medication for her stress. The DON confirmed the bed call light indicator light was off and he informed R2 he would bring her a bell after she confirmed she did not have one already. A bell was not visualized within her reach or in her room. R2 stated, "My light is not reliable." -At 11:16 a.m., 106 was absent of its resident. The DON confirmed the display identified the room and the bed call light indicators was off; however, the BR indicator light was activated. The DON attempted to turn the BR call light indicator light off; however, the light remained on. Upon inspection of the device, the device lacked the required clip inserted into the bottom of the call light [a required component to satisfy a safety feature of the call light]. -At 1:17 a.m., 113's resident visited with a visitor and denied she placed the call light on. The DON confirmed the bed call light indicator was not on. The DON tested 113's call light which activated the indicator light. -At 11:18 a.m., room 122 was absent of its resident due to her emergent hospital transfer earlier that morning. The DON confirmed the bed call light indicated light was off. He tested the button and the indicator light turned red. The DON stated maintenance staff have done "everything they can do but a professional [was] needed" to fix the call light system. A functioning call light system ensured resident needs were met as this allowed staff to be made aware the resident required assistant in some way. He was unsure how staff were to know which call lights were on if the system did not function as expected: "Thank god staff round and look in rooms ...and know the residents." He explained maintenance performed audits to ensure the call	F 919			

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F 919	Continued From page 21 lights functioned and so they could address any identified concerns right away. The DON stated the facility had attempted to fix the call light concerns resolved for "about the last month." He was unable to indicated which residents were issued bells within the past month; however, explained if the call lights malfunctioned the resident(s) were to be provided with a bell and "frequently" rounded on to ensure their needs were met. Call light reports, dated 7/6/23 at 5:01 a.m. through 7/27/23 at 1:27 p.m., identified the following information: -106 bed: On 7/13/23 at 8:20 a.m., the device was activated, and cleared on 7/14/23 at 8:21 a.m., with a reset time of 721 minutes. On 7/26/23 at 9:30 a.m., there was a communication error indicated with a reset time of 2,829 minutes. -106 BR: On 7/25/23 at 11:05 p.m. the device was activated and cleared on 7/26/23 at 8:30 a.m., with a reset time of 565 minutes. On 7/26/23 at 9:30 a.m., there was a communication error indicated with a reset time of 2,829 minutes. -108 bed: No bed device activations or cleared entries identified. -113 bed: The report indicated a device category "Bed" for all triggered events; however, the event description identified the "Bathroom" was always activated and/or cleared. -114 BR: No bathroom device activations or cleared entries identified. -114 bed: On 7/26/23 at 10:57 a.m., the device was activated and cleared. On 7/26/23 at 7:32 p.m., the device was activated and cleared on 7/27/23 at 6:19 a.m., with a reset time of 647 minutes. -116 BR: On 7/24/23 at 7:35 a.m., the device was cleared. The report did not identify an activated	F 919			

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F 919	Continued From page 22 date and time. On 7/25/23 at 4:48 p.m. the device was activated and cleared on 7/26/23 at 10:56 a.m., with a reset time of 1,088 minutes. On 7/26/23 at 2:13 p.m., the device was activated and cleared at 2:14 p.m. -121-1 bed: One device activation and cleared entry for bed "121" on 7/26/23 at 2:10 p.m. The report lacked any devices specific for 121-1 or 121-2 (roommate). -122 bed: No bed device activations or cleared entries identified. When interviewed on 7/26/23 at 11:22 a.m., nursing assistant (NA)-C stated she was aware of call light concerns for the past month. She explained 106's call light had not worked properly for the past month as there was "no cord to make it go off," 121-2's does no work and "it just goes off," 122's call light "does not ping off or on ...it just says it is going off on the [display]," and 113's light is "in and out. She identified 106, 108, 113, 114, 116, 121-2, and 122 used their call lights to alert staff of needs. NA-C explained non-functioning call lights were a huge risk to the residents, especially when it came to fall risk. She identified the only resident she was aware of who had a bell was room 107. During a follow-up interview on 7/26/23 at 2:19 p.m., with DM-A and MA-A they explained staff were expected to utilize a "TELS" computerized communication system to alert them of maintenance concerns, which included concerns with the call lights. This information was accessible on both of their computers and once they received the information, they wrote it down and deleted the concerns from the system. Due to this, they were unable to provide information on call light concern work order requests. When	F 919			

