

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 02/13/2025
NAME OF PROVIDER OR SUPPLIER The Terrace at Crystal LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 Vera Cruz Avenue North Crystal, MN 55422	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>49877</p> <p>Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight consecutive hours a day. This had the potential to affect all 62 residents who resided at the facility.</p> <p>Findings Include:</p> <p>Review of Payroll Based Journal (PBJ) Staffing Data Report, submitted for the fourth quarter of 2024 (July 1-September 30), identified no RN hours for the following dates: 7/7/24, 7/21/24, 8/18/24, 9/1/24, and 9/15/24.</p> <p>Review of the facility staffing schedules for the following dates 8/18/24, 9/1/24, and 9/15/24 were identified as Sundays and no RN was scheduled. Staffing schedules for 7/7/24 and 7/21/24 were not provided and were also identified as Sundays.</p> <p>During interview on 2/12/25 at 2:36 p.m., staffing coordinator (SC) explained she had started the staffing position a month ago and there was no record of staff schedules prior to 7/20/24. Upon review of staffing schedules for 8/18/24, 9/1/24, and 9/15/24, SC confirmed no RN was scheduled on those dates. SC identified an RN must be scheduled for at least eight hours each day and her practice was to schedule two RN's each weekend to ensure at least eight hours of RN coverage.</p> <p>During interview on 2/12/25 at 2:57 p.m., administrator expected at least eight hours of RN coverage daily and explained the staffing PBJ data was submitted by the corporate office. Administrator contacted the corporate office and requested RN payroll information for the following dates 7/7/24, 7/21/24, 8/18/24, 9/1/24, and 9/15/24 and planned to submit this information once obtained. RN payroll information for the above listed dates was not provided.</p> <p>A facility policy titled Departmental Supervision, Nursing revised 8/2022, identified a register nurse provides services at least eight consecutive hours every 24 hours, seven days a week.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656</p> <p>Based on interview and document review the facility failed to ensure admission orders on 1/8/25 for a diuretic (medicine that increases urine production and help lower blood pressure and fluid retention) were clarified and followed up for R1. As a result, R1 did not receive diuretic for sixteen days. This resulted in a significant medication error and actual harm when R1 was hospitalized for congestive heart failure (CHF) exacerbation.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE] identified R1 admitted to facility from hospital on 1/8/25, had intact cognition, required substantial assistance for toileting and personal hygiene, and did not reject care. In addition, R1 had medical diagnoses of congestive heart failure, atrial fibrillation (irregular heart rhythm), arthritis, and a history of a left femur fracture. Also, R1 taking diuretics.</p> <p>R1's hospital discharge orders to facility dated 1/8/25 identified medication order of Furosemide (diuretic) 40 MG tablet For: Cardiac Failure, High Blood Pressure. Commonly know as: LASIX Take 1 Tablet (40 mg) by mouth two times a day. 1 tab daily, extra tab as directed by cardiology.</p> <p>R1 nursing progress note (PN) from licensed practical nurse (LPN)-C dated 1/8/25 at 7:51 p.m., stated, [R1] arrived at facility around 3:10 p.m.</p> <p>R1's nursing PN from LPN-C dated 1/9/25 at 12:00, Late Entry: Note Text: Writer called [hospital] for clarification on resident's Lasix order from discharge. Writer spoke with the HUC (health unit coordinator) on the unit who stated that nursing staff was busy and was unable to come to the phone. The HUC said a nurse would return the call when they have time. Writer updated oncoming PM staff.</p> <p>Review of R1's PN from 1/9/25 to 1/23/25 indicated no mention of follow up regarding Lasix order.</p> <p>R1's provider order dated 1/23/25 at 5:53 p.m., identified order for lasix to 40 mg po BID scheduled (AM and 2pm daily. Diagnosis associated with order state, Acute on chronic systolic (congestive) heart failure.</p> <p>Review of R1's January 2025 medication administration treatment administration record (MARTAR) identified Lasix was not ordered for R1 until 1/24/25 at 2:00 p.m., indicating R1 did not receive Lasix for sixteen days. R1's January MAR/TAR Chart Codes indicated R1 was coded as a 6 starting on the January 24, 2025, evening time slot which correlated with 6=hospitalized .