



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: WBZ712

Dear Administrator:

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

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

On October 17, 2023, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0623 -- S/S: D -- 483.15(c)(3)-(6)(8) -- Notice Requirements Before Transfer/discharge
F0661 -- S/S: D -- 483.21(c)(2)(i)-(iv) -- Discharge Summary
F0725 -- S/S: E -- 483.35(a)(1)(2) -- Sufficient Nursing Staff
20685 -- MN Rule 4658.0465 Subp. 2 -- Transfer, Discharge, And Death
20690 -- MN Rule 4658.0465 Subp. 3 -- Transfer, Discharge, And Death
20800 -- MN Rule 4658.0510 Subp. 1 -- Nursing Personnel; Staffing Requirements

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:

The Terrace At Crystal LLC

October 27, 2023

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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 WBZ713

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 \$700.00 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 \$700.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling \$63.80, 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 \$763.80 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 18, 2023

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

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

Dear Administrator:

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

On September 8, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey/revisit findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2023.

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

As we notified you in our letter of April 26, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 18, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has

An equal opportunity employer.

The Terrace At Crystal LLC

September 18, 2023

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been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

The Terrace At Crystal LLC

September 18, 2023

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you

The Terrace At Crystal LLC

September 18, 2023

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

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

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

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

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

Feel free to contact me if you have questions.



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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 18, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: WBZ711

Dear Administrator:

The above facility was surveyed on September 6, 2023 through September 8, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(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 10/16/23 - 10/17/23 an onsite revisit was completed to follow up on licensing orders issued from the survey exited 9/08/23. Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was issued.	{2 000}		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

11/06/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(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 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF	{2 000}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/17/2023
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{2 000}	Continued From page 2	{2 000}		
2 690	MINNESOTA STATE STATUTES/RULES. MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interviews and record review the facility failed to identify and document transfer information for the discharge for 1 of 1 resident (R6) reviewed when the facility did not know the details of a resident discharge that occurred. Findings include: R6's Admission assessment dated 8/30/23 indicated R6 was admitted to the facility on 8/30/23 from the hospital for rehabilitation. No diagnosis was noted on the admission assessment. R6's quarterly minimum data set (MDS) dated 9/5/23 R6 was independent with self-care, mobility, and functional cognition. R6's diagnoses were unspecified dementia, morbid obesity,	2 690	Corrected	11/10/23

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2 690	Continued From page 3 cocaine dependence, adjustment disorder, an eating disorder, and alcoholic cirrhosis of the liver. R6's Progress note dated 10/16/23, indicated R6 was discharged to an "LCC" there was no forwarding address or phone number. R1's belongings and medication were reviewed with the caseworker and the resident. The progress notes did not indicate reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, or casework contact information, the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. R6's medical record did not identify forwarding information, and the phone number listed was out of service. Upon interview on 10/16/23 at 2:55 p.m. the director of nursing (DON) stated he was uncertain about the discharges from the facility and if the required documentation had been obtained or completed because he was told the onsite nursing consultants would be managing the discharges. Upon interview on 10/17/23 at 12:25 p.m. the social services designee (SS)-A stated that discharges are part of her job, however she has not been trained on completing them and had not completed a discharge. Upon interview on 10/17/23 at 5:02 p.m. the director of reimbursement (DOR) stated she had opened the discharge summary assessment for R6 but had not completed it. She stated the facility had a plan for discharges, but that plan	2 690			

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2 690	Continued From page 4 had not been implemented or educated to the assistant director of nursing (ADON) or the social service designee. A facility titled Discharge Summary and plan dated 12/2016 indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment .A member of the IDT will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs. b. The post-discharge plan; and c. The discharge summary. 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.	2 690		
{2 800}	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including	{2 800}		11/10/23

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{2 800}	Continued From page 5 registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to provide timely assistance with personal cares and ensure residents safety to access staff while in their rooms according to the residents' assessed need and as directed by the care plan for 5 of 5 residents (R1, R2, R3, R4 and R5) reviewed for staffing needs. Findings include: R1's care plan dated 8/7/23 indicated R1 required, extensive assistance with bed mobility and total dependence with transferring via a mechanical lift. R1 required extensive assistance with dressing and toileting and total assistance with hygiene. R1 was to put on his call light when he was ready to be changed or repositioned. R1 was a high risk for falls, staff was to be sure R1's call light was in reach and encourage R1 to use for assistance as needed. R1 needed prompt response to all requests for assistance. R1's quarterly Minimum Data Set (MDS) dated 8/8/23 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. R1 required extensive assistance of two members with bed mobility transfers and hygiene. R1's diagnoses	{2 800}	Corrected	