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F 919	Continued From page 23 questioned on clarification for the call light company, they identified there was a "big misunderstanding" on which company managed the call light system, thus they attempted to work with Global Tech and not Stanley. They explained a service technician from Stanley was scheduled to come on 7/27/23. They stated the DON approached them this day and asked them to do a whole house call light audit which they started and which they continued to work on. So far, the second-floor call lights all functioned properly, three call lights on the third floor were "unresponsive," and the hallway displays in the southwest corner of all three floors failed to function. They explained they previously knew the third-floor display failed to work in which they unplugged it about two months ago and attempted to fix it. They were unsuccessful. During the current audit, they replaced the batteries of the three units on the third floor; however, the devices continued to malfunction and were determined they needed to be programmed. The call light indicator light lit up but failed to display on the hallway displays. DM-A confirmed the 4/19/23 audit was the only audit maintenance completed on the call light system. During interview on 7/26/23 at 2:41 p.m., the human resources manager (HRM) stated the facility was previously on a payment hold with "Stanley" (the company who managed the call light system and supplies): however, they were currently required to pre-pay for services in advance. She explained she contacted Stanley on 6/29/23 to pre-pay for services and was informed a service technician would be sent to the facility on 7/6/23; however, a technician never came. She again called on 7/10/23 to request system recalibration and for call light pager assist	F 919			

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F 919	Continued From page 24 in which she also ordered new pagers. The pagers arrived but no technician. She denied any additional attempted contacts with Stanly since 7/10/23. On 7/26/23 at 3:24 p.m., the administrator and DON were interviewed. The DON stated he expected staff to update him, or a manager, when call lights malfunctioned in which they then updated maintenance. Maintenance concerns were overall communicated verbally. If a call light concern was identified, the administrator expected maintenance to trouble shoot the call light concern and if unable to resolve, he expected them to contact him so he could check the system "on the back end." The administrator confirmed he was the only one able to program the call lights. A call was placed to Stanley in May and then again that morning to request technical support. The administrator stated Stanley was called "many times" between that time frame and explained DM-A and MA-A may have confused Stanley and Global Tech. Global Tech was their computer technical support. The administrator stated call lights audits were conducted on 4/29/23, 5/6/23, and 5/13/23; however, he and the DON confirmed no audits were conducted in June and July. The DON stated he conversed with maintenance about call light issues this day and denied any other recent call light conversations. The administrator explained there were potential risks associated with a non-functioning call light system; however, denied knowledge of any adverse outcomes related to the call light system concerns. On 7/27/23 at 11:05 a.m. the first floor's northeast hallway display identified the following information:	F 919			

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F 919	Continued From page 25 -101 bed, 106 bed, 106 BR, 108 bed, 114 BR, 115 bed, 119 bed, 119 BR, 121-2 bed, and 122 BR. When interviewed on 7/27/23 at 11:15 a.m., NA-D stated if she identified a call light concern, she was expected to place it in the "TELS" system; however, she just called maintenance instead. She denied updating maintenance recently on her expressed call light concerns as "we know they do not work, and they are working on it." She explained she "just [kept] rounding" which she completed more frequently over the past week as some call lights were not functioning "again" and there were "bugs in the system." NA-D confirmed concerns with the call light in 108, 114, 115, 121, 122, and 119 which just started to have an issue. In addition, she confirmed all those residents utilized a call light to alert staff of their needs. She explained if call lights failed to function staff were expected to provide residents with bells as residents required a way to immediately contact staff for them to respond. She indicated there were a few residents, not all residents, who were provided bells; however, was unsure if all the rooms she mentioned were provided bells. During interview on 7/27/23 at 11:47 a.m., registered nurse (RN)-A stated he expected staff to follow the chain of command if a call light failed to work. If they approached him, he attempted to fix it right away and if unable he contacted maintenance. He explained a functioning call light was important for resident safety: "They may not need something important but at times it could be." If a resident was no provided with a functioning call light the residents were deprived of care as staff would be unaware of any required needs. RN-A stated there were past issues with	F 919			

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F 919	Continued From page 26 the call lights where the call light showed it was activated in the room; however, not on the hallway display. He confirmed 106, 108, 113, 114, 121-2, and 122 use their call lights. He stated all the call lights functioned and he was unaware of any concerns. He denied her participated in any recent call light audits. When interviewed on 7/27/23 at 1:28 p.m., Stanley service technician stated he identified that morning a "repeater was offline and missing." The second concern identified were that two of the hallway displays failed to function (first and third floor). A third concern identified 14 alerts were present within the Ariel computer system in which "seven or eight" were missing devices. He reprogrammed three devices and instructed MA-A on the process. In addition, he identified a couple call lights where the transmitters were bad within the device, and he instructed the facility to replace the entire device as there was not a way to fix them. He also recommended if a device presented concerns and all options were tried to fix it, the device should be replaced. The technician denied there were manufacture recommendations on when to replace the devices or when to have the system serviced. He explained some of the facility concerns were related to the missing repeater which he expected there based on the system identified repeater locations in which with a missing repeater there was not a strong enough signal to push it through to clear the activated devices. In addition, he explained the missing repeater's location controlled the area where most of the problems were identified. An Answering the Call Light policy, dated 11/22, identified its purpose was to ensure timely	F 919			

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 07/27/2023
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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F 919	Continued From page 27 responses to resident requests and needs. The policies General Guidelines directed staff to ensure the call light was plugged in and functioned at all times and to report all defective call lights to the nurse supervisor promptly. No other polices related to call lights were provided.	F 919			

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 C 07/27/2023
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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2 000	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 7/24/23-7/27/23, 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

08/14/23

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 C 07/27/2023
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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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was reviewed: H52893756C (MN00095380) with a licensing order issued at 1550. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 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		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide pharmaceutical services to assure 2 of 3 residents (R1 & R2) received their physician ordered medications. Findings include: R1's admission Minimum Data Set (MDS) dated 6/19/23, noted R1 had moderately impaired cognition, no refusal of cares, and required the extensive assistance of 2 staff for bed mobility, transfers, dressing toileting and personal hygiene. R1's diagnoses included: wedge compression fracture of the 4th lumbar vertebra, repeated falls, hepatic (liver) failure, and hepatic encephalopathy (brain function affected). R1's electronic medical record (EMR) contained hospital discharge orders dated 7/10/23, with that	21550	CORRECTED	9/1/23

Minnesota Department of Health

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21550	Continued From page 3 included the medication rifaximin 550mg tab orally twice a day. R1's July 2023 medication administration record (MAR) noted rifaximin 550mg tablet twice a day for diarrhea to start on 7/10/23, at 4:00 p.m. and was coded 9. According to the MAR legend, 9 means "other/see progress notes". The order was discontinued and rewritten on 7/11/23, rifaximin 550mg by mouth twice a day for hepatic encephalopathy. The MAR noted a "9" for the dates 7/10/23-7/15/23, on 7/16/23-7/20/23 it was coded a 6, the legend noted a "6" meant the resident was hospitalized. Progress notes dated 7/11/23-7/15/23, noted the rifaximin was "on order" or "awaiting supply/delivery". There were no progress notes regarding follow up to obtain the medication from the pharmacy until 7/16/23. A progress note dated 7/16/23, noted R1 was verbally unresponsive did not receive her rifaximin and lactulose (medications for her hepatic failure), follow was made with the pharmacy, and they were still awaiting delivery. R1 was transferred to the hospital due to her change in condition. During an interview on 7/24/23, at 2:27 p.m. the pharmacy technician (PH) noted a prior authorization was sent to the facility on 7/10/23, for R1's rifaximin as it was an expensive medication, and they did not receive a response to the request for authorization. During an interview on 7/24/23, at 1:30 p.m. the director of nursing (DON) stated he was called the pharmacy for R1's medication and had been told the medication was coming and then the	21550			

Minnesota Department of Health

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21550	Continued From page 4 medication was not in next the delivery. The DON stated he thought the nurses were also calling or faxing the pharmacy for medications and that there was no tracking of which medications were called in to be refilled. During an interview on 7/25/23, at 10:19 a.m. the nurse practitioner (NP) stated she was not notified of any difficulty in getting R1's rifaximin from the facility until 7/14/23, they were notified the medication required a prior authorization. During an interview with R1's physician on 7/26/23, at 3:09 p.m. he stated R1 has many comorbidities contributing the her hepatic encephalopathy and that R1 missing the medication administration of rifaximin would not cause her to be hospitalized.. R2's quarterly MDS dated 5/3/23, noted R2 had intact cognition, required the extensive assistance of 2 staff for transfers, bed mobility, dressing and toileting. R2's diagnoses included: morbid obesity, major depressive disorder, epilepsy. R2's May, June and July 2023, MAR noted an order for ropinirole HCl 0.25mg 1 tablet by mouth every 8 hours as needed for restless leg syndrome that began on 9/24/22, no doses had been administered to R2. During an interview on 7/24/23, at 10:16 a.m. R2 stated she had trouble with restless legs and ended up with her head over one side of the bed and her legs the other. R2 stated she was aware there was an order for ropinirole that was on her most recent discharge orders from the hospital and that she had asked for the medication to help her restless legs but had been told that the facility did not have it and that it had not been ordered,	21550		

Minnesota Department of Health

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21550	Continued From page 5 even with continued follow up from R2. R2 stated she reminded a nurse the other day to order it and was told they would as there is a new pharmacy providing medications. There were no progress notes regarding contacting the pharmacy from 5/1/23-7/24/23 to order or refill R2's ropinirole. During an interview on 7/27/23, at 9:57 a.m. trained medication aide (TMA)-C noted she called the pharmacy for ordering and refilling resident medications, however, she documented in a notebook and would shred the sheets after receiving the medications. During an interview with licensed practical nurse (LPN)-B stated she would call the facility to request medication refills or new medications ordered as when she faxed and called to follow up, the pharmacy commonly stated they did not receive the fax. LPN-B stated the calls to the pharmacy were not documented anywhere or tracked. During an interview on 7/27/23, at 11:01 a.m. LPN-A stated he would call the pharmacy for refills or new orders, he would fax a request if there were 5 or more medications that he needed. LPN-A stated the calls and follow up were not documented. During an interview on 7/27/23, at 1:18 p.m. TMA-A stated she would look for R2's medication but knew it was not there as R2 asked for that medication that morning. The TMA-A went to a computer and then to a box full of bubble packs of medications to look. R1's medication was not in the box and TMA-A stated she just ordered a refill now on the computer but wanted a nurse to	21550		

Minnesota Department of Health

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21550	Continued From page 6 verify she ordered the refill correctly. During an interview on 7/27/23, at 1:28 p.m. registered nurse (RN)-A stated the new pharmacy will not send PRN (as needed) medications unless they are specifically requested and that a phone call to the pharmacy is the quickest way to get the medication to the pharmacy. RN-A called the pharmacy to confirm the request to refill was submitted and requested R2's medication to be delivered this evening. The RN-A stated, R2 "asked me for it this morning when I went in to care for her wounds, she said it was for her restless legs". RN-A stated he had been busy with wound treatments, so he did not have the chance to request a refill that morning. A facility policy titled Pharmacy Services Overview last reviewed in November of 2022, noted residents have a sufficient supply of their prescribed medications and receive medications in a timely manner. Further, the policy noted nursing staff communicate prescriber ordered to the pharmacy and are responsible for contacting the pharmacy is a residents medication in not available for administration. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21550			

Minnesota Department of Health

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{2 000}	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/16/23 - 10/17/23, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 7/27/23 by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was	{2 000}		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/06/23

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 10/17/2023
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{2 000}	Continued From page 1 issued. 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 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	{2 000}		

Minnesota Department of Health

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{2 000}	Continued From page 2	{2 000}			
{21550}	IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide pharmaceutical service to assure 2 of 3 (R7 & R9) received their physician ordered medications. Findings include: R7's quarterly Minimum Data Set (MDS) dated 7/7/23, indicated he had intact cognition and required extensive assistance of another person for bed mobility, transfers, dressing and toileting. R7 diagnoses included amputation of right leg above the knee, muscle weakness, and type II diabetes mellitus. R7's electronic medical record (EMR) indicated R7 was hospitalized from 10/3/23-10/7/23. R7's October 2023 medication administration record (MAR) accessed on 10/17/23, indicated several blank spaces for his medications. The MAR also had medications that had a number 9 in the box, a number 9 indicated "other/see progress notes". For the dates of 10/14/23,	{21550}	Corrected	11/10/23	

Minnesota Department of Health

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{21550}	Continued From page 3 10/15/23 and 10/16/23 a number 9 was listed for R7's Metolazone, a diuretic medication to help the body get rid of excess water, typically used to treat high blood pressure. The coordinating progress notes for 10/14/23 noted "on order", for 10/15/23 noted "meds on order", and on 10/16/23 "on order". R7's MAR noted a number 9 listed for his Ipratropium Albuterol solution, used to treat, and prevent symptoms of wheezing and shortness of breath caused by ongoing lung disease, on 10/16/23. The coordinating progress note indicated "awaiting supply". R9's 5-day MDS dated 7/18/23, did not assess his cognition, required limited assistance of one person for bed mobility, transfers, dressing and toileting. His diagnoses included: spinal stenosis, failure to thrive and hyperglycemia. R9's brief interview for mental status (BIMS) dated 10/6/23, noted he had intact cognition. R9's October 2023 MAR accessed on 10/17/23, noted the number 9 for his 8:00 a.m. Losartan potassium, used to treat high blood pressure, for the dates of 10/2/23, 10/3/23, and 10/5/23. The order included instructions to hold the medication if R9's systolic blood pressure was less than 90. R9's MAR lacked blood pressure readings for the mornings of 10/2/23 and 10/3/23. R9's coordinating progress notes did not indicate a reason the medication was not given for 10/2/23 and 10/3/23 but indicated on 10/5/23 the medication was "on order". It noted a 9 for his Sitagliptin phosphate, used to control blood sugars, for the dates of 10/1/23, 10/6/23, 10/7/23, 10/8/23, and 10/9/23. The coordinating progress note for 10/1/23, did not indicate a reason the medication was not given. The coordinating progress notes indicated "n/a"	{21550}			

Minnesota Department of Health

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{21550}	Continued From page 4 for the dates of 10/6/23, 10/7/23, 10/8/23. For 10/9/23, the progress note indicated the medication was "on order". A progress note dated 10/9/23, noted R9 had an elevated blood sugar of 390 at 6:24 p.m. the provider was notified, the pharmacy was called and confirmed the medication would be delivered that evening. During an interview on 10/16/23, at 12:29 p.m. licensed practical nurse (LPN)-C stated she would click a button in the electronic health record (EHR) to reorder a medication, would probably reorder when there were 5 days left and if she noticed a resident was missing a medication for a few days she would call the pharmacy to find out where it was. During an interview on 10/16/23, at 12:38 p.m. trained medication aide (TMA)-A stated there is a button in the EHR that is used to reorder medications, notification is sent to the pharmacy medications should be reordered when they only have 7 days left. If she saw that a resident did not have their medications for a few days she would notify the nurse and if the nurse were not available, she would call the pharmacy. During an interview on 10/16/23, at 3:37 p.m. registered nurse (RN)-D stated in the EHR, go to the MAR and click on the medication, it will tell you if the medication was already reordered, if it was on the way, or received as sometimes the medications have gone to the wrong floor. RN-D stated she thought they were supposed to reorder when there was 3 days left of medications. RN-D stated if she noticed a resident did not have a medication for a few days she would call the pharmacy to find out where it was.	{21550}			

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 10/17/2023
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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{21550}	Continued From page 5 During an observation on 10/17/23, at 9:58 a.m. TMA-B was seated at the nursing station on the 3rd floor and was on the phone, she was listing several resident names and medications. During an interview on 10/17/23, at 10:15 a.m. TMA-B stated she was on the phone with the pharmacy refilling resident medications, some residents were completely out of their medications. TMA-B stated she called the pharmacy because there were less than 7 doses of medications left and when refilling in the EHR, receiving the medications could take 2-3 days. TMA-B stated she wound document the resident names and medications on a missing medication log and then would give the log to the nurse manager. TMA-B stated this was not a new process to the facility but was a new process to her to use a missing medication log, it was initiated that day. During an interview on 10/17/23, at 12:58 p.m. the assistant director of nursing (ADON) stated she was not mentored in her position and that she was responsible to go to the medication carts and remove expired medications. The ADON stated refilling medications was a button that is clicked in the EHR. During an interview on 10/17/23, at 4:18 p.m. the director of reimbursement (DOR) stated nursing staff had the ability to refill medications within the EHR by clicking a button though had just learned there was a glitch, and the button was now active. The DOR stated she expected staff to refill a medication prior to them running out and the process was that nursing staff would refill a medication when the resident had 7 doses of the medication left, if the medication was not refilled	{21550}			

Minnesota Department of Health

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{21550}	Continued From page 6 and received then the nurse should call the pharmacy and call the physician, they could also look in the emergency kit from the pharmacy to see if a dose was available in the facility, and then to document their actions in a progress note. A facility policy titled Pharmacy Services Overview last reviewed in November of 2022, noted residents should have a sufficient supply of their prescribed medications and receive medications in a timely manner, nursing staff were responsible for contacting the pharmacy if the medication was not available for administration and if medications were missing or need to be reordered the staff would notified the DON or designee. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	{21550}			

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NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
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{F 000}	INITIAL COMMENTS On 10/16/23 - 10/17/23, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited on 7/27/23. The facility was NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. 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 838} SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population,	{F 838}		11/10/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/06/2023

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 838}	Continued From page 1 including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing	{F 838}			

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{F 838}	Continued From page 2 information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to assess the overall acuity of the resident population when identifying the level and types of care needed for the resident population. The facility assessment did not include the Administrator, the director of nursing (DON), or direct care staff. This deficient practice had the potential to affect all 66 residents who resided at the facility. Findings include: The facility assessment dated 8/1/22 indicated the facility staffing plan was one DON full-time days. One RN assisted director of nursing (ADON) full-time days, one RN nurse manager, fulltime, one licensed practical nurse health unit coordinator. RN and LPN day/evening ratio per shift was 1:14 and RN/LPN night ratio was 1:28 per shift. Direct care staff days/evening was 1:10 ratio, and direct care staff night ratio was 1:14. The facility assessment dated 7/28/23 facility staffing plan indicated one DON, RN full-time days, two RN nurse managers, fulltime. RN and LPN day/evening shift ratio was 1:14 and RN and LPN nights ratio was 1:28 per shift. Direct care staff days/evening ratio was 1:12 and nights the ratio was 1:20. Facility assessments dated 8/1/22 and 7/28/23 both indicated under the title Guidelines for	{F 838}	1. Facility reviewed Facility Assessment with the proper individuals required to incorporate accurate information based on resident population and resources the facility needs to care for the residents. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Facility educated leadership on Facility Assessment. 4. Facility educated Staffing Coordinator on staffing based on the facility assessment, facility census and resident acuity. 5. Facility will audit schedule once weekly for two weeks, then once every 2 weeks for the next 2 weeks, then monthly thereafter to ensure that facility is following staffing pattern in the facility assessment. All audits will be brought to QAPI to assess for compliance and the continued need for audits. 6. Administrator and Staffing Coordinator are responsible for this plan of correction.		

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{F 838}	Continued From page 3 conducting the Assessment to ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, and the director of nursing. The environmental operations manager and other department heads (e.g., the dietary manager, director of rehabilitation services, or other individuals including direct care staff) should be involved as needed. Facilities are encouraged to seek input from residents, their representative(s), or families, and consider that information when formulating their assessment. Upon interview on 10/17/23 at 4:21 p.m. the Administrator stated facility assessment dated 7/28/23 was updated the day following the state survey of 7/27/23. He stated the only item that was changed on the facility assessment were the ratio of staff to residents. "Corporate made the assessment match with what we were currently able to staff." The Administrator stated the patient acuity was not considered; the assessment was based on the resident payment per day. He stated he was told what numbers were to be placed into the assessment per the owner. He stated he has had multiple conversations with the owner telling the owner he was "being set-up to fail" with the decreasing of staff and would not be able to make changes needed to put the facility back into compliance with the Minnesota Department of Health (MDH) and Centers for Medicare and Medicaid Services (CMS). The Administrator resigned from the facility with a last date of employment on 10/19/23. The Administrator stated the owner had hired a consultant company that started on 10/2/23 and the consultants recognized after a few days that the was a need for more staff so	{F 838}			

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{F 838}	Continued From page 4 they have added nursing assistants (NA) on days when they could find extra help, however the facility assessment had not been changed. Upon interview on 10/17/23 at 4:38 p.m. the director of nursing stated that he was not involved in the changing of the facility assessed. He stated he was told by the Administrator the facility was changed to align with the current levels the facility was using. He stated he followed the facility assessment for scheduling until the "last couple of weeks" when the consultants had told him to add additional staff daily wherever he found staff to be available. On 10/17/23 at 4:50 p.m. a voicemail was left for the owner. No call was returned. Upon interview at 5:03 p.m. the Regional Operation Manager (ROM) stated the owner reached out to him and asked him to interview on his place. The ROM stated he was not employed by the facility at the time when the facility assessment was changed and would not be able to answers any questions regarding the assessment changes.	{F 838}			