



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

December 20, 2023

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

Re: Reinspection Results
Event ID: YUXM12

Dear Administrator:

On December 6, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 31, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 13, 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 informed you of imposed enforcement remedies.

On October 31, 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. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 30, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(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

The Terrace At Crystal LLC

November 13, 2023

Page 2

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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Crystal LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 17, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
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/lrc_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
November 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: YUXM11

Dear Administrator:

The above facility was surveyed on October 24, 2023 through October 31, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

The Terrace At Crystal Llc

November 13, 2023

Page 2

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 10/24/23, 10/25/23, 10/27/23, 10/30/23, and 10/31/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F689, when R2 was observed to overdose requiring Narcan to be administered and facility failed to implement interventions and efforts to prevent future overdoses for R2 who had a history of substance use. The IJ began on 8/19/23, and the immediacy was removed on 10/30/23. The above findings constituted substandard quality of care, and an extended survey was conducted on 10/30/23 and 10/31/23. The following complaint was reviewed: H52896554C (MN97826/MN97812) with a deficiency issued at F689. As a result of the investigation additional deficiencies were cited at F660, F740, F742 and F838. 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	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1	F 000			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 660			11/30/23

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 660	Continued From page 2 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's	F 660			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page 3 discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a discharge planning process to ensure discharge goals were achieved for 2 of 3 residents (R1, R2) who were reviewed. Findings include: R1's quarterly minimal data set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. Further, MDS revealed R1's discharge planning had not been assessed. R1's Social Service Care Conference dated 11/15/22, revealed discharge planning was needed as well as enrolling for relocation services. R1's care plan dated 11/14/22, indicated R1's goal was discharge to the community and social services will coordinate services for necessary discharge. R1's care plan lacked evidence of detailed discharge plan or services needed upon discharge and had not been revised since 11/15/22. R2's quarterly MDS dated 7/12/23, indicated R2 diagnoses included: opioid dependence with other opioid induced disorder, viral hepatitis C, anxiety disorder, and cognitively intact. R2 was independent with ADLs. Further, MDS revealed R1's discharge planning had not been assessed.	F 660	1. R1's care plan was updated to reflect detailed discharge plan and/or services needed upon discharge. R2's care plan was updated to reflect a discharge goal and plan to return to the community. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Residents will be asked their discharge preference to obtain a baseline and care plans updated accordingly. 4. Facility educated social services, nurse managers and licensed nursing staff on the discharge planning process. 5. Facility implemented a Transfer and Discharge Log for social services to utilize to track discharges and to ensure all items are complete. 6. DON, nurse manager or designee will audit discharges weekly for one month to ensure it is being completed appropriately. All audits will be brought to QAPI to assess for compliance and continued need for audits. 7. DON, nurse managers or designee will be responsible for the completion of this plan of correction.		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page 4 R2's care plan, undated, lacked evidence of a discharge goal or discharge plan to return to the community. R2's progress note from Associate Clinic of Psychology (ACP) dated 4/26/23, revealed R2's current plan was to regain ambulation and return to the Philippines to be with his wife and children. On 10/25/23 at 1:13 p.m., licensed practical nurse (LPN)-A indicated she was not aware of the facility's discharge planning process, but stated social services would be involved in discharge planning with the residents, and LPN-A was not involved. LPN-A stated currently there were no residents on her unit that had a discharge goal to return to the community, and confirmed she was not aware R1 or R2 wanted to discharge. On 10/25/23 at 3:15 p.m., director of nursing (DON) stated the facility did not have a good discharge planning process at this time. However, DON expected the interdisciplinary team (IDT) to be involved in the process which would include social services. Discharge planning would be expected to be discussed at the care conferences every quarter and with changes, but care conferences were not occurring often. DON confirmed R1's discharge goal was to return to the community and R1 required a low level of care since completing rehabilitation services at the facility. DON confirmed R1's record lacked evidence of discharge meetings or attempts to assist with discharge planning since 5/5/23. On 10/27/23 at 10:18 a.m., relocation case worker (RCW) stated she was assisting the facility with R1's discharge plan. Further, RCW	F 660			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page 5 stated the facility would make a referral to relocation services to assist with discharge planning, however the facility was figuring out management changes and the facility had been difficult to communicate with related to discharge planning. Further, RCW stated care conferences had not been completed as planned due to different reasons, and a discharge plan was hard to obtain and progress forward. On 10/27/23 at 10:52 a.m., DON stated social service designee (SSD) would be expected to complete the discharge planning (section Q) on the MDS, but this section had not been completed due to care conferences not being completed and not having a good process. On 10/27/23 at 11:08 a.m., SSD stated she was not involved in the discharge planning process, updating the care plan, or updating plan following a care conference. SSD stated she was aware R1 and R2's discharge goals were to return to the community, but the administrator was involved in R1 and R2's discharge planning. Further, SSD stated she does not complete Section Q on the MDS regarding discharge planning. On 10/27/23 at 12:26 p.m., administrator indicated he had been overseeing social services and discharge planning. Administrator indicated R1's plan was to discharge to the community and was being assisted with plan by relocation services and administrator had been in contact with relocation services "occasionally" by email regarding R1's discharge plan. In addition, administrator indicated SSD was expected to have the discharge conversations at care conferences and put the details in a note in the resident record, and DON was expected to	F 660			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page 6 update each resident care plan with the discharge plan and/or goal. Review of facility policy titled Discharge Summary and Plan revised 12/16, revealed when a resident's discharge was anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Further, every resident would be evaluated for his or her discharge needs and will have an individualized post discharge plan which would be developed by the care planning/IDT with the assistance of the resident and his or her family. The post-discharge plan would include where the individual plans to reside, arrangements that have been made for follow-up care and services, a description of the resident's stated discharge goal, how the IDT will support the resident in the transition to post-discharge care.	F 660			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident's safety, by assessing each resident for the risk of substance abuse, and develop a care plan with interventions for each resident, who had been	F 689	1. R1's care plan was updated to include substance abuse history and interventions for efforts to prevent a future overdose. R1 had a Trauma Informed Care assessment completed and care plan		11/30/23