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{2 800}	Continued From page 6 included heart failure, fusion of the spine lumbar region, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R1 indicated call light staff response times of: 10/3/23 bed 251 minutes and 5 seconds 10/3/23 bed 36 minutes and 29 seconds 10/4/23 bed 94 minutes and 34 seconds 10/4/23 bed 341 minutes and 11 seconds 10/5/23 bed 143 minutes and 1 second 10/5/23 bed 32 minutes and 44 seconds 10/5/23 bed 43 minutes and 1 second 10/6/23 bed 210 minutes and 49 seconds 10/7/23 bed 31 minutes and 10 seconds 10/8/23 bed 26 minutes and 59 seconds 10/8/23 bed 33 minutes and 46 seconds 10/9/23 bed 36 minutes and 46 seconds 10/9/23 bed 36 minutes and 37 seconds 10/9/23 bed 34 minutes 17 seconds 10/11/23 bed 33 minutes and 43 seconds 10/12/23 bed 26 minutes and 49 seconds 10/14/23 bed 161 minutes and 21 seconds Upon observation and interview on 10/16/23 at 9:14 a.m. R1 was resting in bed. R1 had two wrinkled bath blankets under him, and he was covered with a top sheet. He had no fitted sheet on his bed. R1 was only wearing on an incontinent brief. R1 stated when he presses his call light for staff assistance the response is sometimes hours before a staff arrives to his room. R1 stated he cannot get out of bed himself and if he needed his brief changed or to be repositioned in his bed, he needs to call for assistance. He stated he had sat in a soiled brief for hours. R1 stated he would start yelling from his room if the situation got "really bad". Upon interview on 10/16/23 at 9:39 a.m. Nursing assistance (NA)-C stated he had not been in R1's	{2 800}		

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{2 800}	Continued From page 7 room yet that morning. He stated the first few hours of the day staff is "always" behind because there are only three NA's working on the floor for 33 residents and eight of the residents required mechanical lifts with the assistance of two NA's. He stated it was difficult to answer the call lights when two staff are taken up in multiple rooms upon morning cares. He stated the staff now carry pagers, so they are aware when a call light is going off, but they still can't leave a resident to assist another resident. He stated the morning cares and around lunch time were the most difficult times. NA-A stated the nurse, and the trained medication assistant (TMA) are busy completing their tasks and are unable to assist during those times. NA-A stated R1 often has the just the bath blankets on his bed as the night shift puts those on him and due to R1's obesity and poor mobility it takes a lot of time to place a proper sheet underneath him. R2's care plan dated 4/18/23 indicated R2 required extensive assistance of one staff member to dress him. He required extensive assistance of one staff member to assist with personal hygiene. R2 required total assistance of one staff for toilet use and transferring. Encourage resident to use call bell and be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for Assistance as R2 was a fall risk. R2's significant change MDS dated 8/4/23 indicated R2 had a BIMs score of 6 indicating severe cognitive impairment. R2 required extensive assistance of two staff members for bed mobility, transferring, dressing and personal hygiene. R2's diagnoses were a wedge	{2 800}			

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{2 800}	Continued From page 8 compression fracture of the first lumbar vertebra, adult failure to thrive, chronic obstruction pulmonary disease, and liver disease. A device activity report dated 10/2/23 - 10/16/23 for R2 indicated call light staff response times of: 10/2/23 bed 50 minutes and 39 seconds 10/2/23 bed 79 minutes and 26 seconds 10/4/23 bed 26 minutes and 12 seconds 10/5/23 bed 31 minutes and 24 seconds 10/7/23 bed 40 minutes and 30 seconds 10/14/23 bed 31 minutes and 50 seconds 10/15/23 bed 28 minutes and 26 seconds Upon observation and interview on 10/16/23 at 9:53 a.m. R2 was seated in his room in his wheelchair. R2 was wearing soiled clothing. R2's call light was on the floor approximately 15 feet away from him by his bedside table. R2 stated he could wheel himself over to the call light but would not be able to bend over to pick it up off the floor. He stated instead of using the call light, it was easier to wheel himself out into the hallway and ask for assistance. R2 stated he usually dresses himself, but he could not recall if he slept in his clothing the previous night and dressed himself in the morning or not. Upon interview on 10/16/23 at 9:56 a.m. registered nurse (RN)-A stated she would get staff immediately to assist R2 in changing his clothing. She was uncertain if R2 was dressing himself in the mornings or if staff were dressing him. RN-A believed with the call light being on the floor that R2 could use his chair to maneuver himself over to the call light and pull the cord, but stated he should have it next to him in his chair. R3 care plan dated 4/18/23 indicated R3 is totally	{2 800}			

