



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2023

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

RE: CCN: 245289
Cycle Start Date: December 22, 2022

Dear Administrator:

On January 30, 2023, we notified you a remedy was imposed. On February 13, 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 February 10, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 30, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 22, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 10, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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

January 30, 2023

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

RE: CCN: 245289
Cycle Start Date: December 22, 2022

Dear Administrator:

On December 30, 2022, we informed you that we may impose enforcement remedies.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- 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 March 22, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 22, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 22, 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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 22, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Terrace At Crystal LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 22, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 22, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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) 565-9462

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

The Terrace At Crystal LLC

January 30, 2023

Page 5

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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



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January 30, 2023

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

Re: Event ID: 4ECG11

Dear Administrator:

The above facility survey was completed on January 19, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa 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

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 01/19/2023
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 1/19/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED:	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

01/31/23

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 01/19/2023
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2 000	Continued From page 1 H52897140C (MN89689), H52897275C (MN89840), H52897640C (MN90163), however due to actions take by facility prior to survey, no licensing order issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			

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

PRINTED: 02/15/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2023	
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
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F 000	INITIAL COMMENTS On 1/19/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52897140C (MN89689), with a deficiency cited at F689, H52897275C (MN89840), with a deficiency cited at F689, H52897640C (MN90163), with a deficiency cited at F558. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced			F 558			2/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/31/2023

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.

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

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F 558	Continued From page 1 by: Based on observation, interview and record review the facility failed to ensure a call light was available in the bathroom for 1 of 2 residents (R3) reviewed for call lights. Findings include: R3's admission assessment dated 1/9/23, indicated R3 was alert and oriented times four, used a wheel chair for mobility and required 1 person assist for transfers. R3's diagnoses list created 1/9/23, indicated R3 had muscle weakness and dizziness. R3's bowel and bladder assessment dated 1/9/23, indicated R3 was occasionally incontinent of bladder, never incontinent of bowel and required one person assistance to use the toilet. R3's functional ability assessment dated 1/9/23, indicated R3 required partial/moderate assistance with toilet hygiene and toilet transfer. R3's fall risk assessment dated 1/9/23, indicated R3 had 1-2 falls in the past three months, required assistance with elimination, took 1-2 medications that could contribute to falls, and had 1-2 predisposing diseases. R3 had a total fall risk score of 12 indicating R3 was a high falls risk. R3's care plan last revised 1/13/23, indicated R3 required minimum assistance with transfers and moderate assistance with bathroom. R3's undated TCU Nursing Job Description for Residents (care sheet) indicated R3 was incontinent of bowel and bladder and lacked			F 558	1. R3 changed rooms on 01/19/2023. 2. Call light placed in room 101 bathroom. 3. Cal lights will be audited weekly to ensure that they work and that all call lights are in place. 4. All residents interviewed on their room preferences. 5. Quarterly preference audit to be completed on residents to ensure that their preferences are being met and needs accommodated. 6. IDT will discuss the interview responses and respond as accordingly to resident preferences and accommodations. 7. Any accommodations or preference concerns will be bought to QAPI		

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F 558	Continued From page 2 reference to transfer status. During interview on 1/19/23, at 8:17 a.m. ombudsman stated she visited R3 yesterday (1/18/23) and saw there was no call light in R3's bathroom. Ombudsman further stated R3 was a fall risk and since admission on 1/9/23, had been asking for a call light or to move to a new room. During interview on 1/19/23, at 10:41 a.m. R3 stated she was admitted over a week ago and still did not have a call light in the bathroom. R3 further stated she was a falls risk and that she is supposed to have someone assist with transfers. During observation on 1/19/23, at 11:01 a.m. the call light panel in R3's bathroom was situated approximately five feet high beside the toilet. There was a button labeled call and a hole labeled pull for help with no cord attached. There was no bell or other means for alerting staff. During interview on 1/19/23, at 1:15 p.m. nursing assistant (NA)-B stated R3 was a one person assist for transfers using a stand and pivot. NA-B stated staff assist R3 into the bathroom and instruct her to put on her call light when she was done. NA-B walked into R3's bathroom and confirmed that the call light cord was missing. During interview on 1/19/23, at 1:20 p.m. license practical nurse (LPN)-A stated R3 was a stand by assist and that R3 would sometimes self-transfer although she was supposed to get help into the bathroom. LPN-A further stated R3 was a fall risk and if she fell in the bathroom would have to pull the call light or yell for help. LPN-A went into R3's bathroom and confirmed the call light cord was supposed to be plugged in but was missing.	F 558			

