



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2022

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

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

Dear Administrator:

On October 29, 2022, we notified you a remedy was imposed. On November 16, 2022 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 16, 2022.

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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



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November 23, 2022

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

Re: Reinspection Results
Event ID: CTDD12

Dear Administrator:

On November 16, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 29, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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October 17, 2022

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

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

Dear Administrator:

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

On September 29, 2022, the Minnesota Department of Health 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:

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

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

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction

An equal opportunity employer.

The Terrace At Crystal LLC

October 17, 2022

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(ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.



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



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October 17, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: CTDD11

Dear Administrator:

The above facility was surveyed on September 28, 2022 through September 29, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "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 Terrace At Crystal LLC

October 17, 2022

Page 2

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:

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

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

Please feel free to call me with any questions.



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

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

PRINTED: 11/07/2022
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 09/29/2022
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 09/28/22 and 9/29/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52894800C (MN87503) and H52894894C (MN87103), with a deficiency cited at F550 and F759. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550			11/4/22

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

TITLE

(X6) DATE

Electronically Signed

10/24/2022

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

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

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents needs were addressed in a respectful and dignified manner when residents used their call light to ask for assistance (R3). Findings include: R3's significant change Minimum Data Set (MDS)	F 550	F550: 1. R3 call light placed within resident's reach 2. All residents call lights placed within reach 3. Staff educated on placing resident's call light within reach and timely response time 4. To ensure that the call lights are being		

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F 550	Continued From page 2 dated 7/20/22 indicated intact cognition, R3 required extensive assistance in toileting and was always incontinent of urine. R3's medical diagnoses list in point click care indicated R3 had the following diagnoses: other specified urinary incontinence, generalized anxiety disorder, type two diabetes with hyperglycemia, and chronic systolic congestive heart failure. R3's care plan revised 5/27/22, indicated R3 had urge and mixed bladder incontinence and required incontinence changes every two hours and as needed. R3's care plan revised 8/12/22, indicated R3 needed her call light within reach and R3 needed prompt response to all requests for assistance. R3's device activity log on 9/28/22, indicated an average response time of 26 minutes, 13 seconds for R3's call light to be answered. At 7:13 a.m., the log indicated R3 waited 90 minutes, 40 seconds for her call light to be answered. R3's medication administration record (MAR) for September 2022, indicated R3 was taking furosemide (a diuretic) 20 milligrams (mg) daily for heart failure. During interview and observation on 9/28/22, at 9:58 a.m. a sheet of paper was located on R3's door that stated, "Due to privacy, sign sheet has move [SIC] to the resident's closet." R3 stated at 10:00 a.m. that she was going to cry and stated the night nursing assistant (NA) changed her pad at 5:45, left at six and did not get her pad changed until 9:30 and stated she sat in a wet	F 550	answered in a timely manner the facility will change its current system to have group sheets for aides and nurses to have assigned rooms ensuring that the call lights are answered in a timely manner. 5. Groups will be audited individually for compliance to call light response time once a day. 6. All call lights will be checked weekly by maintenance to ensure that the call lights are operational. 7. Call light audits including timely response times will be conducted by DON or designee. Daily audits for 1 week on alternating shifts, then 3x per week for 2 weeks on alternating shifts, then 1x per week for 1 week on alternating shifts 8. All issues will be brought to QAPI		

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F 550	Continued From page 3 pad and stated she takes Lasix and needed to be changed frequently. R3 stated 10 to 15 minutes is a long enough time to wait for her call light to be answered. R3 stated she felt anxious and afraid because she did not know how long she would have to wait in a wet pad before someone answered her call light. During interview and observation on 9/28/22, at 10:05 a.m. R3 stated she had her light on for 20 minutes. The red button was on in R3's room. The sheet in R3's closet indicated a staff person signed the sheet on 9/28/22, at 9:15 a.m. R3 stated that her skin burned from sitting in the pad and stated it was a chronic problem trying to get her pad changed. At 10:15 a.m. R3's light was still on and had not received help. R3 stated she felt afraid she would not be attended to timely if she couldn't breathe or if she was having a heart attack. At 10:19 a.m. R3's call light was still on. During observation on 9/28/22, at 10:28 am registered nurse (RN)-A came down the hall and asked R3 if she needed help. During interview and observation on 9/28/22, at 10:30 a.m. maintenance staff-A stated when a resident needs help, the room number will light up at the end of the hallway. At 10:31 a.m. R3's light was still on and RN-A left R3's room. During observation at 9/28/22, at 10:31 a.m. nursing assistant (NA)-A opened R3's door, went in room and left and stated she had to go to the bathroom and would be back and turned off R3's call light. At 10:36 a.m. NA-A returned to assist R3. During interview and observation on 9/28/22, at	F 550			

