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	03/05/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with known cognitive impairment was comprehensively evaluated and had individualized interventions implemented to ensure safety when leaving the facility independently for 1 of 3 residents (R3) reviewed for safety.Findings include:R3's diagnoses list dated 3/5/26 included stroke, hypertension (high blood pressure), repeated falls, and cognitive communication deficit.R3's hospital discharge transfer orders dated 12/3/25 indicated R3 needed ongoing supervision due to continued need for help with moving, thinking, safety, and eating.R3's elopement risk assessments dated 12/3/25 indicated R3 was low risk for elopement.R3's admission Minimum Data Set (MDS) dated [DATE] indicated moderately impaired cognition R3 required maximum assist from staff for transfers, was dependent of staff for wheelchair mobility, and ambulation was not attempted due to medical condition or safety concerns.R3's care plan dated 12/3/25 included a focus of impaired cognitive function/dementia or impaired thought process related to cerebral infarction and communication deficits with interventions including but not limited to cue, reorient and supervise as needed. The care plan also informed that R3 required assistance from 1 staff member for dressing, personal hygiene, transfers, and locomotion with a manual wheelchair. R3 ambulated with a front wheeled walker and supervision from staff and required reminders to use the walker. R3 was at risk for falls with interventions including but not limited to education on how to sit properly in a wheelchair and encourage R3 to use a manual wheelchair when off the unit. R3's discharge focus indicated R3 wanted to discharge to a skilled nursing facility in a different city to be closer to family with an intervention of social service will coordinate services for discharge.R3's St. Louis University Mental Status assessment (SLUMS)(examination for detecting mild cognitive impairment and dementia) dated 12/12/25 identified a score of 15/30 which indicated dementia.R3's nursing notes dated 2/4/26 identified around 3:30 am, R3 told LPN-A she was leaving the facility. LPN-A tried to convince R3 to stay until morning but R3 refused. R3 signed out of the facility and left. The director of nursing and family were updated. Family was very upset that R3 was allowed to leave and called the police. The police filed a missing person report. At 7:20 pm a family member called to alert the facility R3 was at their home, and they would bring her back the next day. A nursing note dated 2/5/26 identified R3 had returned to the facility around 11:00 p.m.In review of R3's record between 12/3/25 through 2/4/26, the record did not include a comprehensive assessment that identified R3's level of supervision in the community with consideration of R3's documented cognitive deficits and/or R3's vulnerabilities or risks while independent community with applicable individualized interventions to ensure R3's safety in the community.R3's Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified a score of 8 which indicated R3 had moderate cognitive impairment.R3's BIMS assessment dated [DATE] identified a score of 11 which indicated R3 had moderate cognitive impairment.R3's significant change Minimum Data Set (MDS) dated [DATE] indicated R3 had moderately impaired cognition and independence with mobility in a manual. wheelchair. Cognitive Loss/Dementia Care Area Assessment (CAA) indicated R3 had an actual problem of mild cognitive impairment related to a (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history of stroke. Cognitive loss would be addressed in the care plan with overall objectives to include avoid complications and minimize risks.R3's elopement risk assessments dated 2/19/26 indicated R3 was low risk for elopement.A police report dated 3/01/2026 identified at 7:04 a.m. on 3/1/26 an officer arrived at the facility regarding a missing person report. The officer spoke to staff who said R3 had signed out of the book. Staff did not see if R3 left on foot or in a car. Staff supplied the address of R3's family member (FM-A) where R3 was anticipated to be discharged . The officer contacted FM-B who was upset R3 had left the facility. FM-B did not think the facility supervised R3 enough. R3 was in a vulnerable state due to medical emergency, treatment, and ongoing recovery. R3 had recently moved back to Minnesota and did not have any other contacts in the area, and her phone did not have an active wireless plan. The officer received a phone call on 3/01/25 from the facility to inform him R3 had returned.R3's nursing notes dated 3/1/26 identified on 2/28/26 around 7:30 pm, R3 had told the receptionist she was leaving the facility. R3 did not indicate where she was going or when she would be back. Around 5:00 a.m. on 3/1/26 R3 still had not returned to the facility so staff attempted to locate her at the facility then called her cell phone. When she could not be located, the police were called, and a missing person report was filed. R3 returned to the facility around 12:40 p.m. A skin check was completed with no new concerns. R3 Denied pain and shortness of breath. R3 was educated to sign out when leaving the facility and to call the facility when she cannot return to the facility the same day. R3 verbalized understanding.In review of R3's record between 2/4/26 through 3/3/26, the record did not include a comprehensive assessment that identified R3's level of supervision in the community with consideration of R3's documented cognitive deficits and/or R3's vulnerabilities or risks while independent community with applicable individualized interventions to ensure R3's safety in the community.During an interview on 3/3/2026 at 1:37 p.m., R3 stated she had moved back to Minnesota in October 2025. She went into the hospital a few days after arriving in Minnesota then was discharged to the facility. She had a cell phone, but it did not work for making calls. She needed to use the facility phone when she wanted to call someone. On February 4th, 2026, R3 told a staff member she was leaving to go to her cousin's house. Her cousin picked her up, R3 spent the night at the cousin's house, and her brother brought her back to the facility on February 5th, 2026. On February 28th, 2026, R3 called her cousin from the facility phone, who arranged for an Uber to pick R3 up at the facility and bring her back on March 1st, 2026. R3 indicated the facility had not provided her with any safety instructions while out in the community but would ask to borrow someone's phone if she had any trouble.During an interview on 3/3/2026 at 2:49 p.m., FM-A stated he was very upset R3 was allowed to leave the facility by herself. He was concerned R3 would make bad decisions while in the community because she was not right in the head. FM-A could not define what bad decisions R3 might make. FM-A also stated R3's phone did not have cell service and could only be used when on a wi-fi network.During an interview on 3/3/2026 at 3:25 