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F 558	Continued From page 3 During interview on 1/19/23, at 1:38 p.m. director of nursing (DON) stated R3 required assistance with transfers and was aware the call light cord was missing in R3's bathroom. DON stated R3 should have access to a call light in the bathroom. During interview on 1/19/23, at 1:40 p.m. administrator stated maintenance performed a weekly facility-wide check on all call lights at the bedside and in the bathrooms. Administrator stated staff should also be notifying maintenance when a non-functioning call light was discovered. Administrator stated being made aware of R3's missing call light yesterday from the ombudsman. Administrator further stated R3 was provided a jingle bell but could not explain what could have happened to it. During interview on 1/19/23, at 2:31 p.m. R3 stated she was being moved to a new room and that this was the first time a new room had been offered since admission. During interview on 1/19/23, at 3:16 p.m. maintenance (M)-A stated every Saturday he performed a weekly check of all call lights at bedside and in all bathrooms. M-A stated not being aware of the missing call light cord in R3's room until yesterday. Review of facility policy Answering the Call Light revised November, 2022, instructed staff to "Explain to the resident that a call system is also located in his/her bathroom" and to "Be sure that the call light is plugged in and functioning at all times." The policy further instructed staff to ensure the call light was accessible from the toilet.	F 558			

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F 558	Continued From page 4 Based on observation, interview and record review the facility failed to ensure a call light was available in the bathroom for 1 of 2 residents (R3) reviewed for call lights. Findings include: R3's admission assessment dated 1/9/23, indicated R3 was alert and oriented times four, used a wheel chair for mobility and required 1 person assist for transfers. R3's diagnoses list created 1/9/23, indicated R3 had muscle weakness and dizziness. R3's bowel and bladder assessment dated 1/9/23, indicated R3 was occasionally incontinent of bladder, never incontinent of bowel and required one person assistance to use the toilet. R3's functional ability assessment dated 1/9/23, indicated R3 required partial/moderate assistance with toilet hygiene and toilet transfer. R3's fall risk assessment dated 1/9/23, indicated R3 had 1-2 falls in the past three months, required assistance with elimination, took 1-2 medications that could contribute to falls, and had 1-2 predisposing diseases. R3 had a total fall risk score of 12 indicating R3 was a high falls risk. R3's care plan last revised 1/13/23, indicated R3 required minimum assistance with transfers and moderate assistance with bathroom. R3's undated TCU Nursing Job Description for			F 558			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2023
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 558	Continued From page 5 Residents (care sheet) indicated R3 was incontinent of bowel and bladder and lacked reference to transfer status. During interview on 1/19/23, at 8:17 a.m. ombudsman stated she visited R3 yesterday (1/18/23) and saw there was no call light in R3's bathroom. Ombudsman further stated R3 was a fall risk and since admission on 1/9/23, had been asking for a call light or to move to a new room. During interview on 1/19/23, at 10:41 a.m. R3 stated she was admitted over a week ago and still did not have a call light in the bathroom. R3 further stated she was a falls risk and that she is supposed to have someone assist with transfers. During observation on 1/19/23, at 11:01 a.m. the call light panel in R3's bathroom was situated approximately five feet high beside the toilet. There was a button labeled call and a hole labeled pull for help with no cord attached. There was no bell or other means for alerting staff. During interview on 1/19/23, at 1:15 p.m. nursing assistant (NA)-B stated R3 was a one person assist for transfers using a stand and pivot. NA-B stated staff assist R3 into the bathroom and instruct her to put on her call light when she was done. NA-B walked into R3's bathroom and confirmed that the call light cord was missing. During interview on 1/19/23, at 1:20 p.m. license practical nurse (LPN)-A stated R3 was a stand by assist and that R3 would sometimes self-transfer although she was supposed to get help into the bathroom. LPN-A further stated R3 was a fall risk and if she fell in the bathroom would have to pull the call light or yell for help. LPN-A went into R3's bathroom and confirmed the call light cord was	F 558			

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F 558	Continued From page 6 supposed to be plugged in but was missing. During interview on 1/19/23, at 1:38 p.m. director of nursing (DON) stated R3 required assistance with transfers and was aware the call light cord was missing in R3's bathroom. DON stated R3 should have access to a call light in the bathroom. During interview on 1/19/23, at 1:40 p.m. administrator stated maintenance performed a weekly facility-wide check on all call lights at the bedside and in the bathrooms. Administrator stated staff should also be notifying maintenance when a non-functioning call light was discovered. Administrator stated being made aware of R3's missing call light yesterday from the ombudsman. Administrator further stated R3 was provided a jingle bell but could not explain what could have happened to it. During interview on 1/19/23, at 2:31 p.m. R3 stated she was being moved to a new room and that this was the first time a new room had been offered since admission. During interview on 1/19/23, at 3:16 p.m. maintenance (M)-A stated every Saturday he performed a weekly check of all call lights at bedside and in all bathrooms. M-A stated not being aware of the missing call light cord in R3's room until yesterday. Review of facility policy Answering the Call Light revised November, 2022, instructed staff to "Explain to the resident that a call system is also located in his/her bathroom" and to "Be sure that the call light is plugged in and functioning at all times." The policy further instructed staff to	F 558			