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F 550	Continued From page 4 10:47 a.m. NA-A stated R3 did not have the correct incontinent products and would inform the health unit coordinator. NA-A also stated R3 was supposed to have one to one assist and has staff with R3 for 16 hours, but stated the staff person called in sick. During interview on 9/28/22, at 11:03 a.m. RN-A stated when a resident turns on their call light, the light should remain on until the resident's needs are met. RN-A stated staff should not turn off the call light and tell a resident they will be back, they need to sort it out and then turn off the call light. During interview on 9/28/22, at 12:45 p.m. licensed practical nurse (LPN)-A stated call lights should be answered as soon as possible within five minutes and stated R3 is usually one to one, but stated the aide was ill. Facility policy Resident Call Light System indicated all call lights should be answered promptly whether or not staff were assigned to the resident. It also indicated not to make a resident feel staff were too busy to provide assistance and indicated further assistance is offered before leaving the room.	F 550			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 759	1. All nursing staff re-educated on		11/4/22

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F 759	Continued From page 5 review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 36.3% with 4 errors out of 11 opportunities involving 1 of 1 resident (R37) who were observed during medication administration and the facility failed to ensure new admissions received medications in a timely manner for 2 of 2 residents (R2, R3) reviewed for medication errors. Findings include: R37's admission record reviewed 9/29/22, indicated R37 was admitted on 6/15/22 with diagnosis of displaced fracture of greater trochanter of right femur, type II diabetes, and chronic obstructive pulmonary disease (COPD) with acute exacerbation. R37's medication administration record (MAR) for September 2022, identified the following orders: -start date 6/16/22, Amlodipine Besylate (high blood pressure medication) 10 MG give 10 MG by mouth one time a day for high blood pressure. -start date 6/16/22, Furosemide (diuretic - "water pill") tablet 40 MG give one tablet by mouth one time a day for edema. -start date 8/20/22, Methadone HCL (pain medication) 5 MG tablet give 5 MG by mouth one time a day for pain. -start date 6/16/22, Polyethylene Glycol (constipation medication) 3350 packet 17 GM give 17 gram by mouth one time a day for constipation. -start date 6/16/22, Prednisone (steroid) tablet 10 MG give 10 MG by mouth one time a day for chronic obstructive lung disease. -start date 6/16/22, Senna-Docusate Sodium	F 759	medication administration policy, medication error policy and general overview of medication services 2. All residents have the potential to be affected by this type of situation 3. All nursing staff will be educated upon the hire and yearly thereafter on medication administration policy, medication error policy and proper procedure for updating appropriate parties for any medication concerns. 4. Audits conducted by DON or designee 3 times a week for 4 weeks 5. All issues found will be brought to QAPI		