p.m., receptionist (R)-A stated a resident needed to sign out in the book with the time they were leaving and where they are going before leaving the facility. There was an elopement book with a list of residents who needed an escort to leave the facility. A resident could leave the facility independently if they were not listed in that book. R-A confirmed R3 was not on the list of residents who needed an escort to leave the facility.During a phone interview on 3/4/2026 at 2:43 p.m., the occupational therapy assistant (OTA) stated R3 scored 15/30 on a SLUMS examination completed on 12/12/25 which indicated R3 had dementia. OTA was not requested to assess R3 for safety in the community. OTA would have recommended R3 have supervision in the community due to memory problems and would need clear directions on coming and going to/from facility.During a phone interview on 3/5/2026 at 9:14 a.m., speech therapist (ST) stated a person with a SLUMS score of 15/30 would need supervision in the community because of memory issues. ST indicated there had not been a referral or request to do a screening or evaluation for community safety.During an interview on 3/4/2026 at 9:54 a.m., licensed practical nurse (LPN)-A stated a resident could leave the facility independently if they were alert and oriented, independent with mobility, were not an elopement risk, and could make their own decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The BIMS was used to determine a resident's cognitive ability.During an interview on 3/4/2026 at 11:41 a.m., the Nurse Manager (NM) stated a resident's ability to safely enter the community was based on cognition, mobility, elopement risk and a safety in the community assessment completed by therapy. NM asserted that while R3 would not have been capable of independent community travel upon admission, she had improved enough with her mobility to allow it, however no formal assessment had been completed to determine R3's level of improvement that would ensure R3 was safe or if R3 required interventions to ensure R3's safety.During an interview on 3/5/2026 at 11:56 a.m., director of nursing (DON) stated a resident's ability to safely go into the community independently was based on cognition and elopement risk. A resident with severely impaired cognition would not be deemed safe to leave independently. DON explained PT would complete an assessment for power chair mobility on facility grounds but she didn't know if therapy would do a safety in the community assessment. DON further indicated the facility did not have a process to assess residents for safety in the community.During a phone interview on 3/5/2026 at 1:14 p.m., the medical director (MD) stated nursing should do an in-depth assessment when a resident requested to leave the facility independently. The assessment should include if the resident was safe, demonstrated insight and reasonable decision making as well as if the resident was physically able to navigate where they wanted to go. If a resident had moderately impaired cognition, they should not be allowed in the community independently unless the family was comfortable and the resident had been navigating the community for years.Facility policies did not address protocols and criteria for residents to leave the facility independently.The Elopement Prevention and Missing Resident policy dated 3/3/26 instructed the facility endured the safety of residents be providing unsupervised departure (elopement) and responding promptly when a resident was missing.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 1 of 1 resident (R3) reviewed for accidentsFindings includeR3's diagnoses list dated 3/5/26 included stroke, hypertension (high blood pressure), repeated falls, and cognitive communication deficit.R3's provider order dated 1/15/26 instructed clonidine (a medication that lowers blood pressure) oral tablet 0.3 milligrams (MG). Give one tablet by mouth three times a day for hypertensive urgency. Hold if heart rate is less than 60 beats per minute or if systolic blood pressure is less than 100 millimeters of mercury (mmHg).R3's nursing notes dated 3/1/26 identified on 2/28/26 around 7:30 pm, R3 had told the receptionist she was leaving the facility. R3 did not indicate where she was going or when she would be back. Around 5am on 3/1/26 R3 still had not returned to the facility so staff attempted to locate her at the facility then called her cell phone. When she could not be located, the police were called, and a missing person report was filed. R3 returned to the facility on 3/1/26 around 12:40 pm.R3's medication administration audit report for February 2026 indicated a dose of clonidine was scheduled for 2/28/26 at 2200 was signed on 2/28/26 at 9:36 p.m. (even though R3 was not in the facility at the time the medication was documented as administered).R3's medication administration record for February 2026 indicated a dose of clonidine scheduled for 2/28/26 at 11:00 p.m. was administered with a blood pressure of 121/74 and a pulse of 72 by licensed practical nurse (LPN)-B (even though R3 was not in the facility at the time the medication was documented as administered).During an interview on 3/9/2026 at 10:07 a.m., LPN-B stated on 2/28/26 he administered all of R3's evening medications at the same time because she liked getting all of her pills together. If she was approached twice with medications and blood pressure checks, she would often refuse the second approach. He could not document the clonidine with the other medications because it was too early. LPN-B subsequently entered the documentation at a later time to appear as though the medication was given as ordered. Furthermore, LPN-B could not provide a clinical explanation for the conflicting blood pressure readings documented at 6:22 p.m. and 9:36 p.m., as he had previously stated he only approached the resident once for all medications and vitals.During an interview on 3/5/2026 at 4:55 p.m. director of nursing (DON) stated medications could be administered up to one hour before or one hour after the scheduled administration time. If a resident was out of the building when a medication was due to be administered, the nurse should choose the code that applied to the situation (for example, at the hospital or leave of absence with medications). The nurse could also choose code 9 which prompts the nurse to write a note explaining why the medication was not administered. DON verified R3's 2/28/26 dose of clonidine and blood pressure check scheduled at 11:00 p.m. was documented as administered on 2/28/26 at 9:36 p.m. with corresponding blood pressure information. DON confirmed according to documentation, R3 was out of the building at the documented administration time. DON stated accuracy of documentation in the medical record was important.The Documentation of Medication Administration policy dated 4/2007 instructed administration of medication must be documented immediately after (never before) it is given.The Charting and Documentation policy dated 7/2017 instructed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.