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 689	Continued From page 7 identified as "at risk," with efforts to prevent overdose (OD), which would include increased monitoring and supervision, resulting in risk of potential serious harm, injury, impairment, or death to 2 of 3 residents (R1, R2) who were reviewed. The immediate jeopardy began on 8/19/23, when R2 overdosed, was hospitalized and the facility failed to assess, develop and implement care planning interventions to prevent overdose for R2. The administrator and interim director of nursing (DON) were notified of the immediate jeopardy on 10/27/23. The immediate jeopardy was removed on 10/30/23, but noncompliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimal Data Set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. R1's physician orders dated 10/24/23, revealed R1 had orders for antidepressant and antipsychotic medications. R1's care plan dated 10/24/23, lacked evidence of substance abuse history and interventions for efforts to prevent an overdose. R1's Emergency Department (ED) Note dated	F 689	updated accordingly. R1 was asked if she would like to see ACP and/or have a CD referral, to which she declined both. 2. R2's care plan was updated to include substance abuse history and interventions for efforts to prevent a future overdose. R2 received a new CD referral and social services have begun searching for treatment facilities. R2 expressed interest in NA meetings and detoxing and social services have begun searching for specific items. 3. All residents in the facility have the potential to be affected by this deficient practice. 4. Residents were assessed for the risk of substance abuse using the Drug Abuse Screening Tool and care plans updated to include interventions with efforts to prevent overdose, to include increased monitoring and supervision. 5. Facility will review and revise if needed, the Substance Abuse policy and educate nursing staff on the policy. 6. DON, nurse manager or designee will audit all resident care plans to ensure they are updated accordingly. 7. DON, nurse manager or designee will audit risk management for completion five times per week for four weeks. All audits will be brought to QAPI to assess for compliance and continued need for audits. 8. DON, nurse managers or designee will be responsible for the completion of this plan of correction.		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 8 12/5/22, revealed R1 was brought to the ED related to altered mental status. History of drug use was of suspicion for altered mental stated. R1 had endorsed she used heroin yesterday and was given 0.5 (milligram) mg of Narcan on her way to the ED by EMS. R1's record lacked evidence R1's substance use incident had been investigated and interventions were implemented in efforts to prevent future OD. R1's Behavioral Health Comprehensive Assessment dated 12/16/22, indicated R1 had revealed personal triggers for substance use which included: son dying, trying to cope with the loss on her own, and physical pain. R1 had stated, "I want to be clean again, but I don't want to be in pain. I don't want to be depressed and I don't want to have anxiety either." R1 had reported beginning Methadone and seeing a psychologist would be helpful in making this change. Further, R1's reasons for drug use included: to cope with stress, to relieve physical pain, to cope with anxiety, to cope with depression, makes it easier to talk with people, to cope with family problems, and afraid of withdrawal symptoms/to feel better. R1's Regulatory Visit note dated 8/10/23, indicated R1 had a history of being found unresponsive and she had been discovered with a needle in her hand while using drugs. R1 exhibited drug seeking behavior and drug use as very common. Nursing reported episodes of, "acting fun, like she is high on something." R1 had a a history of substance abuse and appears to be using drugs currently per call notes from nursing staff, R1 would refuse to be sent in and had instances where they have had to administer	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 9 Narcan. R2's quarterly MDS dated 7/12/23, indicated R2 diagnoses included: opioid dependence with other opioid induced disorder, viral hepatitis C, anxiety disorder, and cognitively intact. R2 was independent with ADLs. R2's care plan dated 10/24/23, lacked evidence of substance abuse history and any interventions for efforts to prevent an overdose. R2's Physician Orders dated 4/21/23, revealed referral to chemical dependency for evaluation and treat related to substance abuse. However, R2's record lacked evidence a referral was made. Review of R2's progress notes indicated: -On 8/17/23 at 9:35 p.m., R2 was found unresponsive in another resident's room but had a pulse. Narcan 4 mg was administered and 911 was called. R2 became responsive after approximately 6 minutes. R2 declined going to the hospital upon police and paramedic's arrival. -On 8/19/23 at 8:22 p.m., R2 overdosed outside. Another resident came to alert nursing staff and had already called 911. R1 was taken by paramedics to the hospital. -On 8/20/23 at 1:30 a.m., R2 returned from the hospital. R2 reported pain on right shoulder rating 8/10 and R2 stated he suspects injury to his right collar bone during the OD incident. R2's record lacked evidence R1's overdose incident had been investigated and interventions were implemented in efforts to prevent future OD.	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 689	Continued From page 10 R2's Progress Note from Associated Clinic of Psychology (ACP) dated 8/30/23, indicated R2 expressed he was doing better, and reflected on his overdose. R2 had admitted the incident was his 19th overdose. R2 reported he had been struggling with pain and depression. ACP treatment recommendations/plan included R2 had agreed to attend narcotics anonymous (NA) which social services agreed to follow up, and R2 agreed to try to detox to help getting into the methadone clinic for help with his pain and drug addiction. R2's Progress note from ACP dated 9/27/23, indicated R2 presented with a labile, depressed affect and mood. R2 expressed that he was struggling at this time and observed him to be under the influence. ACP consulted with social services after the session. ACP treatment recommendations/plan included R2 again agreed to NA and social services agree to follow up, and R2 again agreed to try to detox. In addition, ACP added bipolar disorder, current episode depressed severe with psychotic features and alcohol use disorder severe to R2's diagnoses. However, R2's record lacked evidence ACP recommendations were followed-up on regarding offering R2 NA meetings or detox options. R2's History and Physical note dated 8/30/23, indicated visit was warranted due to R2 being found unresponsive and Narcan administered. R2 had multiple emergency department hospitalizations in the month of August 2023 with most recent 8/19/23 to 8/20/23 for opiate overdose.	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 11 On 10/24/23 at 1:58 p.m., nursing assistant (NA)-A stated R1 was observed to be "high" and would be slumped over "all the way down" in her wheelchair, and "that is how we know". In addition, NA-A stated R2 was also suspected of substance abuse. On 10/24/23 at 4:57 p.m., R1 was observed in her room laying in bed with the lights off and appeared to be sleeping. R1 stated she was not feeling well and declined interview and requested not to be approached again. On 10/24/23 at 5:01 p.m., R2 was observed in his room laying in his bed with the lights off and appeared to be sleeping. R2 stated he was not feeling well and declined to be interviewed. On 10/25/23 at 10:21 a.m., licensed practical nurse (LPN)-B stated R1 does illegal drugs but was unsure what type of drug, adding staff have "caught her with needles and passed out". Further, LPN-B stated R1 uses so many drugs we will find her slumped over in her wheelchair and LPN-B added she assumed R1 was using methamphetamine. LPN-B indicated R2 would report to the nurse and say, "I took some stuff and I don't want to die" and R2 had reported he had taken Fentanyl. LPN-B stated R2 had overdosed due to substance abuse and staff had sent him to the ER a lot. Further, LPN-B stated when a resident was suspected of substance abuse staff are expected to call 911, update the physician, hold any medications, notify the director of nursing (DON), as well as assessing	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 12 the resident and monitoring vital signs every 4 hours. On 10/25/23 at 10:43 a.m., registered nurse (RN)-A stated staff were made aware if a resident was determined to be at risk of substance abuse by referring to each resident's care plan. RN-A stated R1 had a history of using substances and had been suspected to actively use but was unsure what substance or where R1 would get her supply. Further, RN-A identified R2 was suspected of substance abuse but was unsure what substance or where R2 gets his supply. RN-A stated R2 had OD approximately a month ago and Narcan had to be administered. RN-A indicated she was unaware of interventions for efforts to prevent overdose for R1 or R2. In addition, RN-A stated staff were expected to notify the physician and get orders to hold medications and obtain vitals, complete hourly checks, and notify the DON if substance abuse was suspected. On 10/25/23 at 11:12 a.m., NA-B stated staff are made aware of substance abuse risk in each resident's care plan, however the resident's care plan does not always contain the information. NA-B stated she had observed R1, "slumped over" and maybe she was under the influence. On 10/25/23 at 1:13 p.m. LPN-A stated upon admission each resident's medical record was reviewed and would reveal if a resident had a history of substance abuse. LPN-A stated she would be responsible for initiating substance abuse risk in the resident's care plan when identified but was unaware of who would be responsible for developing and/or implementing interventions related to substance abuse. Further,	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 13 LPN-A stated staff were expected to obtain vital signs every shift, monitor the resident "as best they will allow", and visually see the resident every couple hour, when a resident was suspected of substance abuse. LPN-A stated OD incidents were discussed in IDT meetings but was unaware of R1 and R2's OD incidents. Further, LPN-A stated no staff had reported concerns of R1 or R2 using any substances or being under the influence and LPN-A was unaware of R1 and R2's history of substance abuse. In addition, LPN-A confirmed R1 and R2's care plans lacked evidence of risk of substance abuse and interventions or efforts to prevent future OD. On 10/25/23 at 3:15 p.m., DON stated currently there was no facility process to assess resident's and determine substance abuse risk. DON confirmed there are 8 residents residing in the facility who have been suspected of substance abuse and are at risk for OD, which included R1 and R2. DON stated nurse managers would be expected to update resident's care plans to include risk of substance abuse and interventions. Further, DON stated if staff expected substance abuse the provider would need to be updated, obtain orders to hold medications, monitor vital signs every shift, and visual contact every 1-2 hours. DON stated following an OD incident, staff would be expected to complete an incident report in Risk Management and the incident would be discussed in IDT meeting to determine a plan going forward. DON confirmed for R1 and R2 "that has not happened." DON also indicated social services and physicians were not very involved in substance abuse "right now".	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 14 On 10/27/23 at 10:52 a.m., DON was unaware of when or why R2 had stopped seeing ACP. DON stated R1 and R2 were both offered ACP services and declined following suspicion of illegal drug use incidents, however R1 and R2's records lack evidence of when R1 and R2 were offered or refusals and stated usually the record will have a note from staff or from ACP. Further, DON confirmed R2 had an order for referral to chemical dependency treatment, however this order was not completed. On 10/27/23 at 11:08 a.m., social service designee (SSD) stated she was not involved with interventions for residents with substance use disorders, and this would be a nursing function. Further, SSD confirmed she was aware R1 had a history of illegal substance use, adding she believed R2's drug of choice was Heroin and was aware of R2's illegal substance use which was Fentanyl pills. SSD confirmed both R1 and R2 had OD and required Narcan to be administered while receiving services at the facility. In addition, SSD stated OD incidents were discussed with the IDT, but efforts to prevent future ODs were not discussed. SSD denied assisting neither R1 or R2 with any behavioral health services related to substance abuse disorders, treatment planning, safety related to overdose prevention, or therapies related to mental health disorders and/or loss and grief therapy and groups. On 10/27/23 at 11:55 a.m., nurse practitioner (NP)-A indicated R1 had a history of substance abuse and was actively using. NP-A stated she was aware R1 required Narcan to be administered for an OD, and NP-A had observed R1 not being able to hold a conversation during	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 15 an assessment she was attempting to conduct with R1. NP-A also noted she had been made aware R1 had been observed by staff in August of 2023 to be unresponsive with a needle in her hand. NP-A confirmed she was aware R2 had a history of using illegal substances as well and was aware Narcan had to be administered for an OD. In addition, NP-A stated staff were expected to notify the physician when they suspect illegal drug use so the physician could provide orders to hold medications, and staff would be expected to monitor the individual frequently and obtain vitals per facility policy. NP-A stated the facility had psychiatry services and would be expected to make a referral for the individuals who have substance abuse disorders to ensure their mental health would be managed appropriately. On 10/27/23 at 12:26 p.m., administrator indicated R1 was admitted to the facility as "an active drug user" and ACP services were offered and declined as R1 denied having a drug problem. Administrator stated since admitting to the facility, R1 had to have Narcan administered on two separate occasions for a drug overdose. Administrator confirmed R2 was also actively using illegal substances and would go to the community to buy drugs and staff were all aware of this. In addition, administrator stated staff were aware which residents were using illegal substances and who were "current users" and staff were expected to "keep an eye on the individual as they can" but there was no specific protocol. Administrator stated ODs were discussed in morning meeting with the IDT, however IDT would not discuss efforts to prevent future ODs. At the time of survey, facility failed to provide	F 689			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 16 evidence of a substance abuse policy or protocol. The immediate jeopardy that began on 8/19/23, was removed on 10/30/23, when the facility re-assessed R1 and R2 using the Drug Abuse Screening test, facility reached out to behavioral health services to review R1 and R2 current status, reviewed drug patterns, implemented 15-minute checks for 24 hours and vital sign checks every two hours for 24 hours for R1 and R2 if suspicion or witnessed use of illegal substances. and care plans had been updated as indicated. Facility policy and procedures were developed related to substance abuse. Additionally, all staff were trained on new policy and procedure and revised care plans for R1 and R2.	F 689			
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan with appropriate services, treatments, and prevention interventions for substance use disorders for 2 of 3 residents (R1, R2) reviewed.	F 740	1. R1's care plan was updated to include substance abuse history, services/treatments offered and interventions for efforts to prevent illegal substance use. R1 was asked if she		11/30/23

