



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: C13B12

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 Departments 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

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

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.

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 27, 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
P.O. Box 64900

The Terrace At Crystal LLC

October 27, 2023

Page 5

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 C13B13

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 \$500.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on November 28, 2023 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$500.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling \$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
September 8, 2023

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

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

Dear Administrator:

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

On August 24, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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 May 4, 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,

An equal opportunity employer.

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:

Renee McClellan, Unit Supervisor
Metro A District 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

The Terrace At Crystal LLC

September 8, 2023

Page 3

Email: renee.mcclellan@state.mn.us

Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

The Terrace At Crystal LLC

September 8, 2023

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: C13B11

Dear Administrator:

The above facility was surveyed on August 22, 2023 through August 24, 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:

Renee McClellan, Unit Supervisor
Metro A District 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/04/2023
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR		STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(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) COMPLETE DATE
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 10/3/23 - 10/4/23, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

10/23/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/04/2023
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR		STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102			
(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) COMPLETE DATE
2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H55245878C (MN97213) & H55246203C (MN96239) with a licensing orders issued at 1435 and 1445. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR		STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(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) COMPLETE DATE
2 000	Continued From page 2 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		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 3 of 3 residents (R1, R3, R4) who were dependent on staff for activities. Findings include: Upon observation on 10/3/23 at 9:12 R1 was seated fully dressed and groomed seated in her wheelchair outside of the nurse's stations. There was another resident seated in a wheelchair next	21435	Corrected	10/23/23

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21435	Continued From page 3 to her. The two residents were not conversing back and forth. Upon observation on 10/3/23 at 10:59 a.m. R1 was seated outside the nursing station in her wheelchair. There were two other residents in wheelchairs outside the nurse's station. All three residents were asleep in their wheelchairs. Upon observations on 10/3/23 at 12:36 p.m. R1 was being wheeled by staff back to her room to lay down for a nap. Upon observations on 10/3/23 at 2:09 p.m. R1 was seated in her wheelchair in her room alone. R1 was facing a television that was not turned on. R1's room was quiet, and the lights were off. Upon observation on 10/3/23 at 3:13 p.m. R1 was seated in her wheelchair by the nurse's station. Upon observation on 10/4/23 at 9:00 a.m. R1 was fully dressed and groomed seated in her wheelchair outside the nurse's station. Upon observation on 10/4/23 at 11:25 a.m. R1 was seated in her wheelchair outside the nurse's station. Two other residents were seated in their wheelchairs. The residents were not conversing back and forth and there was not activity being performed. Upon observation on 10/4/23 at 2:28 p.m. R1 was seated in her wheelchair outside of the nurse's station. There was one other resident seated outside in her wheelchair. The two were not conversing. R1's care plan (CP) dated 3/22/19 indicated the facility will adapt all activities for any physical and	21435		

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21435	Continued From page 4 visual impairments for R1. R1 will be invited to all larger special activities or books on tape. She enjoys walking or jogging. She enjoyed multiple genres of music. She enjoyed watching television privately in her room. A revision was made on 10/13/22 indicating R1 watched television in her room and had stuffed animal pets that she keeps near her. She sits with other residents at the nurse's stations; gets manicures monthly, loves pet visits, likes to look at picture books. R1's goal was she would be involved in activity programming of her choosing once per week over the next 90 days to include group of 1:1 activity. R1's interventions were 1:1 visits so resident could socialize as she wished. R1's Activity Assessment dated 11/1/22, indicated under status the assessment was an error. There were only two questions completed on the form. 1. How is important is it for you to choose what clothes you wear? The response was, "not very important". 2. How important is it to you to take care of your personal belongings or things? The response was, 'not very important". No other questions were completed and there was no place to leave any comments. R1's annual Minimum Data Set dated 11/2/22, indicated R1 had unclear speech, rarely makes self-understood verbally and nonverbally, rarely understands others, highly impaired vision. R1 had short and long-term memory problems and her cognitive skills for decision making were severely impaired. The MDS indicated R1 had physical behaviors symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing). The staff assessment of Daily and Activity Preferences indicated R1 enjoyed listening to music, being around animals, doing things with groups of people, and participating in her favorite	21435			

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21435	Continued From page 5 activities. R1's pertinent diagnoses were vascular dementia, (a form of dementia caused by impairment of blood to the brain), legal blindness, and aphasia (a language disorder that control language expression, leaving people unable to communicate effectively with others). The Care Area Assessment (CAA) did not indicate an activity concern. R1's Progress activity note dated 2/1/23 indicated: Quarter 1. R1 is assisted in her wheelchair to activities. She would attend parties, musical offerings, and balloon toss. R1 gets a manicure monthly. When offered, she looks forward to Canine Callie visits very much. She always carries her "pet" bear with her. R1 would visit with staff and peers at the nurses' station but was often sleepy. Her care plan had been updated. R1's Progress Activity note dated 4/26/23 indicated: Quarter 2. R1 is in a wheelchair, aided by staff or propelled by herself. She did not sleep well at night so was very sleepy during the day. R1 can get weepy but stops when this writer shows her pictures of dogs or talks about dogs in general; she loves pet visits a lot. R1 had her stuffed animals that she clings to; likes to watch TV shows or naps while watching TV; she socializes with staff at nurses' station or in hallways as she moved herself around. Her care plan has been updated. R1's activity progress note dated 7/20/23 indicated: Quarter 3. R1 spends much of her time in her wheelchair, propelling herself around her floor. She will chat at times but is very tired because of not sleeping well at night. She clutches her stuffed animals, smiles if you want to talk to her about them. R1 likes looking at picture	21435		