</p> <p>R1's PN from LPN-D dated 1/24/25 at 3:15 a.m., R1 was sent to the hospital for decreasing oxygen saturations and wheezing noted to left upper lobe of lung.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's hospital admission progress note dated 1/24/25 stated R1 was brought in today due to complaint of SOB (shortness of breath) and dyspnea on exertion with orthopnea (exertion) Oxygen saturation was reported as low in the 80's at the facility, but, up to the 90's on arrival of EMS and also here in the hospital. According to transfer records, patient was not taking Lasix at TCU due to some confusion about her medication orders.</p> <p>R1's hospital discharge summary dated 2/10/25 stated R1 was hospitalized . R1 hospitalized from 1/24/25 to 2/10/25 due to CHF exacerbation.</p> <p>During interview with LPN-C on 2/11/25 at 9:31 a.m., LPN-C stated, I was the one who admitted [R1] that day. [LPN-A] put orders in. She told me to double check them. I called hospital to clarify [Lasix order] on the 9th. I think I asked overnight to follow up. I asked to speak to the nurse at the hospital and the HUC said [nurse] was busy. I never got a call back. LPN-C stated the follow up got lost in the queues. It was a big thing. [R1's] missed doses. Because she has CHF (congestive heart failure). The way we do orders is not good. We really don't know who is doing what and things get missed. Things like this should not happen.</p> <p>During interview with LPN-B on 2/11/25 at 9:29 a.m., LPN-B stated, expectation for orders is we go through the information. Put the orders in and another nurse is to double check to make sure nothing gets missed.</p> <p>During interview with R1 on 2/11/25 at 9:45 a.m., R1 stated, No, I don't think I got that pill. I take it to keep me from filling up with fluid. Got short of breath and tired. Couldn't catch my breath. They had to send me back to the hospital for it.</p> <p>During interview with administrator on 2/11/25 at 10:10 a.m., the administrator stated, it is fair to say that the orders were not clarified and double checked. It was missed and should not have been. Fair to say [R1] went from the [January] 8th to the 24th when she was admitted to the hospital without having the medication and should have. We are looking into the process of double checking the orders. Need to work on that.</p> <p>During interview with nurse practitioner (NA)-A on 2/11/25 at 10:37 a.m., NP-A stated, [R1] was supposed to be taking [furosemide] from the hospital. NP-A stated R1 takes it because of heart failure. It looks like on 1/23/25 [facility] reached out to us. Wanted a range. NP-A stated, missing a dose or multiple doses[sic] it is a concern because it could increase the fluid overload and cause heart failure exacerbation. NP-A stated the facility was in charge of putting in orders from the hospital and, it was not in. Lasix was not [clarified] or put in. NP-A stated, This is a major medication error and I have major concerns on medication orders not being followed up and double checked at that facility.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During interview with LPN-A on 2/11/25 at 11:25 a.m., LPN-A stated she had been in unit manager role of 3rd floor for a year and half. LPN-A stated, the call was put out to the hospital to clarify [Lasix] order. The nurse was busy and never called back here. LPN-A stated expectation of staff is to notify her if there is no response from the hospital. I was not aware or notified to follow up. LPN-A stated On the 24th [January] someone came to me or maybe in report [R1] was having problems breathing. And that is how I was made aware. LPN-A stated the process for putting in orders and clarifying and following up with orders is the responsibility of either me or the admitting nurse. LPN-A stated, concern for missed doses because [R1] has CHF. That is the last thing we want is for her to go back to the hospital.</p> <p>During interview with facility's medical director (MD) on 2/12/25 at 12:00 p.m., MD stated, [facility] messed up with [R1] orders. And the staff are accountable. They have had issues with orders and faxes. Turnover there is also high. We start new policies and procedures and then there is turnover and we have to start over. It is frustrating for the provider to practice like that and the staff too. It is a vicious cycle. MD stated R1 did not receive Lasix for 16 days prior to being readmitted to the hospital for CHF exacerbation.