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 740	Continued From page 17 In addition, the facility failed to follow physician orders for referral to behavioral health services 1 of 3 residents (R1) and failed to follow behavioral health specialist's recommendations regarding managing continued substance abuse for 1 of 3 residents (R2) reviewed for behavioral health services. Findings include: R1's quarterly minimal data set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. R1's physician orders dated 10/24/23, revealed R1 had orders for antidepressant and antipsychotic medications. R1's care plan lacked evidence of substance abuse history, appropriate services, treatments, and any interventions for efforts to prevent illegal substance use. R2's quarterly MDS dated 7/12/23, indicated R2 diagnoses included: opioid dependence with other opioid induced disorder, viral hepatitis C, anxiety disorder, and cognitively intact. R2 was independent with ADLs. R2's care plan lacked evidence of substance abuse history, appropriate services, treatments, and any interventions for efforts to prevent illegal substance use. On 10/25/23 at 1:13 p.m., LPN-A stated upon	F 740	would like to see ACP and/or have a CD referral, to which she declined both. 2. R2's care plan was updated to include substance abuse history, services/treatments offered and interventions for efforts to prevent illegal substance use. R2 received a new CD referral and social services have begun searching for treatment facilities. R2 expressed interest in NA meetings and detoxing and social services have begun searching for specific items. 3. All residents in the facility have the potential to be affected by this deficient practice. 4. Facility will review and revise if needed, the Substance Abuse policy and educate nursing staff on the policy. 5. Facility will review and revise if needed, the Medication and Treatment Orders policy to include the protocol for referrals to behavioral health services and educate licensed nursing staff on the policy. 6. Facility will review and revise if needed, the Social Services Referrals policy and educate social services staff on the policy. 7. Facility will review and revise if needed, the consultants policy to include the protocol the facility follows to follow-up after receiving the report following each consultation to ensure coordination of care and educate social services and licensed nursing staff on the policy. 8. Facility will obtain ACP contract to ensure resident population is supported. 9. DON, nurse manager or designee will audit all resident care plans to ensure they are updated accordingly. 10. HUC or designee will review R1 and		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page 18 admission each resident's medical record is reviewed and would reveal if a resident had a history of substance abuse or not or asking the resident upon admission. LPN-A stated she would be responsible for initiating substance abuse risk in the resident's care plan when identified but was unaware of who would be responsible for developing and/or implementing interventions related to substance abuse. LPN-A confirmed both R1 or R2's care plan lacked evidence of illegal substance use and history, as well as services, treatments and interventions to prevent illegal substance use. On 10/25/23 at 3:15 p.m., interim director of nursing (DON) confirmed R1 and R2's care plans lacked evidence of illegal substance use and history, as well as services, treatments and interventions to prevent illegal substance use. DON stated social services and resident's providers have not been involved with substance use previously. Requested Substance Abuse policy at time of survey, however facility did not have a policy regarding substance abuse. AND R1's quarterly minimal data set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. R1's physician order dated 12/1/22, indicated an order for ACP (Associated Clinic of Psychology) to evaluate and treat.	F 740	R2's orders in TCP portal on Wednesdays/Thursdays for four weeks to audit for new referral orders for behavioral health services. Any orders received will be given to social services and nurse managers. 11. DON, nurse managers or designee will be responsible for the completion of this plan of correction.		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page 19 R1's record lacked evidence R1 was offered ACP services since 11/15/22. On 10/27/23 at 10:52 a.m., DON stated R1 was offered ACP services and declined, however R1's record lacked evidence of refusal and stated usually the record will have a note from staff and/or from ACP. On 10/27/23 at 11:08 a.m., social service designee (SSD) stated R1 declined to see ACP services but was unsure when ACP was offered to R1. On 10/27/23 at 12:26 p.m., administrator stated R1 was offered ACP services to discuss substance use however, R1 had declined and denied having a drug problem. Administrator was unable to provide evidence of when R1 was offered ACP services and when she declined. Review of facility policy titled Medication and Treatment Orders revised 7/16, did not give staff direction on protocol for referrals to behavioral health services to evaluate and treat. AND R2's quarterly MDS dated 7/12/23, indicated R2 diagnoses included: opioid dependence with other opioid induced disorder, viral hepatitis C, anxiety disorder, and cognitively intact. R2 was independent with ADLs. R2's care plan lacked evidence of substance abuse history, appropriate services, treatments, and any interventions for efforts to prevent illegal substance use.	F 740			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page 20 R2's Progress Note from Associated Clinic of Psychology (ACP) dated 8/30/23, indicated R2 expressed he was doing better, and reflected on his overdose. R2 had admitted the incident was his 19th overdose. R2 reported he had been struggling with pain and depression. ACP treatment recommendations/plan included R2 had agreed to attend narcotics anonymous (NA) which social services agreed to follow up, and R2 agreed to try to detox to help getting into the methadone clinic for help with his pain and drug addiction. R2's Progress note from ACP dated 9/27/23, indicated R2 presented with a labile, depressed affect and mood. R2 expressed that he was struggling at this time and observed him to be under the influence. ACP consulted with social services after the session. ACP treatment recommendations/plan included R2 again agreed to NA and social services agree to follow up, and R2 again agreed to try to detox. In addition, ACP added bipolar disorder, current episode depressed severe with psychotic features and alcohol use disorder severe to R2's diagnoses. R2's record lacked evidence these recommendations were addressed by the facility and no attempts were made to get R2 into NA meetings and assist with detox efforts. On 10/27/23 at 11:08 a.m., SSD stated she was not involved with interventions for residents with substance use disorders, and nursing would be involved with discussions with the residents. SSD was unaware of R2's goal for detox or treatment interventions. SSD denied assisting neither R1 or R2 with any behavioral health services related to	F 740			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page 21 substance abuse disorders, treatment planning, safety related to overdose prevention, or therapies related to mental health disorders and/or loss and grief therapy and groups. On 10/25/23 at 3:15 p.m., DON stated "there has not been a lot done to help him" referring to R2 and R2 had reported to staff that he does want to get help with his substance use. Further, DON stated she didn't feel previous management had explored all avenues of R2's pain, which was his trigger to using illegal substances. Request of ACP service contract however facility did not have a current contract with ACP. Review of facility policy titled Consultants dated 12/09, indicated the facility may use as needed outside resources to furnish specific services to residents and to the facility. Written, signed and dated agreements are maintained for each consultant which would contain: the responsibilities of the consultant and the responsibilities of the facility. Further the policy revealed each consultant would provide the administrator with written, dated, and signed reports of each consultation visit which would contain recommendations, plans for implementation of his/her recommendations, findings and plans for continued assessments. However, policy lacked protocol what the facility does for follow-up after receiving the report following each consultation to ensure coordination of care.	F 740			
F 742 SS=D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive	F 742			11/30/23