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F 558	Continued From page 7	F 558			
F 689 SS=D	ensure the call light was accessible from the toilet. 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 interview and document review, the facility failed to develop the care plan to include falls interventions and safe smoking plan for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's discharge/return anticipated minimum data set (MDS) dated 12/30/22, indicated R1 required extensive assistance for transfers. R1's diagnoses list created 12/3/22, indicated R1 had flaccid hemiplegia (paralysis on one side of the body) affecting right dominant side, tobacco use, and neuralgia and neuritis (nerve pain and inflammation). R1's admission summary dated 1/6/23, indicated R1 was alert and oriented to person, time, place, and situation. R1's fall risk assessment dated 11/29/22, indicated R1 had no history of falls in the past	F 689			2/10/23
			1. R1 discharged from the facility. 2. All residents care plans were updated with appropriate interventions 3. Fall assessments to be completed on all residents all high-risk residents Kardax to be updated appropriately with fall interventions. Smoking assessments were also done on all residents and care plans updated 4. IDT will discuss cause of falls and interventions to be put in place to prevent falls from occurring during morning IDT meeting as well as all residents who smoke and the appropriateness of smoking alone. At time of meeting care plan will be audited by DON or designee to note intervention is in place 5. Monitoring and changes to care plans regarding fall interventions and smoking assessments will be done Daily in morning IDT meeting by DON or designee. 6. Care plans will be audited 3x a week for		

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F 689	Continued From page 8 three months but other factors contributed to R1's total fall risk score of 11 which indicated R1 was a high fall risk. R1's fall risk assessment dated 12/24/22, indicated R1 had 1-2 falls in the past three months and other risk factors contributing to R1's total fall risk score of 14 which indicated R1 was a high fall risk. R1's fall risk assessment dated 1/6/23, indicated R1 had 1-2 falls in the past three months, required assistance with elimination, took 3-4 medications which could contribute to falls, and had 3 or more predisposing diseases. R1's total fall risk score was 15 which indicated R1 was a high fall risk. R1's smoking assessment dated 11/29/22, indicated R1 had a history of smoking related incidents including smoking in a non-smoking area. The assessment further indicated R1 was educated and R1's care plan was initiated or updated. R1's smoking assessment dated 12/24/22, indicated R1 had a history of smoking related incidents including disposing of lighted products in trash or other inappropriate area and smoking in a non-smoking area. The assessment further indicated R1 was educated and R1's care plan was initiated or updated. R1's smoking assessment dated 1/18/23, indicated R1 had a history of smoking related incidents including disposing of lighted products in trash or other inappropriate area, smoking in a non-smoking area, and smoking in bed. The assessment further indicated R1 was educated	F 689	2 weeks then 1x a week for 2 weeks to ensure that the solutions are sustained. 7. Any issues found will be brought to QAPI		

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F 689	Continued From page 9 and R1's care plan was initiated or updated. R1's care plan last revised 12/30/22, lacked any reference of R1's falls risk or smoking status or plan. R1's undated TCU Nursing Job Description for Residents (care sheet) indicated R1 required 2 person assist with transfer and all activities of daily living, but lacked any reference to fall prevention. The care sheet lacked any indication R1 was a smoker or interventions to ensure a safe smoking plan. R1's progress note dated 12/1/22, indicated R1's room smelled of cigarette smoke and when asked, R1 confirmed that she was smoking in her room. R1's progress note dated 12/15/22, indicated R1 was found lying on floor and when asked R1 confirmed she slipped out of her chair while trying to self-toilet. The note further indicated, "Resident was advised to use her call light for any help, and she was also advised not to use her bathroom for smoking because a search in the bathroom found cigarettes' smoke [sic]." R1's progress note dated 12/18/22, indicated R1 was found on the floor and told staff she had slid out of bed. The progress note further indicated, "Will continue to monitor." R1's progress note dated 12/26/22, indicated R1 told staff that she fell from her wheelchair the day before but did not report it to anyone. R1's progress note dated 1/9/23, indicated R1 was found on the bathroom floor and stated she	F 689			