</p> <p>During interview with LPN-D on 2/12/25 at 6:49 a.m., LPN-D stated she was the nurse that sent R1 to the hospital on 1/24/25. LPN-D stated, for my first visual check with [R1] around midnight her vitals signs and oxygenation were fine, and then on my second time 2-3 hours later I checked [R1] again and the O2 sat was low. So I did the vital signs again and it was still low, Like 80% on room air. I asked staff to help me sit [R1] up and they helped me. It was [still] low and I had to put [R1] on 4 liters of oxygen nasal cannula. Her lungs were not clear. I have a son with asthma and know that [R1] lungs were definitely not clear. LPN-D stated she contacted the provider on-call and they gave me orders to send [R1] in to the ER. LPN-D stated she was familiar with R1 so I knew her baseline. LPN-D stated, the process for obtaining orders was, whoever obtains the order they put it in the computer. It is not acted on yet until a second nurse verifies the order. LPN-D reviewed R1's EMR and verified the Lasix order was never entered on admission to the facility on [DATE].</p> <p>During interview with R1 on 2/12/25 at 7:03 a.m., R1 stated, I am feeling better since I got back [to facility]. I knew what meds I was supposed to be taking when I was first admitted . I was taking the water pill [Lasix] at home. Been taking it for years. But it wasn't given to me right when I was admitted . That is why I had to go back [to the hospital]. Should never ever have happened.</p> <p>Facility policy titled Medication and Treatment Orders revised July 2016, state Orders for medications and treatments will be consistent with principles of safe and effective order writing.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>49339</p> <p>Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 2 of 2 residents (R18, R15) reviewed. This had potential to affect a total 33 of 33 residents identified to reside on the unit where the meals were served and sample tray tested .</p> <p>Findings include:</p> <p>R18's admission Minimum Data Set (MDS) assessment, dated 1/16/25, indicated R18 had intact cognition.</p> <p>R15's admission MDS assessment, dated 1/2/25, indicated R15 had intact cognition.</p> <p>On 2/09/25 at 09:18 a.m., R18 was interviewed. R18 stated meals are always cold.</p> <p>On 2/09/25 at 2:23 p.m., R15 was interviewed. R15 stated the food sucks. Furthermore, R15 stated the food is cold when should be hot, hot when should be cold, they were running out of apple juice, and sometimes it was watered down. R15 stated they don't get the planned menu.</p> <p>On 2/12/25, the following observations were made:</p> <p>-12:20 p.m. steam table was set up on the 3rd floor. Dietary aid (DA)-A was going through the meal tickets with the nursing staff to ensure correct diet orders. Once this was completed, as residents were brought into the dining room, they were served their meals. The items on the steam table were covered with tin foil which included sauerkraut, sweet potatoes and ham. Behind the steam table was an open metal cart with plastic trays, empty glasses, silverware and napkins on them.</p> <p>-12:40 p.m. regional director of dietary services (RDD) stated they changed the process of how they were preparing room trays. RDD stated they prepped 1-3 trays and then delivered the trays to the rooms to help ensure the food did not get cold while on the trays.</p> <p>-12:43 p.m. nursing staff was observed assisting a resident with eating.</p> <p>-12:44 p.m. nursing staff continued to bring room trays that had been prepared to resident rooms.</p> <p>-12:52 p.m. a sample tray was requested from the steam table. The sample tray was placed on the metal cart with the other prepared trays.</p> <p>-12:56 p.m. nursing staff were preparing the drinks on the prepared trays on the metal cart. There were approximately 9 resident trays on the metal cart. After the drinks were filled, nursing staff started to deliver the trays to the resident rooms.</p> <p>-1:08 p.m. the nursing staff continued to deliver room trays to resident rooms. The sample tray was removed from the cart and sampled by licensed practical nurse (LPN)-B who stated, the flavor is bland and cold.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/12/25 at 2:59 p.m., dietary manager (DM) and RDD indicated they would expect meals to be the correct temperature whether it is a room tray or in the dining room. RDD indicated they were able to identify what happened during the meal service today to cause the delay with room trays being delivered and were working on a solution.</p> <p>A facility policy titled Time and Temperature Control and Recording, undated, indicated under section Transporting: timeliness of meal delivery will impact palatability, temperature, and overall resident satisfaction. It is imperative to limit the time between tray preparation and delivery.</p>		