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 742	Continued From page 22 assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address a diagnosis of post-traumatic stress disorder (PTSD) by obtaining a history of trauma, and develop a person-centered care plan to avoid triggers related to past trauma for 1 of 3 residents (R1) reviewed for mental disorders. Findings include: R1's quarterly minimal data set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. R1's physician orders dated 10/24/23, revealed R1 had orders for antidepressant and antipsychotic medications. R1's Primary Care PTSD Screen dated 11/15/22, directed PTSD should be considered "positive" if a resident answered yes to any three items to which R1 had responded yes to having had any experience that was so frightening, horrible or	F 742	1. R1 had an updated PTSD assessment completed and care plan updated accordingly to include the details related to the PTSD and interventions to prevent re-traumatization. 2. R1 had an updated Trauma Informed Care assessment completed and care plan updated accordingly to include details related to triggers and interventions to prevent re-traumatization. 3. R1's will be asked what activities are meaningful and of interest to her and care plan updated accordingly. 4. All residents in the facility have the potential to be affected by this deficient practice. 5. Residents will have a Trauma Informed Care assessment completed and care plan updated accordingly. 6. Residents with a PTSD diagnosis will have an updated PTSD assessment completed and care plan updated accordingly. 7. Facility will review and revise if needed, the Trauma Informed Care policy and educate social services and licensed nursing staff on the policy.		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 742	Continued From page 23 upsetting that she had night mares about it or thought about it when she did not want to as well as tried hard not to think about it or went out of her way to avoid situations that reminded her of it. Further, assessment lacked evidence or details related to the PTSD that R1 was referring to and lacked evidence of personalized interventions that would be implemented to prevent re-traumatization. R1's Trauma Informed Care History dated 11/15/22, revealed R1 responded yes to having been through anything life threatening or traumatic but did not give any further details on traumatic event. Further, R1 responded yes when asked if she was aware of any particular triggers that may make this worse for her, however assessment lacked further details regarding triggers to prevent re-traumatization. R1's Comprehensive Assessment completed by Partners Behavioral Healthcare dated 1/31/23, R1 had reported both her parents were verbally, physically, and sexually abusive and reported receiving previous formal counseling for the abuse. R1 also reported son, who was also primary caretaker, passed away in November 2022, and R1 had a heroin overdose while experiencing grief from the recent loss. R1's reasons for drug use included: to cope with stress, to relieve physical pain, to cope with anxiety, to cope with depression, makes it easier to talk with people, to cope with family problems, and afraid of withdrawal symptoms/to feel better. Further assessment revealed R1 had difficulty with impulse control and lacks coping skills and thoughts of suicide or harm to others without means however the thoughts may interfere with participation in some treatment activities.	F 742	8. DON, nurse manager or designee will audit all resident care plans to ensure they are updated accordingly. 9. DON, nurse manager or designee will audit screening assessments with MDS schedule to ensure completion and that care plan is updated accordingly. Audits will occur with the ongoing MDS schedule and be brought to QAPI to assess for compliance and continued need for audits. 10. DON, nurse managers or designee will be responsible for the completion of this plan of correction.		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 742	Continued From page 24 R1's care plan dated 11/15/22, indicated R1 had depression related to bipolar disorder, anxiety and PTSD. Further, R1's care plan directed staff to administer medication as ordered and monitor for side effects and effectiveness, arrange for psychiatrist consultation and follow up as indicated (R1 declined on 11/15/22), assist the resident in developing/provide the resident with a program of activities that is meaningful and of interest (care plan lacked evidence of program), discuss with the resident any concern, fears, issues regarding health or other subjects, needs time to talk encourage the resident to express feelings, needs adequate rest periods, and needs to be reminded/escorted/encouraged to attend activities of choice (care plan lacked evidence of what activities of interest are). R1's care plan lacked evidence of trauma-informed care plan with personalized interventions to prevent re-traumatization and lacked evidence of being revised since 11/15/22. On 10/25/23 at 1:13 p.m., licensed practical nurse (LPN)-A stated she was unaware of an assessment to complete for a resident upon admission regarding past trauma but stated social services would complete one. LPN-A confirmed she was not aware of any past trauma for R1. On 10/25/23 at 3:15 p.m., interim director of nursing (DON) stated social services would be expected to complete a trauma assessment upon admitting to the facility as well as implementing a trauma informed care plan with individualized interventions. DON confirmed she was not aware of R1's past trauma or if any staff had reviewed	F 742			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 742	Continued From page 25 R1's Comprehensive Assessment completed by Partners Behavioral Healthcare. On 10/27/23 at 8:32 a.m., social service designee (SSD) stated she was not aware of a trauma informed care plan or assessment but confirmed she had not completed any.SSD denied assisting neither R1 with any behavioral health services related to treatment planning, or therapies related to mental health disorders and/or loss and grief therapy and groups. Facility policy for Trauma Informed Care was requested but facility failed to provide a copy.	F 742			
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity,	F 838			11/30/23

