



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

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December 20, 2023

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

Re: Reinspection Results
Event ID: 2J0512

Dear Administrator:

On December 19, 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 November 28, 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
December 8, 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 November 28, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 17, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 17, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 17, 2023.

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

As we notified you in our letter of October 27, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 17, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt

The Terrace At Crystal Llc

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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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 17, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

The Terrace At Crystal Llc

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.



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



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Electronically delivered
December 8, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 2J0511

Dear Administrator:

The above facility was surveyed on November 28, 2023 through November 28, 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

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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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 11/28/2023
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 11/28/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52897333C (MN98743) with a deficiency issued at F656, F677, and F926. H52897401C (MN98744) with a deficiency issued at F656, F677, and F926. H52897334C (MN98741) with a deficiency issued at F656 and F926. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		12/15/23	

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

Electronically Signed

TITLE

(X6) DATE

12/14/2023

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

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F 656	Continued From page 1 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document	F 656			
			1.R1 had an updated smoking		

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 11/28/2023
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F 656	Continued From page 2 review, the facility failed to ensure the care plan was updated to ensure smoking interventions were re-evaluated and implemented for 1 of 1 resident (R1) reviewed for smoking. Findings include: R1's quarterly Minimum Data Set (MDS) dated 10/27/23, indicated R1 was cognitively intact. R1's Diagnosis List printed 11/28/23 indicated R1 had diagnoses of tobacco use, and history of traumatic brain injury. R1's Smoking Assessment dated 10/26/23, indicated R1 had a history of burned clothing, smoking in bed, and smoking in a non-smoking area. The assessment further indicated staff did not review the policy related to smoking times and storage of smoking materials with the resident, and indicated the care plan was not updated. R1's care plan indicated the following: 2/23/23, R1 had a history of smoking in his room and refused to allow staff to secure smoking materials. 6/25/23, R1 was identified as a smoker with an intervention to instruct about the facility smoking policy. 6/13/23, instruct about smoking risks/ hazards, refused to wear a smoking apron R1's care plan lacked an update related to smoking as the smoking assessment dated 10/26/23. R1's progress notes indicated the following: 11/11/23 at 11:19 a.m., R1 was smoking in his room, staff reminded him not to smoke in his	F 656	assessment completed and care plan updated to ensure smoking interventions were re-evaluated and implemented. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Residents that smoke had an updated smoking assessment completed and care plan updated accordingly. 4. Facility will review and revise the current smoking policy and guidelines. 5. Facility will educate staff on the current smoking policy and guidelines. 6. Facility will educate residents that smoke on the current smoking policy and guidelines and will have those residents sign for acknowledgment. 7. DON, nurse manager or designee will audit smoking resident's care plans to ensure accuracy based on updated smoking assessment. Audits will be completed initially upon compliance date, then with the MDS schedule and/or updated smoking assessment to ensure accurate information. 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.		

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F 656	Continued From page 3 room, and R1 yelled at staff to leave him alone. 11/19/23 at 11:01 a.m., R1 refused to go outside to smoke. 11/20/23 at 4:23 p.m., (late entry) Staff talked to resident about smoking in his room. 11/25/23 at 10:22 a.m., R1 was smoking in his room, staff removed the lighted cigarette from R1's table and provided education about smoking in a room when there were other rooms where oxygen was in use. On 11/28/23 at 1:44 p.m., R1's room smelled of cigarette smoke, a cigarette was observed on the side table, and cigarette ash was noted on R1's bedside table. R1 was sitting up in bed and a bag of marijuana, a marijuana pipe, and lighter were on the bed next to R1. R1 stated he was, "more apt to hit my weed pipe in here than my cigarette, but I do both. Here is my pipe, here is my weed. I roll my own cigarettes in here." R1 declined to say when he last smoked in his room. On 11/28/23 at 2:51 p.m., trained medication aide (TMA)-A stated she had seen R1 smoke in the building, had asked R1 not to, but R1 smoked anyway. TMA-A further stated management staff knew R1 smoked in the building. On 11/28/23 at 4:04 p.m., registered nurse (RN)-C stated, "[R1] smokes. We have tried everything. We have educated him, reviewed the policy with him, talked about the risks with him, and he still does it. We don't know what else to do." On 11/28/23 at 5:20 p.m. the administrator stated, "We tell [R1] to smoke outside. When you have someone non-compliant the most we can do is continue to work with him. We could discharge	F 656			