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{2 800}	Continued From page 9 dependent one staff for transferring, ambulating and toileting. Encourage R3 to use bell to call for assistance. Staff was to be sure residents call light was within his reach and encourage R3 to use the call light. R3 is a fall risk and requires prompt response to all requests. R3's quarterly MDS dated 8/15/23 indicated R3 had a BIMs score of 5 indicating severe cognitive impairment. R3 required extensive assistance of one staff member with bed mobility, transferring, dressing and hygiene. R3's diagnosis were pain in unspecified knee, low back pain, tremors, syncope (fainting or loss of consciousness) and collapse. A device activity report dated 10/2/23 - 10/16/23 for R3 indicated call light staff response times of: 10/8/23 bed 24 minutes and 30 seconds 10/11/23 bed 103 minutes and 4 seconds 10/14/23 bed 151 minutes and 13 seconds R3 did not use his call light 10/3/23 - 10/7/23 and 10/9/23 - 10/10/23. Upon observation and interview on 10/16/23 at 10:34 a.m. R3 was seated in a chair in his room he had a walker next to him. His call light was across room on the floor by his bedside table approximately 15 feet from R3. R3 stated he rarely uses his call light because he often doesn't have it within reach. He stated he is unable to stand without assistance because he gets dizzy. He stated he had fallen at the facility but could not recall when. He stated he had gone without his call light for days. He stated he spends his time seated in his chair in his room and can see staff walking by, and he would yell for staff to come in and assist him. Upon interview on 10/16/23 at 10:40 a.m. RN-B	{2 800}			

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{2 800}	Continued From page 10 stated R3 can walk on his own, so he could have gotten to his call light. R4's care plan dated 6/29/23 indicated R4 ambulated independently with a two wheeled walker. R4 was independent with dressing, toilet use and transferring. A revision was made to R4's care plan during the survey on 10/17/23 that R4 prefers his call light placed on his nightstand, not clipped to his bed. The care plan did not indicate any further call light interventions. R4's quarterly MDS indicated R4's short-term and long-term memory was okay. R4 used a wheelchair for ambulation. R4 was independent with activities of daily living. R4's diagnoses included hemothorax (a serious condition where blood collects between your lungs and your rib cage), opioid dependence, anxiety, and depression. A device activity report dated 10/2/2/23 - 10/16/23 for R4 indicated call light staff response times of: 10/2/23 bed 50 minutes and 22 seconds 10/2/23 bed 50 minutes and 6 seconds 10/3/23 bed 96 minutes and 25 seconds 10/3/23 bed 67 minutes and 58 seconds 10/4/23 bed 112 minutes and 13 seconds 10/4/23 bed 93 minutes and 46 seconds 10/4/23 bed 124 minutes and 22 seconds 10/5/23 bed 40 minutes and 7 seconds 10/5/23 bed 34 minutes and 18 seconds 10/5/23 bed 35 minutes and 32 seconds 10/6/23 bed 125 minutes and 4 seconds 10/8/23 bed 26 minutes and 47 seconds 10/9/23 bed 42 minutes and 8 seconds 10/10/23 bed 26 minutes and 24 seconds 10/11/23 bed 25 minutes and 15 seconds 10/14/23 bed 39 minutes and 48 seconds 10/14/23 bed 42 minutes and 46 seconds	{2 800}			

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{2 800}	Continued From page 11 10/14/23 bed 123 minutes and 42 seconds 10/15/23 bed 40 minutes and 17 seconds 10/15/23 bed 51 minutes and 10 seconds Upon observation and interview on 10/16/23 at 10:18 a.m. R4 was in his room, slumped over in his wheelchair. R4 was shouting out, "I'm sick, I'm sick, if you're not a nurse get one." The call light on R4's wall near his bed with a part of the call lights cord missing. A piece of the cord had become unconnected, leaving on about four inches of cord connected to the outlet. The rest of the cord was not seen. RN-B came into the room, as she stated she heard R4 yelling. RN-B noticed the call light was missing part of the cord and stated she would tell maintenance. R4 stated "why have one, they don't answer then anyway, now get out and get a nurse who can help me." R5's care plan dated 7/6/23 indicated R5 required assistance of one staff member for bed mobility, transferring, and dressing. R5 was totally dependent of one staff member for toilet use. The care plan does not indicate any call light interventions. R5's admission MDS dated 7/11/23 indicated R5 had a BIMs score of 15 indicating she was cognitively intact. She required extensive assistance of one staff member for bed mobility, transfers, hygiene, and toilet use. Her diagnoses were hemiplegia following a cerebral infarction affecting the left side (stroke), seizures, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R5's indicated call light staff response times of: 10/2/23 bathroom 75 minutes and 1 second	{2 800}		