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 838	Continued From page 26 and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by:	F 838			

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 838	Continued From page 27 Based on interview and document review, the facility failed to identify specific care or practices necessary to meet identified care needs regarding substance abuse disorders. This had the potential to affect all residents currently residing in the facility with a diagnosis or history of substance use disorders. Findings include: The facility assessment dated 7/28/23, indicated administrator and interim director of nursing (DON) were involved in completing the facility assessment. The facility assessment lacked evidence of including residents with diagnosed substance abuse disorders. The facility assessment revealed there were no special treatments and conditions for mental health such as behavioral health needs or active or current substance use disorders, which were both marked with a 0. Further, the facility assessment lacked evidence of substance abuse and specific cares or practices related to alcohol and/ or substance abuse. On 10/31/23 at 8:59 a.m., interim DON stated the administrator completed the facility assessment and moving forward DON stated she would be involved with completing the assessment. DON stated substance abuse disorders would be reviewed as part of the facility assessment and confirmed current facility assessment lacked evidence of addressing substance abuse needs. On 10/31/23 at 9:04 a.m., at interview with administrator was attempted and unsuccessful. Review of facility policy titled Facility Assessment	F 838	1. Facility reviewed and revised the Facility Assessment to include residents with diagnosed substance abuse disorders, special treatments and conditions for mental health, including behavioral health needs and current or history of substance use disorders and specific cares and practices related to alcohol and/or substance abuse. Facility educated the leadership team on the updated Facility Assessment. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Facility will review and revise if needed, the Facility Assessment policy and educate the leadership team on the policy. 4. Administrator or designee will audit facility assessment and related policies to ensure they are updated accordingly. 5. Administrator or designee will be responsible for the completion of this plan of correction.		

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 10/31/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 838	Continued From page 28 revised 10/18, indicated a facility assessment was conducted to determine and update facility capacity to meet the needs of and competently care for the residents during day-to-day operations. Further, policy indicated the team responsible for conducting, reviewing and updating the facility assessment included the administrator and DON. The facility assessment includes a detailed review of the resident population which included: cognitive or behavioral impairments, conditions or diseases that require specialized care, resources available to meet the needs of the resident population, equipment and supplies, contracts or agreements with third parties to provide services, and a breakdown of the training, licensure, education, skill level and measures of competency for all personnel.	F 838			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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 10/24/23, 10/25/23, 10/27/23, 10/30/23, and 10/31/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of	2 000		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