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

PRINTED: 11/07/2022
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 09/29/2022
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
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F 759	Continued From page 6 (laxative-constipation medication) 8.6-50 MG give two tablets by mouth in the morning for constipation. -start date 6/16/22, Spironolactone (diuretic - "water pill") tablet 25 MG give 25 MG by mouth one time a day for high blood pressure. -start date 6/16/22, Tiotropium Bromide Monohydrate (lung disease medication) Aerosol Solution 2.5 MG/ACT two puffs inhale orally one time a day for COPD. -start date 6/16/22, Venlafaxine HCL extended release (ER) (depression medication) 24 hour 75 MG tablet give 225 MG by mouth one time a day for mood. -start date 8/19/22, Gabapentin (seizure medication) capsule 300 MG give 600 MG by mouth two times a day for anticonvulsant. -start date 6/15/22, Metoprolol Tartrate (high blood pressure medication) tablet 50 MG give one tablet by mouth two times a day for hypertension. -start date During an observation on 9/29/22, at 8:27 a.m. trained medication aide (TMA)-A prepared R37's morning medications. TMA-A included Amlodipine Besylate 10 MG, Furosemide 40 MG, Methadone HCL 5 MG, Spironolactone 25 MG, Gabapentin 600 MG, Metoprolol Tartrate 50 MG, and Venlafaxine HCL ER 150 MG into a plastic medication cup. TMA-A placed Polyethylene Glycol 17 GM into an eight-ounce plastic cup and mixed it with eight ounces of water. TMA-A took the plastic cup with medications and the water cup with medication into R37's room and administered the medications to R37. R37 took all medications and drank all the water with medication. TMA-A went back to the medication cart to sign off medications. State Agency (SA)	F 759			

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F 759	Continued From page 7 surveyor reviewed medications with TMA-A and made TMA-A aware of scheduled medications not given to R37: Senna-Docusate 8.6-50 MG two tablets, Prednisone 10 MG, Venlafaxline HCL ER 75 MG, and Tiotropium Bromide Monohydrate Aerosol Solution two puffs. TMA-A attempted to locate the Tiotropium inhaler, after not being able to locate the inhaler TMA-A asked R37 if the inhaler was in the room. R37 explained the inhaler had not been offered to him in over a week. TMA-A did not find the inhaler. Upon interview on 9/29/22, at 8:51 a.m. TMA-A verified the Senna-Docusate 8.6-50 MG two tablets, Prednisone 10 MG tablet, Venlafaxline HCL ER 75 MG capsule, and the Tiotropium Bromide inhaler were not administered to R37 until reviewed with the surveyor. TMA-A stated the MAR wasn't read completely and the five rights of medication administration should have been used. Upon interview on 9/29/22, at 9:02 a.m. licensed practical nurse manager (LPN)-A stated TMA-A should always use the five rights of medication administration prior to administering the medications to the resident. Further, stated if a medication wasn't located the staff should call the pharmacy to re-order the medication and call the physician to inform of the missed medication. R2's admission record reviewed on 9/29/22, indicated R2 admitted on 9/15/22 with diagnosis of wedge compression fracture of T11-T12 vertebrae, chronic pain syndrome, and spinal stenosis. R2's medication administration record (MAR) for September 2022, indicated the following			F 759			

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F 759	Continued From page 8 medication orders: -Start date 9/16/22, at 8:00 a.m. Lidocaine patch 4% apply to the T-12 topically one time a day for pain. Apply to intact skin to most painful area, not given until 9/17/22, at 8:00 a.m. -Start date 9/17/22, at 6:00 a.m. Pantaprazole Sodium tablet delayed release give 40 MG by mouth one time a day for esophagitis, not given until 9/18/22, at 6:00 a.m. -Start date 9/17/22 at 8:00 p.m. Belbuca Film 150 MG (Buprenorphine HCL) place and dissolve one film buccally two times a day for pain, not given until 9/21/22, at 8:00 a.m. -Start date 9/16/22, at 9:00 a.m. Cyclobenzapine HCL 10 MG give one tablet by mouth three times a day for compression of T-12 vertebrae, not given until 9/16/22, at 9:00 p.m. -Start date 9/16/22, at 2:00 p.m. Gabapentin capsule 300 MG give two capsules three times a day for compression of T-12 vertebrae, not given until 9/16/22, at 9:00 p.m. -Start date 9/16/22 11:00 p.m. Ibuprofen 600 MG give one tablet by mouth three times a day for analgesic, not given until 9/17/22, in the a.m. -Start date 9/16/22, at 10:00 a.m. Acetaminophen 500 MG give two tablets by mouth every six hours for compression of T-12 vertebrae, not given until 9/16/22, at 4:00 p.m. Review of R2's electronic medical record (EMR) on 9/29/22, lacked evidence of any medications being administered to R2 on 9/15/22, R2's admission date. On 9/29/22, reviewed R2's Allina Health discharge summary which indicated R2 was discharged on the morning of 9/15/22 with medication orders to continue at the admitting facility.	F 759			

