STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Crystal LLC	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to sufficiently prepare, orientate, and understanding of discharge 1 of 3 residents (R1) reviewed for discharge. R1 was sent home without ordered home care services, which led to worsening of his wounds and an admission to the hospital. Findings include: R1's care plan dated 4/23/25 - 5/19/25 did not indicate any discharge focus, goals, or interventions. R1's admission Minimum Data Set (MDS) dated [DATE] did not include a Brief Inventory of Mental Status (BIMS) score to indicate his cognition level. R1 was dependent upon staff for toileting hygiene, bathing, and rolling in bed. He required maximum assistance with dressing lower body and minimal assistance dressing his upper body. R1's pertinent diagnoses were after care for surgical amputation, immunodeficiency (bodies inability to defend the body from foreign or abnormal cells), diabetes, obesity, absence of right leg above the knee. R1 required application of nonsurgical dressing, applications of ointments/medications other than to feet, and application of dressing to feet. A Notice of Medicare Non-Coverage (NOMNOC) form dated 5/1/25 indicated beginning on 5/6/25 R1 may have to pay out of pocket for his skilled nursing care at the facility if he did not have other insurance to cover the costs. The estimated services would cost $408.00 per day. Under the title Additional Information, a handwritten note indicated R1 requested discharge for 5/6/25. The form was signed by the facility social worker (SW)-A and R1 on 5/1/25. A provider Evaluation and Management note dated 5/1/25 indicated R1 the provider ordered skilled nursing in the home to assess/instruct on medication management, provide complex wound care related to current conditions, assessment for complications or exacerbation of patients condition and administer/instruct intravenous (IV) therapy and wound care. Additional services needed were Occupation Therapy for durable medication equipment (DME) recommendations. R1 required assistance of 1-2 people to leave home, required the use of an assistive device. R1's altered mental status required supervision when leaving home, and psychiatric symptoms or severe anxiety interfered with ability to safely leave alone. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 5/6/25 at 11:41 indicated R1 was discharged and going home with a patient care assistant (PCA) and nursing services. He left via electric wheelchair accompanied by a family member (FM)-A. R1 refused wound care done at the facility and stated, I will have wound care done today when I get home. R1's hospital note dated 5/15/25 indicated he was admitted to the hospital with a concern of gluteal wound infection. Surgery was notified to evaluate for necrotizing fasciitis (bacterial skin infection which destroys tissues) for which they had low suspicion. R1 received debridement on 5/16/25 with no concerns for wound infection based on reports. R1 was afebrile (no fever) and had a normal white blood cell count (WBC) (lab result often used to detect inflammation or infection in the body). Upon interview on 5/20/25 at 2:45 p.m. R1 stated he was still in the hospital. He stated he was home for a few days following discharge and no home care agency had reached out to him to set-up cares. His wounds were becoming more painful. He reached out to FM-A and FM-A told him he needed to go to the hospital. He stated chose to leave the facility because he was told he could end up paying over $400 a day to be there. He was told by the facilities provider that she had ordered cares in his home. He was not told which home care agency. R1 was aware that his CADI waivered had closed and that he would not have PCA services for a few weeks but was told he would have nurses for medications and wound cares. Upon interview on 5/20/25 at 3:29 p.m. registered nurse (RN)-A nursing manager stated R1 had open wounds upon his discharge. She believed FM-A would be completing wound care. SW-A sets up services, not nursing therefore RN-A was not certain of what resulted after R1 left the facility. Upon interview on 5/21/25 at 9:56 a.m. R1's provider stated she was aware of R1's discharge. R1 wanted to discharge, but he did not leave against medical advice. The provider completed a face-to-face visit with R1 and provided the facility with homecare orders. The provider was not aware that the facility did not get homecare services set-up for R1 prior to discharge. Upon interview on 5/21/25 at 11:12 a.m. SW-A stated R1 initiated his discharge on [DATE]. She was aware he had discharge orders because SW-A notified the provider that R1 needed a face-to-face visit for upcoming discharge. R1 discharged on 5/6/25. SW-A works only part-time and did not return to work until 5/7/25 when she started searching for home care agencies. She received denials from six home care agencies. SW-A denied reaching out to R1 following his discharge. SW-A's process was to have residents sign the NOMNOC form when the facility believed Medicare would stop paying for services. She believed R1 understood he had other insurance therefore would not be charged to stay at the facility. Upon interview on 5/21/25 at 1:48 p.m. RN-B stated she was the nurse who completed Ra's discharge on [DATE]. She had never been formally trained on discharges. She used her knowledge from prior employment stating for she discharges the residents must have orders, vital signs, medications given, or prescriptions faxed and transportation. She believed SW-A had services in the home set-up as R1 and FM-A told her he would have the home care nurse change his dressing when he refused the dressing change treatment from her on the day of discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/21/25 at 2:02 p.m. the director of nursing (DON) stated she was not aware of R1's case specifically because she had only worked at the facility for a week. She stated her expectation was that homecare services be set-up and if there were difficulties the provider or leadership should have been notified. In addition, facility should have started searching for a homecare agency right when they were aware of the discharge. Upon interview on 5/21/25 at 3:35 p.m. R1's Minnesota Choice assessment worker stated she was aware of R1's discharge and completed his CADI assessment on 5/5/25. She stated she was clear with