11/21/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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 correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H52896554C (MN97826/MN97812) with a licensing order issued at 0830. As a result of the investigation, additional licensing orders were issued at 0240 and 1475. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 240	MN Rule 4658.0065 Subp. 3 Resident Safety and Disaster Planning Subp. 3. Written disaster plan. A nursing home must have a written disaster plan specific to the nursing home with procedures for the protection and evacuation of all persons in the case of fire or explosion or in the event of floods, tornadoes, or other emergencies. The plan must include information and procedures about the location of alarm signals and fire extinguishers, frequency of drills, assignments of specific tasks and responsibilities of the personnel on each shift, persons and local emergency departments to be notified, precautions and safety measures during tornado alerts, procedures for evacuation of all persons during fire or floods, planned evacuation routes from the various floor areas to safe areas within the building, or from the building when necessary, and arrangements for temporary emergency housing in the community in the event of total evacuation. This MN Requirement is not met as evidenced by:	2 240			11/30/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 240	Continued From page 3 Based on interview and document review, the facility failed to have a discharge planning process to ensure discharge goals were achieved for 2 of 3 residents (R1, R2) who were reviewed. Findings include: R1's quarterly minimal data set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. Further, MDS revealed R1's discharge planning had not been assessed. R1's Social Service Care Conference dated 11/15/22, revealed discharge planning was needed as well as enrolling for relocation services. R1's care plan dated 11/14/22, indicated R1's goal was discharge to the community and social services will coordinate services for necessary discharge. R1's care plan lacked evidence of detailed discharge plan or services needed upon discharge and had not been revised since 11/15/22. R2's quarterly MDS dated 7/12/23, indicated R2 diagnoses included: opioid dependence with other opioid induced disorder, viral hepatitis C, anxiety disorder, and cognitively intact. R2 was independent with ADLs. Further, MDS revealed R1's discharge planning had not been assessed. R2's care plan, undated, lacked evidence of a discharge goal or discharge plan to return to the community.	2 240	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 240	Continued From page 4 R2's progress note from Associate Clinic of Psychology (ACP) dated 4/26/23, revealed R2's current plan was to regain ambulation and return to the Philippines to be with his wife and children. On 10/25/23 at 1:13 p.m., licensed practical nurse (LPN)-A indicated she was not aware of the facility's discharge planning process, but stated social services would be involved in discharge planning with the residents, and LPN-A was not involved. LPN-A stated currently there were no residents on her unit that had a discharge goal to return to the community, and confirmed she was not aware R1 or R2 wanted to discharge. On 10/25/23 at 3:15 p.m., director of nursing (DON) stated the facility did not have a good discharge planning process at this time. However, DON expected the interdisciplinary team (IDT) to be involved in the process which would include social services. Discharge planning would be expected to be discussed at the care conferences every quarter and with changes, but care conferences were not occurring often. DON confirmed R1's discharge goal was to return to the community and R1 required a low level of care since completing rehabilitation services at the facility. DON confirmed R1's record lacked evidence of discharge meetings or attempts to assist with discharge planning since 5/5/23. On 10/27/23 at 10:18 a.m., relocation case worker (RCW) stated she was assisting the facility with R1's discharge plan. Further, RCW stated the facility would make a referral to relocation services to assist with discharge planning, however the facility was figuring out management changes and the facility had been difficult to communicate with related to discharge	2 240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 240	Continued From page 5 planning. Further, RCW stated care conferences had not been completed as planned due to different reasons, and a discharge plan was hard to obtain and progress forward. On 10/27/23 at 10:52 a.m., DON stated social service designee (SSD) would be expected to complete the discharge planning (section Q) on the MDS, but this section had not been completed due to care conferences not being completed and not having a good process. On 10/27/23 at 11:08 a.m., SSD stated she was not involved in the discharge planning process, updating the care plan, or updating plan following a care conference. SSD stated she was aware R1 and R2's discharge goals were to return to the community, but the administrator was involved in R1 and R2's discharge planning. Further, SSD stated she does not complete Section Q on the MDS regarding discharge planning. On 10/27/23 at 12:26 p.m., administrator indicated he had been overseeing social services and discharge planning. Administrator indicated R1's plan was to discharge to the community and was being assisted with plan by relocation services and administrator had been in contact with relocation services "occasionally" by email regarding R1's discharge plan. In addition, administrator indicated SSD was expected to have the discharge conversations at care conferences and put the details in a note in the resident record, and DON was expected to update each resident care plan with the discharge plan and/or goal. Review of facility policy titled Discharge Summary and Plan revised 12/16, revealed when a resident's discharge was anticipated, a discharge	2 240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 240	Continued From page 6 summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Further, every resident would be evaluated for his or her discharge needs and will have an individualized post discharge plan which would be developed by the care planning/IDT with the assistance of the resident and his or her family. The post-discharge plan would include where the individual plans to reside, arrangements that have been made for follow-up care and services, a description of the resident's stated discharge goal, how the IDT will support the resident in the transition to post-discharge care. SUGGESTED METHOD OF CORRECTION: the administrator and designee could review/revise the facility assessment to ensure substance use disorders were addressed as appropriate. The administrator or designee could review/revise the facility assessment to include specific care or practices necessary to meet identified care needs regarding substance abuse disorders. The administrator or designee could educate staff on revisions made to the facility assessment. The administrator or designee could complete audits upon admission to ensure facility was able to meet the needs of the resident. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 240		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		11/30/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 7 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident's safety, by assessing each resident for the risk of substance abuse, and develop a care plan with interventions for each resident, who had been identified as "at risk," with efforts to prevent overdose (OD), which would include increased monitoring and supervision, resulting in risk of potential serious harm, injury, impairment, or death to 2 of 3 residents (R1, R2) who were reviewed. The immediate jeopardy began on 8/19/23, when R2 overdosed, was hospitalized and the facility failed to assess, develop and implement care planning interventions to prevent overdose for R2. The administrator and interim director of nursing (DON) were notified of the immediate jeopardy on 10/27/23. The immediate jeopardy was removed on 10/30/23, but noncompliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	2 830	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 8 Findings include: R1's quarterly Minimal Data Set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility. R1's physician orders dated 10/24/23, revealed R1 had orders for antidepressant and antipsychotic medications. R1's care plan dated 10/24/23, lacked evidence of substance abuse history and interventions for efforts to prevent an overdose. R1's Emergency Department (ED) Note dated 12/5/22, revealed R1 was brought to the ED related to altered mental status. History of drug use was of suspicion for altered mental stated. R1 had endorsed she used heroin yesterday and was given 0.5 (milligram) mg of Narcan on her way to the ED by EMS. R1's record lacked evidence R1's substance use incident had been investigated and interventions were implemented in efforts to prevent future OD. R1's Behavioral Health Comprehensive Assessment dated 12/16/22, indicated R1 had revealed personal triggers for substance use which included: son dying, trying to cope with the loss on her own, and physical pain. R1 had stated, "I want to be clean again, but I don't want to be in pain. I don't want to be depressed