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21435	Continued From page 6 books, especially of dogs; she is always open to pet visits; likes her TV shows and movies. Her care plan has been updated. Upon interview on 10/3/23 at 11:06 a.m. FM-B stated the only personal activity she has seen for R1 was her watching television in her room but is not very relevant anymore due to her decline in memory and vision. She stated the facility is always quiet and see's many residents just sitting around in the hallways. She stated she wishes R1 could play bingo because that is offered a few times a week. Upon interview on 10/3/23 at 12:45 p.m. FM-A stated she has not really seen R1 involved in activities. She stated the facility has mass and rosary every day, but R1 is Lutheran, so she does not sit in on those events. She stated having an activity for R1 personally would be nice, but it would be difficult because R1 is nearly blind. She stated if the facility could find something R1 likes she may not have so many behaviors. Upon observation on 10/3/23 at 10:27 a.m. R3 was in the restorative therapy room. She was seated in a chair, not exercising, one other resident in the room exercising, one other resident seated next to R3. R3 was not engaging in conversation with any of the residents. R3's son was onsite for a visit. Upon observation on 10/3/23 at 12:09 p.m. R3 was in her bedroom sleeping. Upon observation on 10/3/23 at 2:45 p.m. R3 had a family member visiting in her room. Upon observation on 10/3/23 at 4:01 p.m. R3 was in her bed sleeping	21435			

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21435	Continued From page 7 Upon observation on 10/4/23 at 9:03 a.m. R3 was in her bed sleeping. Upon observation on 10/4/23 at 1:08 p.m. R3 was in her bed sleeping. Upon observation on 10/4/23 at 10:48 a.m. R3 was in the restorative therapy room seated in a chair with one other resident and a staff member. R3 was fully dressed and groomed. R3 had a family member with her. Upon observation and interview on 10/4/23 at 3:12 p.m. R3 was in her bed awake. R3 stated "I don't know what to do." R3's care plan dated 4/23/21 indicated activities were important to R3, often complains of being bored, but is often napping. R3 is independent and enjoys being outside when possible. R3 loves fashion, socializing and dogs. R3 will sometimes attend movies, but only in the craft room with the big screen. Often goes outside, to sit in the sun but has a hard time navigating. R3's care plan interventions were to direct R3 to desired activities to assure she is going to the right place as she gets turned around. Staff are to remind R3 of resident's names when in group settings and state their names as R3 has a hard time of hearing. R3's goal was to attend one group activity per month or as desired. R3's quarterly MDS dated 9/28/23 indicated R3 had clear speech, sometimes able to express ideas and wants, sometimes understands others. R3 had highly impaired vision. R3's Brief Inventory of Mental Status (BIMs) score was a two indicating severe cognitive impairment. R3 was identified to have been feeling down,	21435			

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21435	Continued From page 8 depressed, or hopeless nearly every day. R3 indicated it was very important to her to listen to music, be around animals such as pets, keep up with the news, go outside get fresh air and participate in religious services. R3's pertinent diagnoses were last stage Alzheimer's disease, anxiety, and depression. R3's progress note dated 9/28/23 indicated a significant change note: R3 uses a walker if she attends an activity; had trouble seeing so needed guidance and direction. She loved being outside and would go by herself but had been asked by AD-A to please stay in backyard, close to building for safety purposes. She stated that she liked to have magazines available to her; loved music in her room, does not watch TV; keeps up with current events. When asked in what way she does this she could not explain. R3 liked to be with group of people but declines many invitations or is sleeping when approached in her room. She stated having the chapel and mass available to her when desired was important to her. Her care plan was updated. Upon interview on 10/3/23 at 10:02 a.m. family member (FM)-C stated that there was not a full-time activity staff onsite. He stated he visited daily in the morning and FM-D visits R3 every day later in the day or evening. The reason they visit is to get R3 out of bed and converse with them. He stated all R3 does is want to sleep due to boredom. He stated the facility did not always lack activities. He stated R3 is a people person and she used to go visiting with friends, coffee, watching different events, bowling in the hallways, singing, walks outside, but now the only "activity" R3 does is restorative nursing (daily exercising) in the physical therapy room. R3 will speak with family members on the phone and say, "I'm so	21435			

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21435	Continued From page 9 bored, I don't know what to do with myself." Upon interview on 10/3/23 at 10:40 a.m. R3 stated she feels lost, that all she does is go to sleep and hope she does not wake up. She stated "What do you do with yourself when there is nothing to do? That is my entire life." R3 stated she would like to take walks in the garden, bowl in the hallways, listen to music (even if it is alone in her room), have coffee with friends, play group games. She stated if there are activities happening staff are not informing her of them. Upon interview on 10/3/23 at 2:45 p.m. FM-D stated the R3 gets up in the morning, take her medications and goes to the physical therapy department. She stated R3 would love it if the staff played music in her room. FM-D pointed to several CD's and a CD player in the room. She stated if she is not occupied, she will lay down and sleep and that is how she is found each time the family visits her. FM-D about a month ago the facility had signs posted for "resident happy hour." She stated she asked staff to please wake-up R3 up and escort her to happy hour. FM-D stated she called R3 and at the time of happy hour she was still in her room. FM-D stated she went to back to the facility and got R3 ready and escorted her to happy hour. FM-D stated there was no one at Happy Hour so an unidentified staff member told FM-D that it was being cancelled that no residents were coming. FM-D stated she found a few of R3's friends and told the unidentified staff member that they have residents wanting happy hour. A total of three residents had drinks together that day. Upon observation on 10/3/23 at 10:27 a.m. R4 was in the restorative therapy room using an exercise machine. There was a staff member in	21435		

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21435	Continued From page 10 the room. Upon observation on 10/3/23 at 4:03 p.m. R4 was sleeping in the recliner in her bedroom. Upon observation on 10/4/23 at 9:12 a.m. R4 was in her wheelchair heading back to her room. She commented as she scooted by "I'm heading to my room to do absolutely nothing again today." Upon observation and interview on 10/4/23 at 3:18 p.m. R4 was seated in her recliner in room. She stated she had been in her room, singing songs to herself all afternoon. R4's care plan dated 10/17/22 indicated R4 is very independent with self-directed activities in her room. When she wanted to be left alone, she will let staff know. She preferred to be invited to activities and will decide whether she wants to attend or not, liked opportunity for any staff member to take her outside; liked social exercising in the therapy room. R4's interventions indicated staff were to allow R4 to help with crafting projects as needed. Staff to invite R4 to spiritual programs, live music and arts and craft activities. Staff to offer 1:1 visit. Staff to provide pet therapy visits as able. A Revision was added on 7/25/23 for staff to offer R4 outside 1:1 garden visit when the weather is nice. R4's annual MDS dated 5/4/23 indicated R4 had moderate difficulty hearing, no difficulty with speech or making herself understood. R4 had a BIMs score of 15 indicating no cognitive impairment. R4's pertinent diagnoses were heart failure, anxiety, and depression. R3 indicated it was very important for her to keep up with the news, to do things in groups of people, to do her favorite activities, to go outside and get fresh air.	21435		

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21435	Continued From page 11 Upon interview on 10/3/23 at 2:02 p.m. R4 stated she has to keep herself busy at the feeling "activities are poor around here." R4 stated that she makes attempts to promote "something/anything" at the facility. She states she will sometimes go meals and start singing a song herself and try to get other residents to accompany. She stated she lives activities where she can be involved or just watch. She had not had 1:1 visits with staff and had not been offered 1:1 visits in the garden as promised by the facility. Upon interview on 10/3/23 at 10:51 a.m. assistant activity director (AD)-A stated her main job at the facility was gardening. She spent her mornings in the gardens and worked on activities in the afternoon. She stated most of her time is spent doing activity assessments to stay in compliance with those. AD-A stated at least once a week she tried to do a bingo event, board games, a movie, or manicures. She stated just recently one of the Catholic Sisters on staff started doing a ball toss activity on the second floor. She stated the plan was for her to toss the ball with some of the residents prior to lunch. She was uncertain whether this activity had been started or not. She stated there were no 1:1 activity being done with any residents since the 2/2023 when the activities director left the facility. AD-A stated she is aware activities need to document however she had not had time to make-up a process to document. Upon interview on 10/3/23 at 1:04 p.m. licensed practical nurse (LPN)-B stated the nursing staff has not been told to assist with any activities including 1:1. She stated the nursing staff may bring a newspaper to a resident who requests it. She stated the staff does not offer music, television, or any other resident interest or an	21435			

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21435	Continued From page 12 activity in the resident's room. She stated the residents sleep and have snacks. Upon interview on 10/3/23 at 3:05 p.m. LPN-C stated there are rarely any activities the shift he works, the residents either sit in the hallway or a few read in their room. Upon interview on 10/4/23 at 11:27 a.m. trained medical assistant (TMA)-A stated she does not see many activities in the facility anymore. She stated that the facility only has one person in activities who only does activities in the afternoons. TMA-A stated she did not believe there were any 1:1 activity currently happening. Upon interview on 10/4/23 at 11:35 a.m. Registered nurse (RN)-A stated, "I do wish there were more activities going on here, it would help nursing staff with falls and behaviors." Upon interview on 10/4/23 at 12:31 p.m. licensed practical nurse (LPN)-A stated she worked the p.m. shift and were "never" activities on the p.m. shift. She stated sometimes during the afternoon, at the beginning of the shift, some of the residents will be watching a movie or there might be bingo for those who are able to attend. Upon interview on 10/4/23 at 4:09 p.m. the Administrator stated she is aware there are limited activities at the facility. She stated since Covid the number of volunteers had declined. She stated the facility has been actively looking for an activity director. She stated they are waiting for the "right fit". She stated she wanted someone with experience who is energetic and has new and fresh ideas. The Administrator was not aware if any staff members were tracking and documenting activities on the residents.	21435		

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21435	Continued From page 13 A facility policy titled Resident's' Bill of Rights indicated the home has a well-rounded program of activities, including arts and crafts and spiritual services to help achieve personal growth. 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.	21435		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have a qualified activities director to oversee the development, implementation, and ongoing evaluation of the activities program for the facility. Upon interview on 10/3/23 at 10:44 a.m. the assistant activities director (AD)-A stated she was hired at the facility four years ago for facility gardening. AD-A stated when there was not gardening to be done, she would assist the activities department with activities. She stated	21445	Corrected	10/23/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21445	Continued From page 14 the facility had been without an activity director since 2/2023 and she has been filling in since that date. She stated she mainly spends her mornings in the garden and spends her afternoons doing activity assessments or performing an activity. AD-A stated she was not certified as an activity director, and she has not had two years' experience in a social or recreations program within the last five years, one of which was a full-time in a therapeutic activities program. She stated she is not an occupational therapist or occupation therapy assistant. When interviewed on 10/4/23 at 9:20 a.m. the human resource director (HR)-A stated the facility had been actively searching for an activity director. She stated she was aware that AD-A was not a certified activity director. Upon interview on 10/4/23 at 4:10 p.m. the Administrator stated the facility has been searching for an activity director since 2/2023. The facility has interviewed multiple candidates, but she has particular criteria she is looking for in the director and they have not found the "right fit" yet. She stated she was aware that AD-A is not a certified activity director. The Administrator stated she believed AD-A was only performing activities and she believed the Minimum Data Set Coordinator (MDS) was completing the assessments. A review AD-A's personnel file was completed. An Employee Status Change Form dated 7/22/19 indicated AD-A's job title changed from gardener to gardener/activities. AD-A hours changed from 40 hour per pay period to 80 hours per pay period. An Employee Status Change Form dated 5/2/22 indicated AD-A changed her hours per pay period from 80 hours to 64 hours, no other	21445		

Minnesota Department of Health

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21445	Continued From page 15 changes. AD-A's file did not show documentation of a condition job offer at the time of hire and did not show a job description. AD-A's initial job offer, her job description and the job description for the activity director were requested, however not provided. A facility policy related to qualifications of an activity director was requested, however not provided. 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.	21445			

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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 8/24/23. 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 755} SS=D	Pharmacy Srvc/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, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	{F 755}			11/10/23

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

Electronically Signed

TITLE

(X6) DATE

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 755}	Continued From page 1 §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 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	{F 755}	1. R7 and R9 had their medications reordered and received from pharmacy. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Facility educated nurses and TMA's on the proper process on documenting medication administration in the eMAR. 4. Facility educated nurses and TMA's on appropriately reordering medications in the correct timeframe to ensure medications do not run out. 5. Facility educated nurses and TMA's on contacting the provider for any missed medications. 6. Pharmacy educated nurses and TMA's on the proper process of reordering medications through the eMAR. 7. Facility implemented a missing medication log at each nurses' station to track medications that are out.		

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{F 755}	Continued From page 2 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, 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,	{F 755}	8. DON, Nurse Manager or designee will audit nurses and TMA's 1x/week for one month, then every 2 weeks for one month, then monthly on reordering medications for residents to ensure it is being completed in the correct timeframe. All audits will be brought to QAPI to assess for compliance and continued need for audits. 9. DON, nurse managers or designee will be responsible for the completion of this plan of correction.		

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{F 755}	Continued From page 3 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" 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	{F 755}			

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{F 755}	Continued From page 4 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. 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	{F 755}			

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{F 755}	Continued From page 5 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 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.	{F 755}			

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

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FORM APPROVED
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F 000	INITIAL COMMENTS On 8/22/23 - 8/24/23, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52894714C (MN96041, MN96183, MN96051) with a deficiency issued at F684, F726, F755. Deficient practice was also identified related to incidental finding. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684			9/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/14/2023

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.

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F 684	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently monitor vital signs for 1 of 3 residents (R1) reviewed for vital sign monitoring. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/26/23, indicated R1 was cognitively intact and had diagnoses of high blood pressure and heart failure. R1's care plan dated 5/27/22, included give cardiac medications as ordered, and to monitor, document, and report any signs or symptoms of congestive heart failure including increased heart rate and respirations. The care plan lacked instruction to monitor R1's blood pressure. R1's Order Summary Report dated 8/24/23, included an order for Losartan Potassium tablet, 25 milligrams (mg) one time per day for high blood pressure starting 3/22/23, and Furosemide 20 mg one time per day for heart failure starting 5/26/22. The report lacked an order for monitoring of R1's vital signs including heart rate, respirations, or blood pressure. R1's Weights and Vitals Summary dated 8/24/23, indicated R1's heart rate, respirations, and blood pressure were last documented on 7/25/23. R1's blood pressure during the two week period from 6/28/23 through 7/11/23, averaged approximately 126/74, and for the two week period from 7/12/23	F 684	1. R1's vital signs were taken on 09/11/2023. 2. R1's care plan and orders were updated to reflect vital signs weekly. 3. All residents care plans and orders were reviewed for weekly vital signs and updated accordingly. 4. This has the potential to affect all residents. 5. The facility provided education to the nursing staff on the importance of taking vital signs and following physician orders for frequency of vital signs. 6. DON, nurse manager or designee will audit that residents who have weekly vital signs are taken. Audits will continue 1x/week for one month, then every two weeks for one month, then monthly. All audits will be brought to QAPI to assess for compliance to stop audits. 7. DON, Nurse Manager or designee will be responsible for the completion of this plan of correction.		

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F 684	Continued From page 2 through 7/25/23, averaged approximately 138/78, demonstrating an upward trend. R1's medical record lacked evidence of resident refusal of vital sign monitoring. During interview on 8/22/23 at 3:29 p.m., R1 stated the facility used to take vital signs once during the day and would rotate between morning and evenings, and then the facility stopped. R1 stated, "No one has checked my vitals in a long time" but did not specify the amount of time. R1 stated she would like the facility to take her vital signs once a week and had voiced her concerns to the staff, but the staff did not have time to do it. During interview on 8/24/23 at 10:25 a.m., trained medication aide (TMA)-A stated any of the nursing staff could take resident vital signs, but usually the TMA's or nurses did it. TMA-A stated the need for vitals popped up on the medication administration record (MAR) in the computer, especially if someone was on a blood pressure medication, since sometimes they needed to take the blood pressure before administering the medication. TMA-A stated most residents had vital signs taken daily, but some were weekly on bath days. TMA-A further stated if a resident refused, the TMA reapproached and informed the nurse who notified the manager and the provider. During interview on 8/24/23 at 11:14 a.m., registered nurse (RN)-A stated nurses identified residents who needed vital signs taken by viewing the MAR, but was unsure if vital sign orders came from the providers or were nursing orders, or what the frequency was based upon. RN-A stated if a resident refused, it was expected to be documented. RN-A stated they use to complete	F 684			

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F 684	Continued From page 3 vital signs weekly but no longer did and was unsure of what the facility policy directed. RN-A stated if a resident had a history of high blood pressure and was on an antihypertensive medication, expected vital signs to be taken daily. RN-A reviewed R1's medical record, confirmed vital signs were not document since 7/25/23, and was unsure why they had stopped, but verified it was important to monitor vital signs regularly to prevent further health issues from arising. During interview on 8/24/23 at 11:27 a.m., director of nursing (DON) stated each resident in the long-term care unit should have vital signs taken weekly or more depending on the provider orders and condition of the resident. DON stated it was important to monitor vital signs on a resident who takes blood pressure medication to identify if the medications are effective or if changes in dose or medications are required. During interview on 8/24/23 at 1:21 p.m., Nurse Practitioner (NP)-A, stated this was discussed with the facility in the past for the need for R1 to have vital signs done regularly after noticing a lack of recorded vital signs. NP-A stated the facility knew what their protocol was and should at the very least have completed R1's vital signs weekly. A facility vital sign policy was requested but not provided.	F 684			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 726			9/21/23

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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 08/24/2023
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 726	Continued From page 4 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure licensed nursing staff were competent to count carbohydrates for 1 of 1 resident (R1) reviewed for insulin administration. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/26/23, indicated R1 was cognitively intact, had	F 726	1. R1 will be educated on Carbohydrate Counting, then assessed with return demonstration showing accuracy and capability of counting her own carbs. 2. All diabetic residents' orders and care plans were audited to check for physician orders for carbohydrate counting. There are currently no other like residents with these orders. 3. Facility will educate nurses on		

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F 726	Continued From page 5 diagnosis of diabetes mellitus, and daily insulin injections during the seven-day look back period. During document review, a progress note was entered on 8/22/23 at 1:12 p.m., which indicated a nurse and R1 disagreed on the amount of insulin that should be given. The note indicated R1 requested 18 units of insulin, but nurse told R1 18 units was too much for R1's blood sugar of 112 and reviewed the food R1 ate. The resident was difficult to redirect, did not accept education on insulin, and was encouraged to allow nurses to make insulin decisions. During observation on 8/23/23 at 9:45 a.m., R1 reported to registered nurse (RN)-D [R1] needed 14 units of insulin. R1's breakfast tray was already removed from their room. RN-D stated R1 needed 17 units of insulin based on the carbohydrate count calculation. RN-D administered 17 units of insulin. During interview on 8/23/23 at 9:56 a.m., RN-D stated R1 completed her carbohydrate counting with meals and knew the calculation but sometimes miscounted. Nursing cross checked whatever amount R1 told them. RN-D stated had checked with other staff regarding what R1 ate and what amount was consumed before entering R1's room to administer the insulin. During observation and interview on 8/23/23 at 1:16 p.m., R1 stated to RN-A [R1] should have ten units of insulin. Then R1 stated because [R1's] blood sugar was 173 according to their blood glucometer machine, R1 wanted 8 units of insulin instead. RN-A gave R1 8 units of insulin. RN-A stated R1 completed her carbohydrate count calculations and gave R1 the amount of	F 726	carbohydrate counting, then provide a quiz to demonstrate their accuracy and capability of counting carbs. 4. Facility will create a policy on carbohydrate counting and provide to all nurses. 5. DON, Nurse Manager or designee will audit nurses staff 1x/week for one month, then every 2 weeks for one month, then monthly to ensure that carbohydrate counting has been completed and is accurate. All audits will be brought to QAPI to assess for compliance and continued need for audits. 6. DON, Nurse Manager or designee will audit R1 1x/week for one month, then every 2 weeks for one month, then monthly to ensure that carbohydrate counting has been completed and is accurate. All audits will be brought to QAPI to assess for compliance and continued need for audits. 7. DON, Nurse Manager or designee will be responsible for the completion of this plan of correction.		

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F 726	Continued From page 6 insulin R1 reported. RN-A stated R1 said they knew how to count their carbohydrates from provider education but was unsure where or if the education was documented. The nurses depended on R1 to tell them how much insulin R1 should be receiving. During observation and interview on 8/23/23 at 2:10 p.m., the cook (C)-A stated the kitchen does not do carbohydrate counting for R1. The meal ticket for R1 provided listed R1's diet, likes, dislikes, type of assistance needed and the food to be provided at the meal. The meal ticket did not list the portion or amount of each food item given nor how many carbohydrates were to be provided at the upcoming meal. During interview on 8/23/23 at 3:53 p.m., the registered dietician (RD) stated the nurses needed to do carbohydrate counting if that was what was required for R1's insulin orders and did not provide further insight about the dietary departments or the resident's involvement in carbohydrate counting. During interview on 8/23/23 at 3:57 p.m., RN-A clarified they calculated how many grams of carbohydrates R1 ate based on the meal ticket slip from the kitchen that lists the food they gave R1 and the amount R1 had eaten based on their observations or what other staff reported to them. RN-A stated the kitchen gave them a paper with the number of grams each food item was but did not provide as requested. RN-A stated nursing does not record the number of grams of carbohydrates R1 ate as the amount of insulin reflects the amount of carbohydrates consumed. During observation and interview on 8/24/23 at	F 726			

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F 726	Continued From page 7 8:50 a.m., R1's breakfast tray was still in their room when licensed practical nurse (LPN)-A brought in R1's insulin pen. R1 told LPN-A what [R1] ate and 18 units of insulin should be given. LPN-A gave R1 18 units of insulin. LPN-A reviewed and stated a bowl of oatmeal was more than 15 grams and had added sugar which would be 1 unit of insulin, a finished 240 mL glass of milk would be six units of insulin but R1 had not finished all their milk, R1 ate all their cereal which was about 5 or 6 units of insulin, and one slice of bread is 2 units of insulin. LPN-A stated every nurse on the floor knew how to count R1's grams of carbohydrates and believed the facility gave her education on carbohydrate counting. However, was unable to provide documentation of the education. During interview on 8/24/23 at 11:25 a.m., about the encounter from 8/22/23, LPN-A stated R1 wanted 18 units of insulin however the nurse calculated R1's carbohydrate count and R1 should receive 8 units based on what R1 ate. LPN-A believed R1 based their calculation out of anticipation that their blood sugar level was going to rise rather than basing the insulin amount on what R1 ate. LPN-A stated R1's blood sugar level was 112 at the time. During interview on 8/24/23 at 11:42 a.m., RN-A stated today was their first time seeing a food list that showed every carbohydrate choice for which R1 would get 2 units of insulin. One serving of the food item listed equaled 15 grams of carbohydrates. RN-A agreed there was previously no standard for tracking the number of grams of carbohydrates eaten and no education on such. RN-A stated R1 would be at risk for receiving too much insulin that could result in dropping blood	F 726			

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F 726	Continued From page 8 sugar levels without a counting standard in place. During interview on 8/24/23 at 1:21 p.m., the Nurse Practitioner (NP) stated R1 was alert, oriented, and cognitively aware. NP believed R1 was aware of her carbohydrate counting in relation to how much insulin R1 should be receiving. NP stated nursing followed the order which read 15 grams of carbohydrates equated to giving 2 units of insulin. If nursing and R1 disagreed on carbohydrate and insulin amounts, nursing should let NP know so they could discuss with R1 and make an appropriate plan. NP verified nursing had not made NP aware of the recent disagreements with R1 and the nursing staff. During interview on 8/24/23 at 2 p.m., the director of nursing (DON) stated nurses understood carbohydrate counting and insulin administration, but there was no way for nurses to verify exact carbohydrates consumed as R1 refused to let nursing see how much R1 had consumed. R1 wanted nursing to give insulin based on what she reported to them. The DON did not provide documentation about nurses receiving education about carbohydrate counting.	F 726			
F 755 SS=D	The facility did not have a policy or procedure regarding carbohydrate counting. 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	F 755			9/21/23

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F 755	Continued From page 9 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, 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 interview and document review, the facility failed to identify a system to obtain and track a carbohydrate count to ensure the correct dose of insulin was administered for 1 of 1 resident (R1) and the facility failed to monitor blood glucose levels and administer diabetes medications for 1 of 3 residents (R2) reviewed for diabetic management. Findings include:	F 755	1. R1 was educated on Carbohydrate Counting, then assessed to ensure R1 was competent. 2. R1's orders and care plan were updated to show carbohydrate counting with meals, which will display on the eMAR for nurses. 3. R2's diabetic medications were reordered and R2 was updated that medications will be given as ordered. 4. R2 will have blood sugar levels		

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F 755	Continued From page 10 R1's quarterly Minimum Data Set (MDS), dated 7/26/23, indicated intact cognition, behavior of rejection of care for one to three days during look-back period, assist of two for bed mobility, dressing, toileting, and personal hygiene, and indicated diagnosis of diabetes mellitus and insulin injections received all seven days of look-back period R1's physician orders sheet for August 2023, included Insulin Lispro Kwik pen 2 units per 15 g [grams] of carbs [carbohydrates] with meals for diabetes. R1's medical record lacked assessment for R1's ability to count carbohydrates in her diet to accurately report to nursing staff how much insulin R1 required with meals. During record review, a progress note was entered on 8/22/23 at 1:12 p.m., which indicated a nurse and R1 disagreed on the amount of insulin that should be given. The note indicated R1 requested 18 units of insulin, but the nurse told R1 18 units was too much for R1's blood sugar of 112 and reviewed the food R1 ate. The resident was difficult to redirect, did not accept education on insulin, and was encouraged to allow nurses to make insulin decisions. During observation on 8/23/23 at 9:45 a.m., R1 reported to registered nurse (RN)-D R1 needed 14 units of insulin. R1's breakfast tray was already removed from the room. RN-D stated R1 needed 17 units of insulin based on RN-D's calculation. RN-D administered 17 units of insulin During observation and interview on 8/23/23 at 1:16 p.m., R1 stated to RN-A [R1] should have	F 755	checked per orders. 5. This has the potential to affect all like residents. 6. All diabetic residents' orders and care plans were audited to check for physician orders for carbohydrate counting and diabetic medications. There are currently no other like residents with orders for carbohydrate counting. 7. Facility will educate nurses on carbohydrate counting, then provide a quiz to demonstrate their accuracy and capability of counting carbs. 8. Facility will create a policy on carbohydrate counting and provide to all nurses. 9. Facility educated nurses on notifying the provider for disagreements between resident/nurse for insulin dosing and missed medications/blood sugar levels. 10. Facility educated nurses on obtaining blood glucose levels as ordered. 11. Facility educated nurses and TMAs on appropriately reordering medications in the correct timeframe to ensure medications do not run out. 12. Facility educated CNA's on appropriately recording nutrition for each resident. 13. DON, Nurse Manager or designee will audit nurses staff 1x/week for one month, then every 2 weeks for one month, then monthly to ensure that carbohydrate counting has been completed and is accurate. All audits will be brought to QAPI to assess for compliance and continued need for audits. All audits will be brought to QAPI to assess for compliance and continued need for		

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F 755	Continued From page 11 ten units of insulin. Then R1 stated because [R1's] blood sugar was 173 according to their blood glucometer machine, R1 wanted 8 units of insulin instead. RN-A gave R1 8 units of insulin instead of the 10 units of insulin required by the carbohydrate count. RN-A stated R1 completed her carbohydrate count calculations and gave R1 the amount of insulin R1 requested. RN-A stated R1 reported knowing how to count their carbohydrates from provider education but was unsure where or if the education was documented. The nurses depended on R1 to tell them how much insulin R1 should receive. During interview on 8/23/23 at 9:56 p.m., RN-D stated R1 completed her carbohydrate counting with meals and knew the calculation but sometimes miscounted. Nursing cross checked whatever amount R1 told them and sometimes needed education about not getting the amount of insulin R1 stated they needed because R1 had not eaten a certain amount. During interview on 8/24/23 at 11:25 a.m., about the encounter from 8/22/23 revealed in the progress notes, licensed practical nurse (LPN)-A stated R1 wanted 18 units of insulin but the nurse calculated the carbohydrate count and R1 should have received 8 units based on what R1 ate. LPN-A believed R1 based their calculation out of anticipation their blood sugar level was going to rise rather than basing the insulin amount on what R1 ate. LPN-A stated R1's blood sugar level was 112 at the time During interview on 8/24/23 at 1:21 p.m., the Nurse Practitioner (NP) stated R1 was alert, oriented, and cognitively aware. NP believed R1 was aware of her carbohydrate counting in	F 755	audits. 14. DON, Nurse Manager or designee will audit R1 1x/week for one month, then every 2 weeks for one month, then monthly to ensure that carbohydrate counting has been completed and is accurate. All audits will be brought to QAPI to assess for compliance and continued need for audits. All audits will be brought to QAPI to assess for compliance and continued need for audits. 15. DON, Nurse Manager or designee will audit nurses 1x/week for one month, then every 2 weeks for one month, then monthly to ensure blood glucose levels are being obtained as ordered. All audits will be brought to QAPI to assess for compliance and continued need for audits. 16. DON, Nurse Manager or designee will audit nurses and TMA's 1x/week for one month, then every 2 weeks for one month, then monthly on reordering medications for residents to ensure it is being completed in the correct timeframe. All audits will be brought to QAPI to assess for compliance and continued need for audits. 17. DON, Nurse Manager or designee will audit CNA's 1x/week for one month, then every 2 weeks for one month, then monthly on recording nutrition for residents to ensure it is being completing appropriately. All audits will be brought to QAPI to assess for compliance and continued need for audits. 18. DON, nurse managers or designee will be responsible for the completion of		