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F 689	Continued From page 10 fell while trying to pull up her underwear. The note further indicated, "cigarettes" ashes were seen in the commode and on the floor which means resident went into the bathroom to smoke and has been advised in the past not to smoke in the room." R1's progress note dated 1/18/23, indicated, "Resident continues to smoke in bed. Resident has been advised not to smoke in bed severally [sic] but continues to smoke in bed. Cigarettes and lighter taken away from resident. Monitoring in progress." During interview on 1/19/23, at 12:01 p.m. nursing assistant (NA)-A stated being assigned to R1 today, but R1 was currently out for an appointment. NA-A stated R1 required 1 person assist using a pivot transfer for all transfers and was supposed to call for assistance. NA-A further stated not being aware that R1 had any falls while in the facility nor was she aware of R1's history of smoking in her room. During interview on 1/19/23, at 1:20 p.m. licensed practical nurse (LPN)-A stated R1 required 2 person assist with all cares. LPN-A stated R1 kept her own cigarettes and lighter R1 was caught smoking in her room just yesterday (1/18/23). LPN-A stated she took R1's lighter away and that R1 did not have any more cigarettes. LPN-A stated R1 now must ask staff for the lighter if she wants to smoke. LPN-A further stated R1 had a fall recently during a self-transfer which hurt her shoulder making it too difficult for R1 to self-propel to go out to smoke independently, therefore requiring staff or visitors to accompany her. LPN-A stated this information was passed along during shift report to nurses	F 689			

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F 689	Continued From page 11 and nursing assistants. LPN-A stated the care sheets were supposed to have all the information needed to care for a resident and should reflect the care plan. LPN-A confirmed R1's care sheet lacked any evidence she was a fall risk or an unsafe smoker. LPN-A further stated the nursing assistants referenced the care sheets to direct resident care. During interview on 1/19/23, at 1:52 p.m. director of nursing (DON) stated R1 had two recent falls while attempting to self-transfer. DON further stated R1 was non-compliant with using the call light to request assistance. DON stated R1 was caught smoking in her room yesterday and also had a previous smoking incident in her room and that nursing was now holding her smoking items since she was not a safe smoker. DON stated a new smoking assessment was completed following each incident. DON stated staff would take R1 out to smoke when she asked but it was unrealistic to provide a staff member every hour to do so. DON further stated smoking and falls should both be addressed on R1's care plan and that it was his responsibility to ensure R1's care plan was accurate and up to date. During interview on 1/19/23, at 1:55 p.m. administrator stated R1 was caught smoking in her room yesterday which was the second or third time she was caught smoking in her room. Administrator stated R1's cigarettes and lighter were taken away after the first incident and could not explain how she got them back. The facility policy, Care Plans, Comprehensive Person-Centered policy revised November, 2022, indicated a comprehensive, person-centered care plan was developed within seven days of required	F 689			

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F 689	Continued From page 12 MDS comprehensive assessment and no more than 21 days after admission. The policy further indicated "care plan interventions were developed after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making." The policy further indicated the care plan was updated when there was a change in condition, or the desired outcome was not met. Based on interview and document review, the facility failed to develop the care plan to include falls interventions and safe smoking plan for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's discharge/return anticipated minimum data set (MDS) dated 12/30/22, indicated R1 required extensive assistance for transfers. R1's diagnoses list created 12/3/22, indicated R1 had flaccid hemiplegia (paralysis on one side of the body) affecting right dominant side, tobacco use, and neuralgia and neuritis (nerve pain and inflammation). R1's admission summary dated 1/6/23, indicated R1 was alert and oriented to person, time, place, and situation. R1's fall risk assessment dated 11/29/22, indicated R1 had no history of falls in the past three months but other factors contributed to R1's	F 689			

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F 689	Continued From page 13 total fall risk score of 11 which indicated R1 was a high fall risk. R1's fall risk assessment dated 12/24/22, indicated R1 had 1-2 falls in the past three months and other risk factors contributing to R1's total fall risk score of 14 which indicated R1 was a high fall risk. R1's fall risk assessment dated 1/6/23, indicated R1 had 1-2 falls in the past three months, required assistance with elimination, took 3-4 medications which could contribute to falls, and had 3 or more predisposing diseases. R1's total fall risk score was 15 which indicated R1 was a high fall risk. R1's smoking assessment dated 11/29/22, indicated R1 had a history of smoking related incidents including smoking in a non-smoking area. The assessment further indicated R1 was educated and R1's care plan was initiated or updated. R1's smoking assessment dated 12/24/22, indicated R1 had a history of smoking related incidents including disposing of lighted products in trash or other inappropriate area and smoking in a non-smoking area. The assessment further indicated R1 was educated and R1's care plan was initiated or updated. R1's smoking assessment dated 1/18/23, indicated R1 had a history of smoking related incidents including disposing of lighted products in trash or other inappropriate area, smoking in a non-smoking area, and smoking in bed. The assessment further indicated R1 was educated and R1's care plan was initiated or updated.	F 689			