and I don't want to have anxiety either." R1 had reported beginning Methadone and seeing a	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 9 psychologist would be helpful in making this change. Further, R1's reasons for drug use included: to cope with stress, to relieve physical pain, to cope with anxiety, to cope with depression, makes it easier to talk with people, to cope with family problems, and afraid of withdrawal symptoms/to feel better. R1's Regulatory Visit note dated 8/10/23, indicated R1 had a history of being found unresponsive and she had been discovered with a needle in her hand while using drugs. R1 exhibited drug seeking behavior and drug use as very common. Nursing reported episodes of, "acting fun, like she is high on something." R1 had a a history of substance abuse and appears to be using drugs currently per call notes from nursing staff, R1 would refuse to be sent in and had instances where they have had to administer Narcan. R2's quarterly MDS dated 7/12/23, indicated R2 diagnoses included: opioid dependence with other opioid induced disorder, viral hepatitis C, anxiety disorder, and cognitively intact. R2 was independent with ADLs. R2's care plan dated 10/24/23, lacked evidence of substance abuse history and any interventions for efforts to prevent an overdose. R2's Physician Orders dated 4/21/23, revealed referral to chemical dependency for evaluation and treat related to substance abuse. However, R2's record lacked evidence a referral was made. Review of R2's progress notes indicated: -On 8/17/23 at 9:35 p.m., R2 was found unresponsive in another resident's room but had	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 10 a pulse. Narcan 4 mg was administered and 911 was called. R2 became responsive after approximately 6 minutes. R2 declined going to the hospital upon police and paramedic's arrival. -On 8/19/23 at 8:22 p.m., R2 overdosed outside. Another resident came to alert nursing staff and had already called 911. R1 was taken by paramedics to the hospital. -On 8/20/23 at 1:30 a.m., R2 returned from the hospital. R2 reported pain on right shoulder rating 8/10 and R2 stated he suspects injury to his right collar bone during the OD incident. R2's record lacked evidence R1's overdose incident had been investigated and interventions were implemented in efforts to prevent future OD. R2's Progress Note from Associated Clinic of Psychology (ACP) dated 8/30/23, indicated R2 expressed he was doing better, and reflected on his overdose. R2 had admitted the incident was his 19th overdose. R2 reported he had been struggling with pain and depression. ACP treatment recommendations/plan included R2 had agreed to attend narcotics anonymous (NA) which social services agreed to follow up, and R2 agreed to try to detox to help getting into the methadone clinic for help with his pain and drug addiction. R2's Progress note from ACP dated 9/27/23, indicated R2 presented with a labile, depressed affect and mood. R2 expressed that he was struggling at this time and observed him to be under the influence. ACP consulted with social services after the session. ACP treatment recommendations/plan included R2 again agreed to NA and social services agree to follow up, and	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 11 R2 again agreed to try to detox. In addition, ACP added bipolar disorder, current episode depressed severe with psychotic features and alcohol use disorder severe to R2's diagnoses. However, R2's record lacked evidence ACP recommendations were followed-up on regarding offering R2 NA meetings or detox options. R2's History and Physical note dated 8/30/23, indicated visit was warranted due to R2 being found unresponsive and Narcan administered. R2 had multiple emergency department hospitalizations in the month of August 2023 with most recent 8/19/23 to 8/20/23 for opiate overdose. On 10/24/23 at 1:58 p.m., nursing assistant (NA)-A stated R1 was observed to be "high" and would be slumped over "all the way down" in her wheelchair, and "that is how we know". In addition, NA-A stated R2 was also suspected of substance abuse. On 10/24/23 at 4:57 p.m., R1 was observed in her room laying in bed with the lights off and appeared to be sleeping. R1 stated she was not feeling well and declined interview and requested not to be approached again. On 10/24/23 at 5:01 p.m., R2 was observed in his room laying in his bed with the lights off and appeared to be sleeping. R2 stated he was not feeling well and declined to be interviewed. On 10/25/23 at 10:21 a.m., licensed practical	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 12 nurse (LPN)-B stated R1 does illegal drugs but was unsure what type of drug, adding staff have "caught her with needles and passed out". Further, LPN-B stated R1 uses so many drugs we will find her slumped over in her wheelchair and LPN-B added she assumed R1 was using methamphetamine. LPN-B indicated R2 would report to the nurse and say, "I took some stuff and I don't want to die" and R2 had reported he had taken Fentanyl. LPN-B stated R2 had overdosed due to substance abuse and staff had sent him to the ER a lot. Further, LPN-B stated when a resident was suspected of substance abuse staff are expected to call 911, update the physician, hold any medications, notify the director of nursing (DON), as well as assessing the resident and monitoring vital signs every 4 hours. On 10/25/23 at 10:43 a.m., registered nurse (RN)-A stated staff were made aware if a resident was determined to be at risk of substance abuse by referring to each resident's care plan. RN-A stated R1 had a history of using substances and had been suspected to actively use but was unsure what substance or where R1 would get her supply. Further, RN-A identified R2 was suspected of substance abuse but was unsure what substance or where R2 gets his supply. RN-A stated R2 had OD approximately a month ago and Narcan had to be administered. RN-A indicated she was unaware of interventions for efforts to prevent overdose for R1 or R2. In addition, RN-A stated staff were expected to notify the physician and get orders to hold medications and obtain vitals, complete hourly checks, and notify the DON if substance abuse was suspected. On 10/25/23 at 11:12 a.m., NA-B stated staff are	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 13 made aware of substance abuse risk in each resident's care plan, however the resident's care plan does not always contain the information. NA-B stated she had observed R1, "slumped over" and maybe she was under the influence. On 10/25/23 at 1:13 p.m. LPN-A stated upon admission each resident's medical record was reviewed and would reveal if a resident had a history of substance abuse. LPN-A stated she would be responsible for initiating substance abuse risk in the resident's care plan when identified but was unaware of who would be responsible for developing and/or implementing interventions related to substance abuse. Further, LPN-A stated staff were expected to obtain vital signs every shift, monitor the resident "as best they will allow", and visually see the resident every couple hour, when a resident was suspected of substance abuse. LPN-A stated OD incidents were discussed in IDT meetings but was unaware of R1 and R2's OD incidents. Further, LPN-A stated no staff had reported concerns of R1 or R2 using any substances or being under the influence and LPN-A was unaware of R1 and R2's history of substance abuse. In addition, LPN-A confirmed R1 and R2's care plans lacked evidence of risk of substance abuse and interventions or efforts to prevent future OD. On 10/25/23 at 3:15 p.m., DON stated currently there was no facility process to assess resident's and determine substance abuse risk. DON confirmed there are 8 residents residing in the facility who have been suspected of substance abuse and are at risk for OD, which included R1 and R2. DON stated nurse managers would be expected to update resident's care plans to include risk of substance abuse and	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 14 interventions. Further, DON stated if staff expected substance abuse the provider would need to be updated, obtain orders to hold medications, monitor vital signs every shift, and visual contact every 1-2 hours. DON stated following an OD incident, staff would be expected to complete an incident report in Risk Management and the incident would be discussed in IDT meeting to determine a plan going forward. DON confirmed for R1 and R2 "that has not happened." DON also indicated social services and physicians were not very involved in substance abuse "right now". On 10/27/23 at 10:52 a.m., DON was unaware of when or why R2 had stopped seeing ACP. DON stated R1 and R2 were both offered ACP services and declined following suspicion of illegal drug use incidents, however R1 and R2's records lack evidence of when R1 and R2 were offered or refusals and stated usually the record will have a note from staff or from ACP. Further, DON confirmed R2 had an order for referral to chemical dependency treatment, however this order was not completed. On 10/27/23 at 11:08 a.m., social service designee (SSD) stated she was not involved with interventions for residents with substance use disorders, and this would be a nursing function. Further, SSD confirmed she was aware R1 had a history of illegal substance use, adding she believed R2's drug of choice was Heroin and was aware of R2's illegal substance use which was Fentanyl pills. SSD