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F 656	Continued From page 4 him, but he has no place to go. The minute staff smells or sees it, they ask him to put it out. We educated him and had one-to-one conversations."	F 656			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral cares and shaving were offered or provided for 1 of 3 residents (R2) who was dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R2's quarterly Minimum Data Set (MDS) dated 10/12/23, indicated R2 was cognitively intact, and indicated R2 required the assistance of two staff for personal hygiene.	F 677	R2s care plan was updated to include the level of assistance required for personal hygiene tasks, including shaving and oral care. 2. All residents in the facility have the potenoal to be affected by this deficient practice. 3. Facility educated nursing staff on providing the correct level of assistance required for each resident based on their care plan, along with proper personal hygiene tasks. 4. Facility updated nursing assistant group		12/15/23

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F 677	Continued From page 5 R2's Diagnosis List printed 11/28/23, indicated R2 had hemiplegia (paralysis on one side of the body)/hemiparesis (partial paralysis on one side of the body) and weakness. R2's care plan dated 7/16/23, lacked direction for shaving or tooth brushing. On 11/28/23 at 2:01 p.m., R2 was observed with chin hair approximately 1/2 inch long. R2 stated she wanted the chin hair removed prior to going to visit family for Thanksgiving, but staff told her they did not have time to shave her. R2 stated she had an electric razor but did not know where it was. R2 further stated, "I feel embarrassed I am not shaved. I didn't want to go to my niece's home looking like this. I can't do it myself." Further, R2 stated staff had not brushed her teeth since she was admitted to the facility, and if she wanted them brushed, her nieces did it for her when they visited. R1 pointed to toothpaste and a toothbrush in the bathroom on a ledge. On 11/28/23 at 2:25 p.m., nursing assistant (NA)-A stated all of R2's care required assistance of two staff, and another staff was not always available to assist NA-A with R2's care. NA-A further stated R2's nieces helped R2 brush her teeth, and they visited "every once in a while." Further, NA-A acknowledged she care for R2 frequently and, "I haven't done her chin hairs in a long time." On 11/28/23 at 2:51 p.m., trained medication aide (TMA)-A stated the facility recently told some staff their services were no longer needed, and she worked short-staff regularly. TMA-A stated, "If someone didn't get shaved, staff didn't have time."	F 677	sheets to include updated and accurate informaOon for residents. 5. DON, nurse manager or designee will audit resident care plans to ensure the level of assistance required is accurate. 6. DON, nurse manager or designee will audit residents to ensure they are shaved and oral care is complete two Omes per week for four weeks. All audits will be brought to QAPI to assess for compliance and conOnued need for audits. 7. DON, nurse managers or designee will be responsible for the compleOon of this plan of correcOon.		

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 11/28/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
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F 677	Continued From page 6 On 11/28/23 at 3:13 p.m., registered nurse (RN)-B stated, "We are short of staff. We are doing the best we can." On 11/28/23 at 3:13 p.m., RN-A stated her floor had never been fully staffed, and that was the reason residents did not get shaved or receive oral hygiene. On 11/28/23 at 4:04 p.m., RN-C stated, "It is disgusting she doesn't get her teeth brushed." RN-C stated staff should shave resident chin hairs if requested. RN-C acknowledged she had not asked female residents about their shaving preferences, but would do that, and would address oral hygiene care with staff also. RN-C stated there was plenty of staff available for cares. On 11/28/23 at 5:20 p.m. the director of nursing (DON) stated it was unacceptable for staff to say they did not have enough staff to provide cares. The DON stated many residents needed assistance of two staff for transfers and turns, but for not all cares, and had been re-educating staff about the difference. The facility policy Activities of Daily Living (ADL) dated 3/18, directed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good grooming and oral hygiene.	F 677			
F 926 SS=D	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and	F 926			12/15/23