the facility that R1 would not have PCA services in the home until his CADI waiver was reinstated, but his skilled nursing and therapy needed to be started right away. She was aware that FM-A could assist with some of the PCA tasks such as food prep, taking R1 out of the house, minor personal cares, and homemaking. The facility policy and procedure titled Discharge Summary and Plan, revised December 2016 indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and their family and will include: -where the individual plans to reside; -arrangements that have been made for follow-up care and services; - description of the resident's stated discharge goals; -the degree of caregiver/support person availability, capacity, and capability to perform required care; -how the IDT will support the resident or representative in the transition to post-discharge care. -what factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences. If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents transferring to another skilled nursing facility or who are discharged to a home health agency, long-term care hospital or inpatient rehabilitation facility will be assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences. Data used in helping the resident select an appropriate facility includes the receiving facility's: -standardized patient assessment data; -quality measure data; and -data on resource use. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed. A member of the IDT will review the final post-discharge plan with the resident and family at least twenty four (24) hours before the discharge is to take place. A copy of the following will be provided to the resident and receiving facility, and a copy will be filed in the resident's medical records: -An evaluation of the resident's discharge needs; -The post-discharge plan; and -The discharge summary

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate discharge documentation was in the medical record for 3 of 3 residents (R1, R2, & R3). R1, R2 and R3's medical records were missing discharge summaries, a recapitulation of their stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication (both prescribed and over the counter medications). Findings include: R1's care plan dated 4/23/25 - 5/19/25 did not indicate any discharge focus, goals, or interventions. R1's list of assessment completed dated 4/23/25 - 5/6/25 did not include a discharge summary assessment. R1's admission Minimum Data Set (MDS) dated [DATE] did not include a Brief Inventory of Mental Status (BIMS) score to indicate his cognition level. R1 was dependent upon staff for toileting hygiene, bathing, and rolling in bed. He required maximum assistance with dressing lower body and minimal assistance dressing his upper body. R1's pertinent diagnoses were after care for surgical amputation, immunodeficiency (bodies inability to defend the body from foreign or abnormal cells), diabetes, obesity, absence of right leg above the knee. R1's provider Evaluation and Management note dated 5/1/25 indicated the provider ordered skilled nursing in the home to assess/instruct on medication management, provide complex wound care related to current conditions, assessment for complications or exacerbation of patients condition and administer/instruct intravenous (IV) therapy and wound care. Additional services needed were Occupation Therapy for durable medication equipment (DME) recommendations. R1 required assistance of 1-2 people to leave home, required the use of an assistive device. R1's altered mental status required supervision when leaving home, and psychiatric symptoms or severe anxiety interfered with ability to safely leave alone. A nursing progress note dated 5/6/25 at 11:41 indicated R1 was discharged and going home with a patient care assistant (PCA) and nursing services. He left via electric wheelchair accompanied by a family member (FM)-A. R1 refused wound care done at the facility and stated, will have wound care done today when I get home. There were no more progress notes regarding R1's discharge documented. Upon interview on 5/20/25 R1 stated he did not recall any discharge planning at the facility. Upon discharge he was told his medications had been sent to his pharmacy and FM-A agreed to pick them up. He was not sent home with a discharge care plan. He was told he would be receiving home care services but was not given any information about the agency. R2's care plan dated 1/22/25 - 5/2/25 did not indicate any discharge focus, goals, or interventions. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's quarterly MDS dated [DATE] indicated R2's BIMS score was a 6 indicating she was cognitively impaired. R2 was dependent upon staff for toileting hygiene and bathing. She required substantial assistance with dressing and rolling in bed. R2's pertinent diagnoses were aftercare for fracture of the humerus (upper arm from shoulder to the elbow), morbid obesity, a respiratory disorder. R2's provider discharge orders dated 4/25/25 indicated R2 was o.k. to discharge from the facility with the current care plan. R2 was to discharge with a 7-day supply of medications including controlled substances. Follow-up with community primary care provider within 7 days of discharge. Send R2's nurse practitioner (NP) and last note to R2's community provider. R2 required homecare services, physical therapy for weakness status post falls and recent arm fracture repair, congestive heart failure, obesity, and diabetes. Occupational therapy for gait instability and durable medication equipment review. Registered nurse for medication management review and care coordination and diabetic teaching. Home health aide for bathing assistance and social worker for community care coordination. R2's progress note dated 4/29/25 indicated R2's discharge was discussed with her family (FM)-B. FM-B was trained on transfers and unidentified nursing education for when R2 got home. Transportation was set-up. R2's progress note dated 5/2/25 indicated R2 would have homecare services for registered nurse, home health aide, physical therapy, occupation therapy and social worker. R2's note did not indicate involvement of the interdisciplinary team (IDT), resident goals of care and treatment preferences, interests in receiving information regarding return to the facility. There were no more additional progress notes regarding R2's discharge. A Social Services - Discharge