confirmed both R1 and R2 had OD and required Narcan to be administered while receiving services at the facility. In addition, SSD stated OD incidents were discussed with the IDT, but efforts to prevent future ODs were not	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 15 discussed. SSD denied assisting neither R1 or R2 with any behavioral health services related to substance abuse disorders, treatment planning, safety related to overdose prevention, or therapies related to mental health disorders and/or loss and grief therapy and groups. On 10/27/23 at 11:55 a.m., nurse practitioner (NP)-A indicated R1 had a history of substance abuse and was actively using. NP-A stated she was aware R1 required Narcan to be administered for an OD, and NP-A had observed R1 not being able to hold a conversation during an assessment she was attempting to conduct with R1. NP-A also noted she had been made aware R1 had been observed by staff in August of 2023 to be unresponsive with a needle in her hand. NP-A confirmed she was aware R2 had a history of using illegal substances as well and was aware Narcan had to be administered for an OD. In addition, NP-A stated staff were expected to notify the physician when they suspect illegal drug use so the physician could provide orders to hold medications, and staff would be expected to monitor the individual frequently and obtain vitals per facility policy. NP-A stated the facility had psychiatry services and would be expected to make a referral for the individuals who have substance abuse disorders to ensure their mental health would be managed appropriately. On 10/27/23 at 12:26 p.m., administrator indicated R1 was admitted to the facility as "an active drug user" and ACP services were offered and declined as R1 denied having a drug problem. Administrator stated since admitting to the facility, R1 had to have Narcan administered on two separate occasions for a drug overdose. Administrator confirmed R2 was also actively using illegal substances and would go to the	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 16 community to buy drugs and staff were all aware of this. In addition, administrator stated staff were aware which residents were using illegal substances and who were "current users" and staff were expected to "keep an eye on the individual as they can" but there was no specific protocol. Administrator stated ODs were discussed in morning meeting with the IDT, however IDT would not discuss efforts to prevent future ODs. At the time of survey, facility failed to provide evidence of a substance abuse policy or protocol. The immediate jeopardy that began on 8/19/23, was removed on 10/30/23, when the facility re-assessed R1 and R2 using the Drug Abuse Screening test, facility reached out to behavioral health services to review R1 and R2 current status, reviewed drug patterns, implemented 15-minute checks for 24 hours and vital sign checks every two hours for 24 hours for R1 and R2 if suspicion or witnessed use of illegal substances. and care plans had been updated as indicated. Facility policy and procedures were developed related to substance abuse. Additionally, all staff were trained on new policy and procedure and revised care plans for R1 and R2. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize illegal substance use for residents at risk to assure they are receiving the necessary treatment/services to prevent overdose. The director of nursing or designee, could conduct random audits of the delivery of care and progress notes; to ensure appropriate care and	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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
2 830	Continued From page 17 services are implemented to prevent illegal substance use and overdoses. TIME FRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to address a diagnosis of post-traumatic stress disorder (PTSD) by obtaining a history of trauma, and develop a person-centered care plan to avoid triggers related to past trauma for 1 of 3 residents (R1) reviewed for mental disorders. Findings include: R1's quarterly minimal data set (MDS) dated 8/16/23, identified R1 had diagnoses which included opioid dependence, post-traumatic stress disorder, anxiety and had moderate cognitive impairment. R1 was independent with activities of daily living (ADLs) such as dressing, transferring, toileting or mobility.	21475	Corrected	11/30/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
21475	Continued From page 18 R1's physician orders dated 10/24/23, revealed R1 had orders for antidepressant and antipsychotic medications. R1's Primary Care PTSD Screen dated 11/15/22, directed PTSD should be considered "positive" if a resident answered yes to any three items to which R1 had responded yes to having had any experience that was so frightening, horrible or upsetting that she had night mares about it or thought about it when she did not want to as well as tried hard not to think about it or went out of her way to avoid situations that reminded her of it. Further, assessment lacked evidence or details related to the PTSD that R1 was referring to and lacked evidence of personalized interventions that would be implemented to prevent re-traumatization. R1's Trauma Informed Care History dated 11/15/22, revealed R1 responded yes to having been through anything life threatening or traumatic but did not give any further details on traumatic event. Further, R1 responded yes when asked if she was aware of any particular triggers that may make this worse for her, however assessment lacked further details regarding triggers to prevent re-traumatization. R1's Comprehensive Assessment completed by Partners Behavioral Healthcare dated 1/31/23, R1 had reported both her parents were verbally, physically, and sexually abusive and reported receiving previous formal counseling for the abuse. R1 also reported son, who was also primary caretaker, passed away in November 2022, and R1 had a heroin overdose while experiencing grief from the recent loss. R1's reasons for drug use included: to cope with stress, to relieve physical pain, to cope with	21475			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
21475	Continued From page 19 anxiety, to cope with depression, makes it easier to talk with people, to cope with family problems, and afraid of withdrawal symptoms/to feel better. Further assessment revealed R1 had difficulty with impulse control and lacks coping skills and thoughts of suicide or harm to others without means however the thoughts may interfere with participation in some treatment activities. R1's care plan dated 11/15/22, indicated R1 had depression related to bipolar disorder, anxiety and PTSD. Further, R1's care plan directed staff to administer medication as ordered and monitor for side effects and effectiveness, arrange for psychiatrist consultation and follow up as indicated (R1 declined on 11/15/22), assist the resident in developing/provide the resident with a program of activities that is meaningful and of interest (care plan lacked evidence or program), discuss with the resident any concern, fears, issues regarding health or other subjects, needs time to talk encourage the resident to express feelings, needs adequate rest periods, and needs to be reminded/escorted/encouraged to attend activities of choice (care plan lacked evidence of what activities of interest are). R1's care plan lacked evidence of trauma-informed care plan with personalized interventions to prevent re-traumatization and lacked evidence or being revised since 11/15/22. On 10/25/23 at 1:13 p.m., licensed practical nurse (LPN)-A stated she was unaware of an assessment to complete for a resident upon admission regarding past trauma but stated social services would complete one. LPN-A confirmed she was not aware of any past trauma for R1. On 10/25/23 at 3:15 p.m., interim director of	21475			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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
21475	Continued From page 20 nursing (DON) stated social services would be expected to complete a trauma assessment upon admitting to the facility as well as implementing a trauma informed care plan with individualized interventions. DON confirmed she was not aware of R1's past trauma or if any staff had reviewed R1's Comprehensive Assessment completed by Partners Behavioral Healthcare. On 10/27/23 at 8:32 a.m., social service designee (SSD) stated she was not aware of a trauma informed care plan or assessment but confirmed she had not completed any. SSD denied assisting neither R1 with any behavioral health services related to treatment planning, or therapies related to mental health disorders and/or loss and grief therapy and groups. Facility policy for Trauma Informed Care was requested but facility failed to provide a copy. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies and procedures to ensure medically related social services are provided to each resident throughout their stay and upon discharge and make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, or substance abuse services. The facility should identify other residents who are at risk for the deficient practice, review, re-educate staff to policies and procedures, and audit services to be provided by social services for a measurable amount of time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21475			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
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	