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F 755	Continued From page 12 relation to how much insulin R1 should be receiving. However, NP did not verify R1 was educated on how to count carbohydrates. NP further stated, if nursing and R1 disagreed on carbohydrate and insulin amounts, nursing should let NP know so they could discuss with R1 and make an appropriate plan. During interview on 8/24/23 at 2 p.m., the director of nursing (DON) did not believe R1 was honest about what R1 ate and did not cooperate with nursing. R1 wanted nursing to give insulin based on what she reported to them. Inaccurate carbohydrate counting could lead to adverse reactions. DON was unable to verify education for competency of carbohydrate counting for R1. During interview on 8/23/23 at 3:53 p.m., the registered dietician (RD) stated the nurses needed to do carbohydrate counting if that was what was required for R1's insulin orders and did not provide further insight about the dietary departments or the resident's involvement in carbohydrate counting. The facility did not have a policy or procedure regarding carbohydrate counting. R2's quarterly Minimum Data Set (MDS) dated 6/19/23, indicated she was cognitively intact, did not reject cares, and had a diagnosis of diabetes. R2's care plan dated 8/2/23, directed staff to take blood sugar levels and administer diabetic medications as ordered by doctor, and monitor/document for side effects and effectiveness.	F 755	this plan of correction.		

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F 755	Continued From page 13 R2's Order Summary Report dated 8/24/23, included check blood sugar level three times per day before meals starting 6/27/23, and administer Glimepiride Tablet 2 milligrams (mg) one time a day starting 2/9/23, and Metformin 500 mg twice per day starting 2/8/23, both for diabetes management. R2's Blood Sugar Summary printed 8/24/23 at 8:40 a.m., included the following blood sugar readings in mg/dL (deciliter): 8/18/23 at 12:35 a.m., - 127.0 8/18/23 at 7:50 p.m., - 110.0 8/19/23 at 2:26 p.m., - 150.0 8/20/23 at 3:37 p.m., - 145.0 8/20/23 at 3:37 p.m., - 120.0 8/22/23 at 4:43 p.m. - 108.0 8/22/23 at 5:24 p.m. - 116.0 R2's medical record lacked documentation of blood sugar levels for 11 of 18 meals from 8/18/23 through 8/23/23. R2's Medication Administration Record (MAR) dated 8/24/23, indicated R2 did not receive her Glimepiride on 8/19/23, or 8/20/23, and did not receive her Metformin on the morning of 8/20/23. R2's Progress Notes dated 8/20/23 at 9:23 a.m., indicated R2 did not receive her prescribed Glimepiride or Metformin as the facility was "Awaiting supply". A progress note dated 8/20/23 at 6:56 p.m. indicated "Resident not seen for BG [blood glucose] before meals." R2's Nutrition - Amount Eaten task sheet (undated), identified R2 ate one meal on 8/19/23, one on 8/21/23, and one on 8/23/23, and included four meals between 8/18/23 and 8/23/23	F 755			

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F 755	Continued From page 14 documented as "Not Applicable". During interview on 8/23/23 at 10:47 a.m., registered nurse (RN)-B stated nurses completed blood sugar checks based upon provider orders and if a resident refused, it's documented in the medical record and the provider is informed. RN-B confirmed R2 required blood sugar checks three times per day before meals and verified R2's medical record lacked evidence of completion or documentation of resident refusal for those missing. RN-B indicated if a resident had a low supply of medications, the nurse ordered them using the electronic record and they arrived within 72 hours, but if they were needed quickly, the nurse called the pharmacy and usually received them the same day. RN-B reviewed R2's medical record and verified R2 had orders for Metformin and Glimepiride, and did not receive all indicated doses on 8/19/23 or 8/20/23. Upon review of the provider portal and the medical record, RN-B was unable to locate documentation of provider notification of missed doses or missed blood sugar levels. She stated it was important to administer diabetic medications and check blood sugars as ordered to ensure R2's diabetes was managed properly and avoid complications. During interview on 8/23/23 at 12:45 p.m., R2 was lying back in her wheelchair in her room in the dark. She stated she wasn't feeling well, had a headache and took some Tylenol but it did not help. She stated she took all her medications that morning, including Metformin and Glimepiride, but did not have anything to eat or drink yet, and she felt like she had low blood sugar, and nobody had come to check it yet.	F 755			

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

PRINTED: 09/15/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/24/2023
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 755	Continued From page 15 During interview on 8/23/23 at 1:16 p.m., pharmacist (Pharm)-A stated if a resident missed a day or two of Glimepiride or Metformin one expected to see a mild increase in blood sugar levels as the previous doses were eliminated from the body. He stated this would also vary with the amount and type of food the resident ate, but there was a potential for impact on the resident. Upon review of pharmacy records, Pharm-A stated a 30-day supply of R2's Glimepiride and Metformin was filled 7/10/23, and they did not receive a refill request until 8/19/23. He stated if they needed something immediately the facility could call and the pharmacy would send it out the same day, otherwise refills took up to 72 hours to arrive. During interview on 8/23/23 at 3:12 p.m., RN-A stated blood sugar levels should be taken as ordered, and refusals should be documented and the provider updated. RN-A stated there was no reason to run out of medications since they were easily ordered through the electronic record or by calling pharmacy. She stated since R2 had her diabetic medications that morning, did not eat, and did not have her blood sugar level checked, there was no way to know what her level might be. She stated staff should have offered R2 a shake or something else to ensure her blood sugar did not go too low. During interview on 8/24/23 at 11:27 a.m., director of nursing (DON) stated the facility had changed pharmacies recently and thought staff may not have properly ordered R2's medication on time due to a process change, but he was unsure why R2's blood sugar checks were not completed. He stated all orders should be completed timely, and staff should have informed the provider of the	F 755			

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F 755	Continued From page 16 missed blood sugar checks and medications to prevent a potential adverse outcome. The facility policy Administering Medications dated 11/2022, indicated medication are administered in accordance with prescriber's orders, including any required timeframe. The facility Insulin Administration policy dated 6/2022, directed staff to check blood glucose per physician order or facility protocol and document the result.	F 755			