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F 689	Continued From page 14 R1's care plan last revised 12/30/22, lacked any reference of R1's falls risk or smoking status or plan. R1's undated TCU Nursing Job Description for Residents (care sheet) indicated R1 required 2 person assist with transfer and all activities of daily living, but lacked any reference to fall prevention. The care sheet lacked any indication R1 was a smoker or interventions to ensure a safe smoking plan. R1's progress note dated 12/1/22, indicated R1's room smelled of cigarette smoke and when asked, R1 confirmed that she was smoking in her room. R1's progress note dated 12/15/22, indicated R1 was found lying on floor and when asked R1 confirmed she slipped out of her chair while trying to self-toilet. The note further indicated, "Resident was advised to use her call light for any help, and she was also advised not to use her bathroom for smoking because a search in the bathroom found cigarettes' smoke [sic]." R1's progress note dated 12/18/22, indicated R1 was found on the floor and told staff she had slid out of bed. The progress note further indicated, "Will continue to monitor." R1's progress note dated 12/26/22, indicated R1 told staff that she fell from her wheelchair the day before but did not report it to anyone. R1's progress note dated 1/9/23, indicated R1 was found on the bathroom floor and stated she fell while trying to pull up her underwear. The note	F 689			

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F 689	Continued From page 15 further indicated, "cigarettes" ashes were seen in the commode and on the floor which means resident went into the bathroom to smoke and has been advised in the past not to smoke in the room." R1's progress note dated 1/18/23, indicated, "Resident continues to smoke in bed. Resident has been advised not to smoke in bed severally [sic] but continues to smoke in bed. Cigarettes and lighter taken away from resident. Monitoring in progress." During interview on 1/19/23, at 12:01 p.m. nursing assistant (NA)-A stated being assigned to R1 today, but R1 was currently out for an appointment. NA-A stated R1 required 1 person assist using a pivot transfer for all transfers and was supposed to call for assistance. NA-A further stated not being aware that R1 had any falls while in the facility nor was she aware of R1's history of smoking in her room. During interview on 1/19/23, at 1:20 p.m. licensed practical nurse (LPN)-A stated R1 required 2 person assist with all cares. LPN-A stated R1 kept her own cigarettes and lighter R1 was caught smoking in her room just yesterday (1/18/23). LPN-A stated she took R1's lighter away and that R1 did not have any more cigarettes. LPN-A stated R1 now must ask staff for the lighter if she wants to smoke. LPN-A further stated R1 had a fall recently during a self-transfer which hurt her shoulder making it too difficult for R1 to self-propel to go out to smoke independently, therefore requiring staff or visitors to accompany her. LPN-A stated this information was passed along during shift report to nurses and nursing assistants. LPN-A stated the care	F 689			

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F 689	Continued From page 16 sheets were supposed to have all the information needed to care for a resident and should reflect the care plan. LPN-A confirmed R1's care sheet lacked any evidence she was a fall risk or an unsafe smoker. LPN-A further stated the nursing assistants referenced the care sheets to direct resident care. During interview on 1/19/23, at 1:52 p.m. director of nursing (DON) stated R1 had two recent falls while attempting to self-transfer. DON further stated R1 was non-compliant with using the call light to request assistance. DON stated R1 was caught smoking in her room yesterday and also had a previous smoking incident in her room and that nursing was now holding her smoking items since she was not a safe smoker. DON stated a new smoking assessment was completed following each incident. DON stated staff would take R1 out to smoke when she asked but it was unrealistic to provide a staff member every hour to do so. DON further stated smoking and falls should both be addressed on R1's care plan and that it was his responsibility to ensure R1's care plan was accurate and up to date. During interview on 1/19/23, at 1:55 p.m. administrator stated R1 was caught smoking in her room yesterday which was the second or third time she was caught smoking in her room. Administrator stated R1's cigarettes and lighter were taken away after the first incident and could not explain how she got them back. The facility policy, Care Plans, Comprehensive Person-Centered policy revised November, 2022, indicated a comprehensive, person-centered care plan was developed within seven days of required MDS comprehensive assessment and no more	F 689			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2023
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 17 than 21 days after admission. The policy further indicated "care plan interventions were developed after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making." The policy further indicated the care plan was updated when there was a change in condition, or the desired outcome was not met.	F 689			