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{2 800}	Continued From page 12 10/4/23 bathroom 29 minutes and 17 seconds 10/5/23 bathroom 54 minutes and 13 seconds 10/8/23 bathroom 41 minutes and 35 seconds 10/8/23 bathroom 24 minutes and 38 seconds 10/12/23 bathroom 22 minutes and 42 seconds Upon observation and interview on 10/16/23 at 10:53 a.m. R5 was in her bathroom. She was dressed in two hospital gowns, one with the ties in the front and one with the ties in the back. She stated she had been helped with morning cares. She stated that was not a concern, because she has improved, and she is more independent around her room. She stated that her concern was when she uses the bathroom, she still feels she is unable to clean herself well and transfer herself from the toilet. She stated she had sat on the toilet for over an hour and that makes her joints sore, and she gets dizzy. She stated it doesn't matter what time of day it is, "some days are good, others are not." Upon interview on 10/17/23 at 12:03 p.m. the Assistant Director of Nursing (ADON) stated she is uncertain what her job duties are, she mainly covers the floor, and she is responsible for infection control and training. She stated she does not have the time to "adequately" train new staff. She stated the reason the training is not adequate is because taking care of the residents' needs to be the priority. Upon interview on 10/17/23 at 2:37 p.m. NA-B stated when the third floor is staffed with three NAs, showers get missed, residents are not in time in the morning, so they are eating breakfast late and residents are not repositioned as often as they should be. She stated over the past few weeks "some" of the days there has been a fourth NA on the floor and then cares get completed	{2 800}			

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{2 800}	Continued From page 13 timely. She stated the best thing about having four NA" s is the residents are not upset due to late care or cares not completed at all. Upon interview on 10/17/23 at 2:46 p.m. NA-C stated she prioritizes her day when there are three NAs scheduled on the floor and the "neediest get the cares" and the other who are less "needy" try to assist themselves or don't get their teeth brushed or showers. Upon interview on 10/17/23 on 2:58 p.m. RN-C stated she is so worried about making a mistake because she is only nurse on the floor with "only a TMA." She stated she passes meds to about 16 residents, the nurse needs to perform all the blood glucose checks on the entire unit, chart on all 33 residents, complete assessments and perform admissions. She stated she gets behind on ordering medications and assessments because she doesn't have enough time. RN-C stated she is supposed to manage and assist the nursing assistants on the floor during the workday, but she does not have the time assist or guide them. Upon interview on 10/17/23 at 4:38 the DON stated he is aware cares are not getting completed with the level of staff he needs to schedule. A facility policy titled Answering the Call Light dated 11/2022 indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary,	{2 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(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
{2 800}	Continued From page 14 educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	{2 800}			

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 R 10/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
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{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 9/8/23. 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 623} SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	{F 623}		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 623}	Continued From page 1 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	{F 623}			

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{F 623}	Continued From page 2 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	{F 623}			

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{F 623}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to identify and document transfer information for the discharge for 1 of 1 resident (R6) reviewed when the facility did not know the details of a resident discharge that occurred. Findings include: R6's Admission assessment dated 8/30/23 indicated R6 was admitted to the facility on 8/30/23 from the hospital for rehabilitation. No diagnosis was noted on the admission assessment. R6's quarterly minimum data set (MDS) dated 9/5/23 R6 was independent with self-care, mobility, and functional cognition. R6's diagnoses were unspecified dementia, morbid obesity, cocaine dependence, adjustment disorder, an eating disorder, and alcoholic cirrhosis of the liver. R6's Progress note dated 10/16/23, indicated R6 was discharged to an "LCC" there was no forwarding address or phone number. R1's belongings and medication were reviewed with the caseworker and the resident. The progress notes did not indicate reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, or casework contact information, the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. R6's medical record did not identify forwarding information, and the phone number listed was out	{F 623}	1. R6 is no longer in the facility. 2. All residents discharging from the facility have the potential to be affected by this deficient practice. 3. The facility will continue education according to the policy for social services and licensed staff as it relates to discharges. 4. The facility will review and revise (if needed), the discharge summary plan policy and discharge assessment form with education to follow. 5. The facility created and educated on a discharge checklist for social services and licensed staff to utilize for discharges. 6. DON or designee will audit all resident discharges the next business day after discharge for the next 30 days to ensure discharges are complete. All audits will be brought to QAPI to assess for compliance and continued need for audits. 7. DON or designee will be responsible for the completion of this plan of correction.		

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{F 623}	Continued From page 4 of service. Upon interview on 10/16/23 at 2:55 p.m. the director of nursing (DON) stated he was uncertain about the discharges from the facility and if the required documentation had been obtained or completed because he was told the onsite nursing consultants would be managing the discharges. Upon interview on 10/17/23 at 12:25 p.m. the social services designee (SS)-A stated that discharges are part of her job, however she has not been trained on completing them and had not completed a discharge. Upon interview on 10/17/23 at 5:02 p.m. the director of reimbursement (DOR) stated she had opened the discharge summary assessment for R6 but had not completed it. She stated the facility had a plan for discharges, but that plan had not been implemented or educated to the assistant director of nursing (ADON) or the social service designee. A facility titled Discharge Summary and plan dated 12/2016 indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment .A member of the IDT will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's	{F 623}			

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{F 623}	Continued From page 5	{F 623}			
{F 661} SS=D	medical records: a. An evaluation of the resident's discharge needs. b. The post-discharge plan; and c. The discharge summary. Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	{F 661}		11/10/23	
			1. R6 is no longer in the facility.		

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{F 661}	Continued From page 6 facility failed to document required health information for 1 of 1 resident (R6) reviewed for discharge summary. Findings include: R6's Admission assessment dated 8/30/23 indicated R6 was admitted to the facility on 8/30/23 from the hospital for rehabilitation. No diagnosis was noted on the admission assessment. R6's quarterly minimum data set (MDS) dated 9/5/23 R6 was independent with self-care, mobility, and functional cognition. R6's diagnoses were unspecified dementia, morbid obesity, cocaine dependence, adjustment disorder, an eating disorder and alcoholic cirrhosis of the liver. R6's Progress note dated 10/16/23, indicated R6 was discharged to an "LCC" there was no forwarding address or phone number R1's belongings and medication was reviewed with the caseworker and the resident. The note did not indicate if the discharge was a facility-initiated discharge of a resident-initiated discharge. R6's discharge summary dated 10/16/23 was incomplete in her chart. R6's medical record did not include a discharge summary that included a recapitulation of R6's stay that included a diagnoses, course of illness/treatment/therapy and pertinent lab, radiology, and consultations, a final summary of R6's status, reconciliation of all predischage medications and post-discharge medications both prescribed and over-the-counter, and a post discharge plan of care that is developed with the participation of R6 that indicate where R6 plans to reside, any	{F 661}	2. All residents discharging from the facility have the potential to be affected by this deficient practice. 3. The facility will continue education according to the policy for social services and licensed staff as it relates to discharges. 4. The facility will review and revise (if needed), the discharge summary plan policy with education to follow. 5. The facility created and educated on a discharge checklist for social services and licensed staff to utilize for discharges. 6. DON or designee will audit all resident discharges the next business day after discharge for the next 30 days to ensure discharges are complete. All audits will be brought to QAPI to assess for compliance and continued need for audits. 7. DON or designee will be responsible for the completion of this plan of correction.		

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{F 661}	Continued From page 7 arrangements that have been made for R6's follow-up care and any post-discharge medical and non-medical services. Upon interview on 10/16/23 at 2:55 p.m. the director of nursing (DON) stated he was uncertain about the discharges from the facility and if the required documentation had been obtained because he stated he was told the onsite nursing consultants would be handling the discharges. Upon interview on 10/17/23 at 12:25 p.m. the social services designee (SS)-A stated that discharges are part of her job, however she has not been trained on completing them and had not completed any yet. Upon interview on 10/17/23 at 5:02 p.m. the director or reimbursement (DOR) stated she had opened the discharge summary assessment for R6 but had not completed it. She stated the facility had a plan for discharges, but that plan had not been implemented or educated to the assistant director of nursing (ADON) or the social service designee. A facility policy titled Discharge summary and plan dated 12/2016 indicated required information to include in a resident's medical record when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established	{F 661}			

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{F 661}	Continued From page 8	{F 661}			
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to provide timely assistance with personal cares and ensure residents safety	{F 725}		11/10/23	
			1. R1, R2, R3, R4 and R5 were immediately assisted with personal cares. 2. All residents in the facility have the potential to be affected by this deficient		

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{F 725}	Continued From page 9 to access staff while in their rooms according to the residents' assessed need and as directed by the care plan for 5 of 5 residents (R1, R2, R3, R4 and R5) reviewed for staffing needs. Findings include: R1's care plan dated 8/7/23 indicated R1 required, extensive assistance with bed mobility and total dependence with transferring via a mechanical lift. R1 required extensive assistance with dressing and toileting and total assistance with hygiene. R1 was to put on his call light when he was ready to be changed or repositioned. R1 was a high risk for falls, staff was to be sure R1's call light was in reach and encourage R1 to use for assistance as needed. R1 needed prompt response to all requests for assistance. R1's quarterly Minimum Data Set (MDS) dated 8/8/23 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. R1 required extensive assistance of two members with bed mobility transfers and hygiene. R1's diagnoses included heart failure, fusion of the spine lumbar region, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R1 indicated call light staff response times of: 10/3/23 bed 251 minutes and 5 seconds 10/3/23 bed 36 minutes and 29 seconds 10/4/23 bed 94 minutes and 34 seconds 10/4/23 bed 341 minutes and 11 seconds 10/5/23 bed 143 minutes and 1 second 10/5/23 bed 32 minutes and 44 seconds 10/5/23 bed 43 minutes and 1 second 10/6/23 bed 210 minutes and 49 seconds	{F 725}	practice. 3. The facility will ensure sufficient nursing staffing on each floor according to current census, resident acuity and facility assessment. 4. The facility will review Facility Assessment and ensure information accurately reflects needs of the facility and ability to meet standards set forth by MDH. 5. Leadership has been educated on appropriate staffing models for the facility. 6. The DON or designee will audit the schedule once weekly for two weeks, then once every 2 weeks for the next 2 weeks, then monthly thereafter to ensure that sufficient nursing staff are scheduled on each floor. All audits will be brought to QAPI to assess for compliance and continued need for audits. 7. The DON or designee will be responsible for the completion of this plan of correction.		

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{F 725}	Continued From page 10 10/7/23 bed 31 minutes and 10 seconds 10/8/23 bed 26 minutes and 59 seconds 10/8/23 bed 33 minutes and 46 seconds 10/9/23 bed 36 minutes and 46 seconds 10/9/23 bed 36 minutes and 37 seconds 10/9/23 bed 34 minutes 17 seconds 10/11/23 bed 33 minutes and 43 seconds 10/12/23 bed 26 minutes and 49 seconds 10/14/23 bed 161 minutes and 21 seconds Upon observation and interview on 10/16/23 at 9:14 a.m. R1 was resting in bed. R1 had two wrinkled bath blankets under him, and he was covered with a top sheet. He had no fitted sheet on his bed. R1 was only wearing on an incontinent brief. R1 stated when he presses his call light for staff assistance the response is sometimes hours before a staff arrives to his room. R1 stated he cannot get out of bed himself and if he needed his brief changed or to be repositioned in his bed, he needs to call for assistance. He stated he had sat in a soiled brief for hours. R1 stated he would start yelling from his room if the situation got "really bad". Upon interview on 10/16/23 at 9:39 a.m. Nursing assistance (NA)-C stated he had not been in R1's room yet that morning. He stated the first few hours of the day staff is "always" behind because there are only three NA's working on the floor for 33 residents and eight of the residents required mechanical lifts with the assistance of two NA's. He stated it was difficult to answer the call lights when two staff are taken up in multiple rooms upon morning cares. He stated the staff now carry pagers, so they are aware when a call light is going off, but they still can't leave a resident to assist another resident. He stated the morning cares and around lunch time were the most	{F 725}			

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{F 725}	Continued From page 11 difficult times. NA-A stated the nurse, and the trained medication assistant (TMA) are busy completing their tasks and are unable to assist during those times. NA-A stated R1 often has the just the bath blankets on his bed as the night shift puts those on him and due to R1's obesity and poor mobility it takes a lot of time to place a proper sheet underneath him. R2's care plan dated 4/18/23 indicated R2 required extensive assistance of one staff member to dress him. He required extensive assistance of one staff member to assist with personal hygiene. R2 required total assistance of one staff for toilet use and transferring. Encourage resident to use call bell and be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for Assistance as R2 was a fall risk. R2's significant change MDS dated 8/4/23 indicated R2 had a BIMs score of 6 indicating severe cognitive impairment. R2 required extensive assistance of two staff members for bed mobility, transferring, dressing and personal hygiene. R2's diagnoses were a wedge compression fracture of the first lumbar vertebra, adult failure to thrive, chronic obstruction pulmonary disease, and liver disease. A device activity report dated 10/2/23 - 10/16/23 for R2 indicated call light staff response times of: 10/2/23 bed 50 minutes and 39 seconds 10/2/23 bed 79 minutes and 26 seconds 10/4/23 bed 26 minutes and 12 seconds 10/5/23 bed 31 minutes and 24 seconds 10/7/23 bed 40 minutes and 30 seconds	{F 725}			

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{F 725}	Continued From page 12 10/14/23 bed 31 minutes and 50 seconds 10/15/23 bed 28 minutes and 26 seconds Upon observation and interview on 10/16/23 at 9:53 a.m. R2 was seated in his room in his wheelchair. R2 was wearing soiled clothing. R2's call light was on the floor approximately 15 feet away from him by his bedside table. R2 stated he could wheel himself over to the call light but would not be able to bend over to pick it up off the floor. He stated instead of using the call light, it was easier to wheel himself out into the hallway and ask for assistance. R2 stated he usually dresses himself, but he could not recall if he slept in his clothing the previous night and dressed himself in the morning or not. Upon interview on 10/16/23 at 9:56 a.m. registered nurse (RN)-A stated she would get staff immediately to assist R2 in changing his clothing. She was uncertain if R2 was dressing himself in the mornings or if staff were dressing him. RN-A believed with the call light being on the floor that R2 could use his chair to maneuver himself over to the call light and pull the cord, but stated he should have it next to him in his chair. R3 care plan dated 4/18/23 indicated R3 is totally dependent one staff for transferring, ambulating and toileting. Encourage R3 to use bell to call for assistance. Staff was to be sure residents call light was within his reach and encourage R3 to use the call light. R3 is a fall risk and requires prompt response to all requests. R3's quarterly MDS dated 8/15/23 indicated R3 had a BIMs score of 5 indicating severe cognitive impairment. R3 required extensive assistance of	{F 725}			

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{F 725}	Continued From page 13 one staff member with bed mobility, transferring, dressing and hygiene. R3's diagnosis were pain in unspecified knee, low back pain, tremors, syncope (fainting or loss of consciousness) and collapse. A device activity report dated 10/2/23 - 10/16/23 for R3 indicated call light staff response times of: 10/8/23 bed 24 minutes and 30 seconds 10/11/23 bed 103 minutes and 4 seconds 10/14/23 bed 151 minutes and 13 seconds R3 did not use his call light 10/3/23 - 10/7/23 and 10/9/23 - 10/10/23. Upon observation and interview on 10/16/23 at 10:34 a.m. R3 was seated in a chair in his room he had a walker next to him. His call light was across room on the floor by his bedside table approximately 15 feet from R3. R3 stated he rarely uses his call light because he often doesn't have it within reach. He stated he is unable to stand without assistance because he gets dizzy. He stated he had fallen at the facility but could not recall when. He stated he had gone without his call light for days. He stated he spends his time seated in his chair in his room and can see staff walking by, and he would yell for staff to come in and assist him. Upon interview on 10/16/23 at 10:40 a.m. RN-B stated R3 can walk on his own, so he could have gotten to his call light. R4's care plan dated 6/29/23 indicated R4 ambulated independently with a two wheeled walker. R4 was independent with dressing, toilet use and transferring. A revision was made to R4's care plan during the survey on 10/17/23 that R4 prefers his call light placed on his nightstand,	{F 725}			

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{F 725}	Continued From page 14 not clipped to his bed. The care plan did not indicate any further call light interventions. R4's quarterly MDS indicated R4's short-term and long-term memory was okay. R4 used a wheelchair for ambulation. R4 was independent with activities of daily living. R4's diagnoses included hemothorax (a serious condition where blood collects between your lungs and your rib cage), opioid dependence, anxiety, and depression. A device activity report dated 10/2/2/23 - 10/16/23 for R4 indicated call light staff response times of: 10/2/23 bed 50 minutes and 22 seconds 10/2/23 bed 50 minutes and 6 seconds 10/3/23 bed 96 minutes and 25 seconds 10/3/23 bed 67 minutes and 58 seconds 10/4/23 bed 112 minutes and 13 seconds 10/4/23 bed 93 minutes and 46 seconds 10/4/23 bed 124 minutes and 22 seconds 10/5/23 bed 40 minutes and 7 seconds 10/5/23 bed 34 minutes and 18 seconds 10/5/23 bed 35 minutes and 32 seconds 10/6/23 bed 125 minutes and 4 seconds 10/8/23 bed 26 minutes and 47 seconds 10/9/23 bed 42 minutes and 8 seconds 10/10/23 bed 26 minutes and 24 seconds 10/11/23 bed 25 minutes and 15 seconds 10/14/23 bed 39 minutes and 48 seconds 10/14/23 bed 42 minutes and 46 seconds 10/14/23 bed 123 minutes and 42 seconds 10/15/23 bed 40 minutes and 17 seconds 10/15/23 bed 51 minutes and 10 seconds Upon observation and interview on 10/16/23 at 10:18 a.m. R4 was in his room, slumped over in his wheelchair. R4 was shouting out, "I'm sick, I'm sick, if you're not a nurse get one." The call	{F 725}			