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F 759	Continued From page 9 R2's progress note dated 9/15/22, at 12:12 p.m. indicated R2 arrived and admitted to the facility at 11:00 a.m. R2's progress note dated 9/15/22, at 4:00 p.m. indicated R2's medications were not at the facility and R2 didn't have his pain medications available. Further, indicated R2 requested to return to the hospital due to pain rating of 9 out of 10. R2 stated, "I can't function like this, in all this pain". Additionally, staff called non-emergency 911 and sent R2 to the emergency room for pain management. The progress note lacked evidence of the staff notifying the physician of R2's pain and medications unavailability. R2's progress note dated 9/17/22, at 8:04 a.m. indicated R2's medications had not arrived from the pharmacy yet due to R2's insurance and payment information had not been supplied to the pharmacy by the facility. The progress note lacked evidence of the staff notifying the physician of the medications unavailability. R2's progress note dated 9/17/22, at 11:11 p.m. indicated R2 inquired about pain medication and was informed pain medication required a prior authorization before the medication can be sent to the facility. Further, indicated R2 inquired about going to the emergency room to have a doctor prescribe a pain medication his insurance would pay for. The progress note lacked evidence of the staff notifying the physician of R2's pain and medications unavailability. R2's progress note dated 9/20/22, at 1:11 p.m. indicated R2's physician was notified regarding pain medication unavailability, five days after	F 759			

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F 759	Continued From page 10 admission. Upon interview on 9/29/22, at 9:02 a.m. licensed practical nurse manager (LPN)-A stated if a medication wasn't located the staff should call the pharmacy to re-order the medication and call the physician to inform of the missed medication. Further, stated a new admission should have their medication list and facesheet with insurance information sent to the pharmacy. Additionally, if medications don't arrive timely the staff should call the doctor to inform of the potential missed medications. Facility policy titled Medication Administration dated 10/1/21, included medication administration needed to include the right resident, drug, dose, dosage form, time and route and verify all against the MAR. Medications were generally considered timely if given one hour before or after the designated time. Additionally, medication errors must be reported immediately to the nursing supervisor as well as physician and resident or resident representative. A medication error report would be completed and submitted for review to the quality assessment and assurance committee and the medical director.	F 759			

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: Surveyor: 43007 On 9/28/22 and 9/29/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/24/22

Minnesota Department of Health

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2 000	Continued From page 1 electronic plan of correction you have reviewed these orders and identify the date when they will be completed The following complaint was found to be SUBSTANTIATED: H52894800C (MN87053) and H52894894C (MN87103), with licensing orders issue at 1545 and 1805. 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 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	2 000			

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication	21545			11/4/22

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21545	Continued From page 3 error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Surveyor: 43007 Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 36.3% with 4 errors out of 11 opportunities involving 1 of 1 resident (R37) who were observed during medication administration and the facility failed to ensure new admissions received medications in a timely manner for 2 of 2 residents (R2, R3) reviewed for medication errors. Findings include: R37's admission record reviewed 9/29/22, indicated R37 was admitted on 6/15/22 with diagnosis of displaced fracture of greater	21545	1. All nursing staff re-educated on medication administration policy, medication error policy and general overview of medication services 2. All residents have the potential to be affected by this type of situation 3. All nursing staff will be educated upon the hire and yearly thereafter on medication administration policy, medication error policy and proper procedure for updating appropriate parties for any medication concerns. 4. Audits conducted by DON or designee 3 times a week for 4 weeks 5. All issues found will be brought to QAPI	