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 11/28/2023
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F 926	Continued From page 7 regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement smoking policies to include smoking marijuana to ensure 1 or 1 residents (R1) reviewed for smoking was assessed for the safe use of a marijuana pipe, and failed to address the risks of smoking marijuana in resident rooms. Findings include: R1's quarterly Minimum Data Set (MDS) dated 10/27/23 indicated R1 was cognitively intact. R1's care plan dated 6/25/23, identified R1 as a smoker. The care plan failed to address the use of marijuana/ smoking marijuana in the facility. R1's Smoking Assessment dated 10/26/23, lacked mention or assessment of R1 smoking marijuana in the facility. On 11/28/23 at 1:44 p.m., R1 was observed sitting up in bed with a bag of marijuana, a marijuana pipe, and lighter on the bed next to R1. R1 stated he was, "more apt to hit my weed pipe in here than my cigarette, but I do both. Here is my pipe, here is my weed." R1 declined to say when he last smoked marijuana in his room. On 11/28/23 at 4:41 p.m., the administrator emailed indicating the facility had no policy for marijuana use. On 11/28/23 at 5:20 p.m. the administrator	F 926	1. R1 had an updated smoking assessment completed to include smoking marijuana in the facility. 2. R1's care plan was updated to include the use of marijuana/smoking marijuana in the facility. 3. All residents in the facility have the potential to be affected by this deficient practice. 4. Facility will review and revise the current smoking policy. 5. Facility will educate staff on the current smoking policy and guidelines. 6. Facility will educate residents that smoke on the current smoking policy and guidelines and will have those residents sign for acknowledgment. 7. DON, nurse manager or designee will audit smoking resident's care plans to ensure accuracy based on updated smoking assessment. Audits will be completed initially upon compliance date, then with the MDS schedule and/or updated smoking assessment to ensure accurate information. 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 11/28/2023
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F 926	Continued From page 8 acknowledged R1 smoked marijuana in his room. The facility Smoking Policy dated 8/22 lacked direction for residents who smoked marijuana.	F 926			

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 11/28/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/28/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

12/14/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/28/2023
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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H5289733C (MN98743) H52897401C (MN98744) H52897334C (MN98741) Licensing orders were issued at 4658.0520 Subp. 1, and 4658.0525 Subp. 6B. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure the care plan was updated to ensure smoking interventions were re-evaluated and implemented for 1 of 1 resident (R1) reviewed for smoking. Findings include: R1's quarterly Minimum Data Set (MDS) dated 10/27/23, indicated R1 was cognitively intact. R1's Diagnosis List printed 11/28/23 indicated R1 had diagnoses of tobacco use, and history of traumatic brain injury. R1's Smoking Assessment dated 10/26/23, indicated R1 had a history of burned clothing,	2 565	Corrected	12/15/23

Minnesota Department of Health

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2 565	Continued From page 3 smoking in bed, and smoking in a non-smoking area. The assessment further indicated staff did not review the policy related to smoking times and storage of smoking materials with the resident, and indicated the care plan was not updated. R1's care plan indicated the following: 2/23/23, R1 had a history of smoking in his room and refused to allow staff to secure smoking materials. 6/25/23, R1 was identified as a smoker with an intervention to instruct about the facility smoking policy. 6/13/23, instruct about smoking risks/ hazards, refused to wear a smoking apron R1's care plan lacked an update related to smoking as the smoking assessment dated 10/26/23. R1's progress notes indicated the following: 11/11/23 at 11:19 a.m., R1 was smoking in his room, staff reminded him not to smoke in his room, and R1 yelled at staff to leave him alone. 11/19/23 at 11:01 a.m., R1 refused to go outside to smoke. 11/20/23 at 4:23 p.m., (late entry) Staff talked to resident about smoking in his room. 11/25/23 at 10:22 a.m., R1 was smoking in his room, staff removed the lighted cigarette from R1's table and provided education about smoking in a room when there were other rooms where oxygen was in use. On 11/28/23 at 1:44 p.m., R1's room smelled of cigarette smoke, a cigarette was observed on the side table, and cigarette ash was noted on R1's bedside table. R1 was sitting up in bed and a bag of marijuana, a marijuana pipe, and lighter were on the bed next to R1. R1 stated he was, "more	2 565			