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 8/22/23 - 8/24/23, 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 was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/14/23

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52894714C (MN96041, MN96183, MN96051) with a licensing order issued at 0300. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000			

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2 000	Continued From page 2	2 000			
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure licensed nursing staff were competent to count carbohydrates for 1 of 1 resident (R1) reviewed for insulin administration. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/26/23, indicated R1 was cognitively intact, had diagnosis of diabetes mellitus, and daily insulin injections during the seven-day look back period. During document review, a progress note was entered on 8/22/23 at 1:12 p.m., which indicated a nurse and R1 disagreed on the amount of insulin that should be given. The note indicated R1 requested 18 units of insulin, but nurse told R1 18 units was too much for R1's blood sugar of 112 and reviewed the food R1 ate. The resident	2 300	CORRECTED	9/21/23	

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2 300	Continued From page 3 was difficult to redirect, did not accept education on insulin, and was encouraged to allow nurses to make insulin decisions. During observation on 8/23/23 at 9:45 a.m., R1 reported to registered nurse (RN)-D [R1] needed 14 units of insulin. R1's breakfast tray was already removed from their room. RN-D stated R1 needed 17 units of insulin based on the carbohydrate count calculation. RN-D administered 17 units of insulin. During interview on 8/23/23 at 9:56 a.m., RN-D stated R1 completed her carbohydrate counting with meals and knew the calculation but sometimes miscounted. Nursing cross checked whatever amount R1 told them. RN-D stated had checked with other staff regarding what R1 ate and what amount was consumed before entering R1's room to administer the insulin. During observation and interview on 8/23/23 at 1:16 p.m., R1 stated to RN-A [R1] should have ten units of insulin. Then R1 stated because [R1's] blood sugar was 173 according to their blood glucometer machine, R1 wanted 8 units of insulin instead. RN-A gave R1 8 units of insulin. RN-A stated R1 completed her carbohydrate count calculations and gave R1 the amount of insulin R1 reported. RN-A stated R1 said they knew how to count their carbohydrates from provider education but was unsure where or if the education was documented. The nurses depended on R1 to tell them how much insulin R1 should be receiving. During observation and interview on 8/23/23 at 2:10 p.m., the cook (C)-A stated the kitchen does not do carbohydrate counting for R1. The meal ticket for R1 provided listed R1's diet, likes,	2 300			

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2 300	Continued From page 4 dislikes, type of assistance needed and the food to be provided at the meal. The meal ticket did not list the portion or amount of each food item given nor how many carbohydrates were to be provided at the upcoming meal. During interview on 8/23/23 at 3:53 p.m., the registered dietician (RD) stated the nurses needed to do carbohydrate counting if that was what was required for R1's insulin orders and did not provide further insight about the dietary departments or the resident's involvement in carbohydrate counting. During interview on 8/23/23 at 3:57 p.m., RN-A clarified they calculated how many grams of carbohydrates R1 ate based on the meal ticket slip from the kitchen that lists the food they gave R1 and the amount R1 had eaten based on their observations or what other staff reported to them. RN-A stated the kitchen gave them a paper with the number of grams each food item was but did not provide as requested. RN-A stated nursing does not record the number of grams of carbohydrates R1 ate as the amount of insulin reflects the amount of carbohydrates consumed. During observation and interview on 8/24/23 at 8:50 a.m., R1's breakfast tray was still in their room when licensed practical nurse (LPN)-A brought in R1's insulin pen. R1 told LPN-A what [R1] ate and 18 units of insulin should be given. LPN-A gave R1 18 units of insulin. LPN-A reviewed and stated a bowl of oatmeal was more than 15 grams and had added sugar which would be 1 unit of insulin, a finished 240 mL glass of milk would be six units of insulin but R1 had not finished all their milk, R1 ate all their cereal which was about 5 or 6 units of insulin, and one slice of bread is 2 units of insulin. LPN-A stated every	2 300			

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2 300	Continued From page 5 nurse on the floor knew how to count R1's grams of carbohydrates and believed the facility gave her education on carbohydrate counting. However, was unable to provide documentation of the education. During interview on 8/24/23 at 11:25 a.m., about the encounter from 8/22/23, LPN-A stated R1 wanted 18 units of insulin however the nurse calculated R1's carbohydrate count and R1 should receive 8 units based on what R1 ate. LPN-A believed R1 based their calculation out of anticipation that their blood sugar level was going to rise rather than basing the insulin amount on what R1 ate. LPN-A stated R1's blood sugar level was 112 at the time. During interview on 8/24/23 at 11:42 a.m., RN-A stated today was their first time seeing a food list that showed every carbohydrate choice for which R1 would get 2 units of insulin. One serving of the food item listed equaled 15 grams of carbohydrates. RN-A agreed there was previously no standard for tracking the number of grams of carbohydrates eaten and no education on such. RN-A stated R1 would be at risk for receiving too much insulin that could result in dropping blood sugar levels without a counting standard in place. During interview on 8/24/23 at 1:21 p.m., the Nurse Practitioner (NP) stated R1 was alert, oriented, and cognitively aware. NP believed R1 was aware of her carbohydrate counting in relation to how much insulin R1 should be receiving. NP stated nursing followed the order which read 15 grams of carbohydrates equated to giving 2 units of insulin. If nursing and R1 disagreed on carbohydrate and insulin amounts, nursing should let NP know so they could discuss with R1 and make an appropriate plan. NP	2 300			

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2 300	Continued From page 6 verified nursing had not made NP aware of the recent disagreements with R1 and the nursing staff. During interview on 8/24/23 at 2 p.m., the director of nursing (DON) stated nurses understood carbohydrate counting and insulin administration, but there was no way for nurses to verify exact carbohydrates consumed as R1 refused to let nursing see how much R1 had consumed. R1 wanted nursing to give insulin based on what she reported to them. The DON did not provide documentation about nurses receiving education about carbohydrate counting. The facility did not have a policy or procedure regarding carbohydrate counting. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300			