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21545	Continued From page 4 trochanter of right femur, type II diabetes, and chronic obstructive pulmonary disease (COPD) with acute exacerbation. R37's medication administration record (MAR) for September 2022, identified the following orders: -start date 6/16/22, Amlodipine Besylate (high blood pressure medication) 10 MG give 10 MG by mouth one time a day for high blood pressure. -start date 6/16/22, Furosemide (diuretic - "water pill") tablet 40 MG give one tablet by mouth one time a day for edema. -start date 8/20/22, Methadone HCL (pain medication) 5 MG tablet give 5 MG by mouth one time a day for pain. -start date 6/16/22, Polyethylene Glycol (constipation medication) 3350 packet 17 GM give 17 gram by mouth one time a day for constipation. -start date 6/16/22, Prednisone (steroid) tablet 10 MG give 10 MG by mouth one time a day for chronic obstructive lung disease. -start date 6/16/22, Senna-Docusate Sodium (laxative-constipation medication) 8.6-50 MG give two tablets by mouth in the morning for constipation. -start date 6/16/22, Spironolactone (diuretic - "water pill") tablet 25 MG give 25 MG by mouth one time a day for high blood pressure. -start date 6/16/22, Tiotropium Bromide Monohydrate (lung disease medication) Aerosol Solution 2.5 MG/ACT two puffs inhale orally one time a day for COPD. -start date 6/16/22, Venlafaxine HCL extended release (ER) (depression medication) 24 hour 75 MG tablet give 225 MG by mouth one time a day for mood. -start date 8/19/22, Gabapentin (seizure medication) capsule 300 MG give 600 MG by mouth two times a day for anticonvulsant.	21545			

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21545	Continued From page 5 -start date 6/15/22, Metoprolol Tartrate (high blood pressure medication) tablet 50 MG give one tablet by mouth two times a day for hypertension. -start date During an observation on 9/29/22, at 8:27 a.m. trained medication aide (TMA)-A prepared R37's morning medications. TMA-A included Amlodipine Besylate 10 MG, Furosemide 40 MG, Methadone HCL 5 MG, Spironolactone 25 MG, Gabapentin 600 MG, Metoprolol Tartrate 50 MG, and Venlafaxine HCL ER 150 MG into a plastic medication cup. TMA-A placed Polyethylene Glycol 17 GM into an eight-ounce plastic cup and mixed it with eight ounces of water. TMA-A took the plastic cup with medications and the water cup with medication into R37's room and administered the medications to R37. R37 took all medications and drank all the water with medication. TMA-A went back to the medication cart to sign off medications. State Agency (SA) surveyor reviewed medications with TMA-A and made TMA-A aware of scheduled medications not given to R37: Senna-Docusate 8.6-50 MG two tablets, Prednisone 10 MG, Venlafaxine HCL ER 75 MG, and Tiotropium Bromide Monohydrate Aerosol Solution two puffs. TMA-A attempted to locate the Tiotropium inhaler, after not being able to locate the inhaler TMA-A asked R37 if the inhaler was in the room. R37 explained the inhaler had not been offered to him in over a week. TMA-A did not find the inhaler. Upon interview on 9/29/22, at 8:51 a.m. TMA-A verified the Senna-Docusate 8.6-50 MG two tablets, Prednisone 10 MG tablet, Venlafaxine HCL ER 75 MG capsule, and the Tiotropium Bromide inhaler were not administered to R37 until reviewed with the surveyor. TMA-A stated	21545			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(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
21545	Continued From page 6 the MAR wasn't read completely and the five rights of medication administration should have been used. Upon interview on 9/29/22, at 9:02 a.m. licensed practical nurse manager (LPN)-A stated TMA-A should always use the five rights of medication administration prior to administering the medications to the resident. Further, stated if a medication wasn't located the staff should call the pharmacy to re-order the medication and call the physician to inform of the missed medication. R2's admission record reviewed on 9/29/22, indicated R2 admitted on 9/15/22 with diagnosis of wedge compression fracture of T11-T12 vertebrae, chronic pain syndrome, and spinal stenosis. R2's medication administration record (MAR) for September 2022, indicated the following medication orders: -Start date 9/16/22, at 8:00 a.m. Lidocaine patch 4% apply to the T-12 topically one time a day for pain. Apply to intact skin to most painful area, not given until 9/17/22, at 8:00 a.m. -Start date 9/17/22, at 6:00 a.m. Pantaprazole Sodium tablet delayed release give 40 MG by mouth one time a day for esophagitis, not given until 9/18/22, at 6:00 a.m. -Start date 9/17/22 at 8:00 p.m. Belbuca Film 150 MG (Buprenorphine HCL) place and dissolve one film buccally two times a day for pain, not given until 9/21/22, at 8:00 a.m. -Start date 9/16/22, at 9:00 a.m. Cyclobenzapine HCL 10 MG give one tablet by mouth three times a day for compression of T-12 vertebrae, not given until 9/16/22, at 9:00 p.m. -Start date 9/16/22, at 2:00 p.m. Gabapentin capsule 300 MG give two capsules three times a	21545			