Minnesota Department of Health

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2 565	Continued From page 4 apt to hit my weed pipe in here than my cigarette, but I do both. Here is my pipe, here is my weed. I roll my own cigarettes in here." R1 declined to say when he last smoked in his room. On 11/28/23 at 2:51 p.m., trained medication aide (TMA)-A stated she had seen R1 smoke in the building, had asked R1 not to, but R1 smoked anyway. TMA-A further stated management staff knew R1 smoked in the building. On 11/28/23 at 4:04 p.m., registered nurse (RN)-C stated, "[R1] smokes. We have tried everything. We have educated him, reviewed the policy with him, talked about the risks with him, and he still does it. We don't know what else to do." On 11/28/23 at 5:20 p.m. the administrator stated, "We tell [R1] to smoke outside. When you have someone non-compliant the most we can do is continue to work with him. We could discharge him, but he has no place to go. The minute staff smells or sees it, they ask him to put it out. We educated him and had one-to-one conversations." The facility Smoking Policy dated 8/22 directed upon admission residents were informed of the facility smoking policy, including designated smoking areas, smoking is only permitted in designated areas only. Smoking is not allowed inside the facility under any circumstances, the facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely, and the facility maintains the right to confiscate smoking items found in violation of smoking policies. SUGGESTED METHOD OF CORRECTION:	2 565			

Minnesota Department of Health

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2 565	Continued From page 5 The director of nursing (DON) or designee could monitor review/revise policies on care plans educate staff, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral cares and shaving were offered or provided for 1 of 3 residents (R2) who was dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R2's quarterly Minimum Data Set (MDS) dated 10/12/23, indicated R2 was cognitively intact, and indicated R2 required the assistance of two staff for personal hygiene. R2's Diagnosis List printed 11/28/23, indicated R2 had hemiplegia (paralysis on one side of the body)/hemiparesis (partial paralysis on one side of the body) and weakness. R2's care plan dated 7/16/23, lacked direction for	2 920	Corrected	12/15/23	

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2 920	Continued From page 6 shaving or tooth brushing. On 11/28/23 at 2:01 p.m., R2 was observed with chin hair approximately 1/2 inch long. R2 stated she wanted the chin hair removed prior to going to visit family for Thanksgiving, but staff told her they did not have time to shave her. R2 stated she had an electric razor but did not know where it was. R2 further stated, "I feel embarrassed I am not shaved. I didn't want to go to my niece's home looking like this. I can't do it myself." Further, R2 stated staff had not brushed her teeth since she was admitted to the facility, and if she wanted them brushed, her nieces did it for her when they visited. R1 pointed to toothpaste and a toothbrush in the bathroom on a ledge. On 11/28/23 at 2:25 p.m., nursing assistant (NA)-A stated all of R2's care required assistance of two staff, and another staff was not always available to assist NA-A with R2's care. NA-A further stated R2's nieces helped R2 brush her teeth, and they visited "every once in a while." Further, NA-A acknowledged she care for R2 frequently and, "I haven't done her chin hairs in a long time." On 11/28/23 at 2:51 p.m., trained medication aide (TMA)-A stated the facility recently told some staff their services were no longer needed, and she worked short-staff regularly. TMA-A stated, "If someone didn't get shaved, staff didn't have time." On 11/28/23 at 3:13 p.m., registered nurse (RN)-B stated, "We are short of staff. We are doing the best we can." On 11/28/23 at 3:13 p.m., RN-A stated her floor had never been fully staffed, and that was the	2 920			

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2 920	Continued From page 7 reason residents did not get shaved or receive oral hygiene. On 11/28/23 at 4:04 p.m., RN-C stated, "It is disgusting she doesn't get her teeth brushed." RN-C stated staff should shave resident chin hairs if requested. RN-C acknowledged she had not asked female residents about their shaving preferences, but would do that, and would address oral hygiene care with staff also. RN-C stated there was plenty of staff available for cares. On 11/28/23 at 5:20 p.m. the director of nursing (DON) stated it was unacceptable for staff to say they did not have enough staff to provide cares. The DON stated many residents needed assistance of two staff for transfers and turns, but for not all cares, and had been re-educating staff about the difference. The facility policy Activities of Daily Living (ADL) dated 3/18, directed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good grooming and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could monitor review/revise policies on personal cares provided to residents, educate staff, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920			