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{F 725}	Continued From page 15 light on R4's wall near his bed with a part of the call lights cord missing. A piece of the cord had become unconnected, leaving on about four inches of cord connected to the outlet. The rest of the cord was not seen. RN-B came into the room, as she stated she heard R4 yelling. RN-B noticed the call light was missing part of the cord and stated she would tell maintenance. R4 stated "why have one, they don't answer then anyway, now get out and get a nurse who can help me." R5's care plan dated 7/6/23 indicated R5 required assistance of one staff member for bed mobility , transferring, and dressing. R5 was totally dependent of one staff member for toilet use . The care plan does not indicate any call light interventions. R5's admission MDS dated 7/11/23 indicated R5 had a BIMs score of 15 indicating she was cognitively intact. She required extensive assistance of one staff member for bed mobility , transfers, hygiene, and toilet use. Her diagnoses were hemiplegia following a cerebral infarction affecting the left side (stroke), seizures, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R5's indicated call light staff response times of: 10/2/23 bathroom 75 minutes and 1 second 10/4/23 bathroom 29 minutes and 17 seconds 10/5/23 bathroom 54 minutes and 13 seconds 10/8/23 bathroom 41 minutes and 35 seconds 10/8/23 bathroom 24 minutes and 38 seconds 10/12/23 bathroom 22 minutes and 42 seconds Upon observation and interview on 10/16/23 at	{F 725}			

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{F 725}	Continued From page 16 10:53 a.m. R5 was in her bathroom. She was dressed in two hospital gowns, one with the ties in the front and one with the ties in the back. She stated she had been helped with morning cares. She stated that was not a concern, because she has improved, and she is more independent around her room. She stated that her concern was when she uses the bathroom, she still feels she is unable to clean herself well and transfer herself from the toilet. She stated she had sat on the toilet for over an hour and that makes her joints sore, and she gets dizzy. She stated it doesn't matter what time of day it is, "some days are good, others are not." Upon interview on 10/17/23 at 12:03 p.m. the Assistant Director of Nursing (ADON) stated she is uncertain what her job duties are, she mainly covers the floor, and she is responsible for infection control and training. She stated she does not have the time to "adequately" train new staff. She stated the reason the training is not adequate is because taking care of the residents' needs to be the priority. Upon interview on 10/17/23 at 2:37 p.m. NA-B stated when the third floor is staffed with three NAs, showers get missed, residents are not in time in the morning, so they are eating breakfast late and residents are not repositioned as often as they should be. She stated over the past few weeks "some" of the days there has been a fourth NA on the floor and then cares get completed timely. She stated the best thing about having four NAs is the residents are not upset due to late care or cares not completed at all. Upon interview on 10/17/23 at 2:46 p.m. NA-C stated she prioritizes her day when there are	{F 725}			

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{F 725}	Continued From page 17 three NAs scheduled on the floor and the "neediest get the cares" and the other who are less "needy" try to assist themselves or don't get their teeth brushed or showers. Upon interview on 10/17/23 on 2:58 p.m. RN-C stated she is so worried about making a mistake because she is only nurse on the floor with "only a TMA." She stated she passes meds to about 16 residents, the nurse needs to perform all the blood glucose checks on the entire unit, chart on all 33 residents, complete assessments and perform admissions. She stated she gets behind on ordering medications and assessments because she doesn't have enough time. RN-C stated she is supposed to manage and assist the nursing assistants on the floor during the workday, but she does not have the time assist or guide them. Upon interview on 10/17/23 at 4:38 the DON stated he is aware cares are not getting completed with the level of staff he needs to schedule. A facility policy titled Answering the Call Light dated 11/2022 indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs.	{F 725}			