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21545	Continued From page 7 day for compression of T-12 vertebrae, not given until 9/16/22, at 9:00 p.m. -Start date 9/16/22 11:00 p.m. Ibuprofen 600 MG give one tablet by mouth three times a day for analgesic, not given until 9/17/22, in the a.m. -Start date 9/16/22, at 10:00 a.m. Acetaminophen 500 MG give two tablets by mouth every six hours for compression of T-12 vertebrae, not given until 9/16/22, at 4:00 p.m. Review of R2's electronic medical record (EMR) on 9/29/22, lacked evidence of any medications being administered to R2 on 9/15/22, R2's admission date. On 9/29/22, reviewed R2's Allina Health discharge summary which indicated R2 was discharged on the morning of 9/15/22 with medication orders to continue at the admitting facility. R2's progress note dated 9/15/22, at 12:12 p.m. indicated R2 arrived and admitted to the facility at 11:00 a.m. R2's progress note dated 9/15/22, at 4:00 p.m. indicated R2's medications were not at the facility and R2 didn't have his pain medications available. Further, indicated R2 requested to return to the hospital due to pain rating of 9 out of 10. R2 stated, "I can't function like this, in all this pain". Additionally, staff called non-emergency 911 and sent R2 to the emergency room for pain management. The progress note lacked evidence of the staff notifying the physician of R2's pain and medications unavailability. R2's progress note dated 9/17/22, at 8:04 a.m. indicated R2's medications had not arrived from the pharmacy yet due to R2's insurance and	21545			

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21545	Continued From page 8 payment information had not been supplied to the pharmacy by the facility. The progress note lacked evidence of the staff notifying the physician of the medications unavailability. R2's progress note dated 9/17/22, at 11:11 p.m. indicated R2 inquired about pain medication and was informed pain medication required a prior authorization before the medication can be sent to the facility. Further, indicated R2 inquired about going to the emergency room to have a doctor prescribe a pain medication his insurance would pay for. The progress note lacked evidence of the staff notifying the physician of R2's pain and medications unavailability. R2's progress note dated 9/20/22, at 1:11 p.m. indicated R2's physician was notified regarding pain medication unavailability, five days after admission. Upon interview on 9/29/22, at 9:02 a.m. licensed practical nurse manager (LPN)-A stated if a medication wasn't located the staff should call the pharmacy to re-order the medication and call the physician to inform of the missed medication. Further, stated a new admission should have their medication list and facesheet with insurance information sent to the pharmacy. Additionally, if medications don't arrive timely the staff should call the doctor to inform of the potential missed medications. Facility policy titled Medication Administration dated 10/1/21, included medication administration needed to include the right resident, drug, dose, dosage form, time and route and verify all against the MAR. Medications were generally considered timely if given one hour before or after the designated time. Additionally, medication errors	21545			

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21545	Continued From page 9 must be reported immediately to the nursing supervisor as well as physician and resident or resident representative. A medication error report would be completed and submitted for review to the quality assessment and assurance committee and the medical director. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication administration. The DON or designee could educate staff to ensure medications are correctly and timely administered. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of time to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545			
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac. Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805			11/4/22

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21805	Continued From page 10 This MN Requirement is not met as evidenced by: Surveyor: 43007 Based on observation, interview and record review the facility failed to ensure residents needs were addressed in a respectful and dignified manner when residents used their call light to ask for assistance (R3). Findings include: R3's significant change Minimum Data Set (MDS) dated 7/20/22 indicated intact cognition, R3 required extensive assistance in toileting and was always incontinent of urine. R3's medical diagnoses list in point click care indicated R3 had the following diagnoses: other specified urinary incontinence, generalized anxiety disorder, type two diabetes with hyperglycemia, and chronic systolic congestive heart failure. R3's care plan revised 5/27/22, indicated R3 had urge and mixed bladder incontinence and required incontinence changes every two hours and as needed. R3's care plan revised 8/12/22, indicated R3 needed her call light within reach and R3 needed prompt response to all requests for assistance. R3's device activity log on 9/28/22, indicated an average response time of 26 minutes, 13 seconds for R3's call light to be answered. At 7:13 a.m., the log indicated R3 waited 90 minutes, 40 seconds for her call light to be answered. R3's medication administration record (MAR) for	21805	1. R3 call light placed within resident's reach 2. All residents call lights placed within reach 3. Staff educated on placing resident's call light within reach and timely response time 4. Call light audits including timely response times will be conducted by DON or designee. Daily audits for 1 week on alternating shifts, then 3x per week for 2 weeks on alternating shifts, then 1x per week for 1 week on alternating shifts 5. All issues will be brought to QAPI	

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21805	Continued From page 11 September 2022, indicated R3 was taking furosemide (a diuretic) 20 milligrams (mg) daily for heart failure. During interview and observation on 9/28/22, at 9:58 a.m. a sheet of paper was located on R3's door that stated, "Due to privacy, sign sheet has move [SIC] to the resident's closet." R3 stated at 10:00 a.m. that she was going to cry and stated the night nursing assistant (NA) changed her pad at 5:45, left at six and did not get her pad changed until 9:30 and stated she sat in a wet pad and stated she takes Lasix and needed to be changed frequently. R3 stated 10 to 15 minutes is a long enough time to wait for her call light to be answered. R3 stated she felt anxious and afraid because she did not know how long she would have to wait in a wet pad before someone answered her call light. During interview and observation on 9/28/22, at 10:05 a.m. R3 stated she had her light on for 20 minutes. The red button was on in R3's room. The sheet in R3's closet indicated a staff person signed the sheet on 9/28/22, at 9:15 a.m. R3 stated that her skin burned from sitting in the pad and stated it was a chronic problem trying to get her pad changed. At 10:15 a.m. R3's light was still on and had not received help. R3 stated she felt afraid she would not be attended to timely if she couldn't breathe or if she was having a heart attack. At 10:19 a.m. R3's call light was still on. During observation on 9/28/22, at 10:28 am registered nurse (RN)-A came down the hall and asked R3 if she needed help. During interview and observation on 9/28/22, at 10:30 a.m. maintenance staff-A stated when a resident needs help, the room number will light up	21805		

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21805	Continued From page 12 at the end of the hallway. At 10:31 a.m. R3's light was still on and RN-A left R3's room. During observation at 9/28/22, at 10:31 a.m. nursing assistant (NA)-A opened R3's door, went in room and left and stated she had to go to the bathroom and would be back and turned off R3's call light. At 10:36 a.m. NA-A returned to assist R3. During interview and observation on 9/28/22, at 10:47 a.m. NA-A stated R3 did not have the correct incontinent products and would inform the health unit coordinator. NA-A also stated R3 was supposed to have one to one assist and has staff with R3 for 16 hours, but stated the staff person called in sick. During interview on 9/28/22, at 11:03 a.m. RN-A stated when a resident turns on their call light, the light should remain on until the resident's needs are met. RN-A stated staff should not turn off the call light and tell a resident they will be back, they need to sort it out and then turn off the call light. During interview on 9/28/22, at 12:45 p.m. licensed practical nurse (LPN)-A stated call lights should be answered as soon as possible within five minutes and stated R3 is usually one to one, but stated the aide was ill. Facility policy Resident Call Light System indicated all call lights should be answered promptly whether or not staff were assigned to the resident. It also indicated not to make a resident feel staff were too busy to provide assistance and indicated further assistance is offered before leaving the room.	21805		

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21805	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805			