summary dated [DATE] at 9:21 a.m. was initiated by SW-A and then stopped in error. The summary indicated services to be initiated were RN (medication management, diabetic training), home health aide, physical therapy, occupation therapy and social worker. The reason for initiation of services indicated to assist with follow-up cares post discharge home. The recapitulation of stay indicated resident was admitted to the facility. No more documentation was completed on the summary. The summary did not indicate a discharge summary to include a full recapitulation of the residents stay including diagnosis, course of illness/treatment, pertinent lab, radiology, and consultation reports. A final summary of R2's status to include contact information of the practitioner responsible for the care of the resident was not included. Resident representative information including contact information. Advance Directive information. All special instructions or precautions for ongoing care, as appropriate. Comprehensive care plan goals. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. There was no documentation of medication reconciliation completed with R2 or representative on the summary. Upon interview on 3/21/25 at 3:19 p.m. FM-B stated R2 left the facility with home care in place. R2 was told by her provider that she needed to follow-up with her community provider in a week or so. She did not receive any discharge care. She stated she did not recall a medication reconciliation taking place because she did not really understand what medication reconciliation was. She stated home care took over R2's medications immediate and to her knowledge they had the medication information. R3's care plan dated 1/21/25 - 4/22/25 did not indicate any discharge focus, goals, or interventions. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's admission MDS dated [DATE] indicated R3's BIMS score was a 14 indicating she was cognitively intact. R3 was dependent for toileting hygiene, bathing, dressing, and rolling in bed. R3's pertinent diagnoses were osteomyelitis of the vertebrae (degenerative joint disease of the spine), chronic pain syndrome, cardiomyopathy (disease of the heart muscle), and respiratory failure. R3's providers Evaluation and Management visit documentation dated 4/22/25 indicated R3 was planning to discharge from the facility 4/22/25 with physical therapy, occupational therapy, registered nurse, and home health aide. R3's list of completed facility assessments dated 1/22/25 - 5/2/25 did not indicate a discharge summary was completed. R3's nursing progress note dated 4/21/25 at 2:50 p.m. indicated R3's discharge orders had been received. The facility spoke with R3's family member FM-C regarding scheduling appointments with her community provider. R3's discharge orders were faxed to her local primary care clinic. R3's nursing progress note dated 4/22/25 at 12:22 p.m. indicated R2 was discharged from the facility at 12:00 p.m. via wheelchair accompanied by a FM-D. All medications, paperwork, and personal belongings were sent with R2. Vital signs taken and body audit was completed. Daily wound was completed to a sacral wound. R3 did not return a call during the survey. Upon interview on 3/20/25 at 3:29 p.m. registered nurse (RN)-A stated a summary of residents discharge should be in progress notes during the discharge process and at discharge. Nursing and/or the facility social worker could perform discharges. She was not aware of a formal discharge summary at the facility. Upon interview on 5/21/25 at 11:12 a.m. social worker (SW)-A stated the nursing department, the social worker or the social workers assistant could work on discharges. There was not a specific stream-lined discharge process at the facility. SW-A stated she was certain what was required per regulation in a discharge summary. Upon interview on 5/21/25 at 2:02 p.m. the director of nursing (DON) stated she had only been at the facility for about a week and was not certain of the entire discharge process. She stated the facility discussed discharges in the morning intradisciplinary team (IDT) meetings. The facility policy and procedure titled Discharge Summary and Plan, revised December 2016, indicated when the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-current diagnosis; -medical history (including any history of mental disorders and intellectual disabilities); -course of illness, treatment, and/or therapy since entering the facility; - laboratory, radiology, consultation, and diagnostic test results; -physical and mental functional status; -ability to perform activities of daily living including: -bathing, dressing, and grooming, transferring, and ambulating, toilet use, eating, and using speech, language, and other communication systems; -the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; and -the ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); Nutritional status and requirements: -weight arid height, nutritional intake, and eating habits, preferences, and dietary restrictions. -special treatments or procedures (treatments and procedures that are not part of basic services provided); -mental and psychosocial status (ability to deal with life, interpersonal relationships, and goals, make health care decisions, and indicators of resident behavior and mood); -discharge potential (the expectation of discharging the resident from the facility within the next three months) Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); Activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); Rehabilitation potential (the ability to improve independence in functional status through restorative care programs); (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and Medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented. Every resident will be evaluated for their discharge needs and will have an individualized post discharge plan. The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and their family and will include: -where the individual plans to reside; -arrangements that have been made for follow-up care and services; -a description of the resident's stated discharge goals; -the degree of caregiver/support person availability, capacity, and capability to perform required care. How the IDT will support the resident or representative in the transition to post-discharge care; What factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences.