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	04/16/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to obtain an order for restraint and perform an assessment following the restraint of 1 of 1 resident (R1) reviewed for physical restraint. Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, no behaviors, independence in activities of daily living and ambulation. R1's diagnoses included schizophrenia. R1's care plan included: 10/9/24 substance abuse/dependence of alcohol and cocaine with interventions to monitor for signs and symptoms of intoxication and update provider as needed7/23/25 resident did not wish to self-administer medications 8/20/25 resident wished to discharge to the community with interventions to arrange required community supports11/6/25 potential to be physically aggressive to others and poor impulse control. Diagnoses included schizotypal disorder (a mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions), alcohol dependence, anxiety, depression, and bipolar disorder. Interventions included a room change, separation of R1 from specific other residents, and 1:1 supervision starting 4/5/26, after an altercation1/22/26 R1 was seeing a psychology provider for psychosocial support3/26/26 R1 was able to go into the community independentlyR1's care plan lacked indication restraint use for behavioral intervention. R1's progress note dated 4/11/26 at 7:00 p.m., indicated R1 had an altercation with another resident, R2. R1 overpowered a staff, and was able to strike R2 on the face. Staff on second floor physically restrained R1. The police were called, and R1 was taken to jail. The progress notes lacked indication R1's provider was notified. R1's progress notes reviewed 4/11/26 through 4/12/26 lacked indication an order was obtained for the restraint noted in the 4/11/26 progress note, nor an assessment of R1 was completed after the use of physical restraint. During an interview on 4/15/26 at 12:39 p.m., nursing assistant (NA)-A stated they observed the incident on 4/11/26 between R1 and R2. NA-A observed licensed practical nurse (LPN)-A hold R1 in, a bear hug from behind, to keep R1 away from the other resident. During an interview on 4/15/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated he was working on 4/11/26, when R1 and R2 were fighting. LPN-A had to, hold him [R1] in a hug hold. to prevent R1 from getting to R2. LPN-A stated he did not get an order for the hold, nor did he know he needed an order. LPN-A stated he did update R1's provider about R1's aggression towards R2, through the provider online portal but LPN-A did not update R1's provider about the hold. During an interview on 4/15/26 at 2:49 p.m., LPN-B stated on 4/11/26 when LPN-B was working, he witnessed R1 become combative and confrontational when he was intoxicated. R1 overpowered the 1:1 staff who was assigned to R1 to get to R2 and LPN-A had to hold R1; R1 was restrained for safety. LPN-B stated staff did not get an order for the restraint, but should have. During an interview on 4/15/26 at 4:33 p.m., the social services designee (SSD)-A stated if a resident was restrained, the staff should obtain an order, and the incident should be reported to the physician and documented. The SSD-A stated she did not find evidence in the medical record of of the restraint being documented, if an order for the restraint requested and/or received, and if the provider was notified, but would have expected the provider to be notified right away. During an interview on 4/16/26 at 4:19 p.m., the director of nursing (DON) stated, We do not do (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

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 04/16/2026
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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restraints here. DON stated, a bear hug to hold a resident, was considered a restraint and required a provider's order, notification to the provider and a debriefing following the event which required the restraint be used. DON was unsure if there was an order, a debriefing, or if staff was trained regarding proper use of restraints.The Use of Restraints policy dated April 2017, indicated emergency use of restraint was permitted to prevent a resident from injuring himself or others. The DON had the authority to order the use of emergency restraint and the attending physician must be notified of such use and the reason for the order. The order may be received by telephone and signed by the physician within 48 hours. The order shall include the specific reason for the restraint, how the restraint will be used to benefit the resident's medical symptom, the type of restraint, and period of time for the use of the restraint. Documentation regarding the use of the restraints shall include:Full documentation of the episode leading to the use of physical restraint that included the resident symptoms but also the conditions, circumstances, and environment associated with the episodeA description of the resident's medical symptoms that warranted the use of restraintHow the restraint use benefit the resident by addressing medical symptomsThe type of restraint usedThe length of effectiveness of the restraint timeObservation, range of motion, and repositioning flow sheets

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 04/16/2026

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 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 document review the facility failed to perform an appropriate discharge for 1 of 1 resident (R1) when R1 was discharged without a reassessment of the facility's ability to meet R1's needs when R1 returned from jail, and failed to identify the specific needs the facility could not meet nor the facility's efforts to meet those needs.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, no behaviors, and independence in activities of daily living (ADLs). R1's diagnoses included schizophrenia. R1's care plan included the following: 10/9/24 substance abuse/dependence of alcohol and cocaine with interventions to monitor for signs and symptoms of intoxication and update provider as needed7/23/25 resident did not wish to self-administer medications 8/20/25 resident wished to discharge to the community with interventions to arrange required community supports11/6/25 indicated R1 had the potential to be physically aggressive to others and had poor impulse control. The care plan indicated R1 had diagnoses that included schizotypal disorder (a mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions), alcohol dependence, anxiety, depression, and bipolar disorder with interventions that included a room change, separation of R1 from specific other residents, and 1:1 supervision starting 4/5/26 after an altercation1/22/26 resident was seeing a psychology provider for psychosocial support3/26/26 resident was able to go into the community independentlyR1's progress note dated 4/11/26 at 7:00 p.m., R1 had an altercation with R2. R1 overpowered a staff, and was able to strike R2 on the face. Staff on second floor restrained the resident. Police were called, and R1 was taken to jail. R1's medical record dated 4/11/26 through 4/12/26, lacked indication an order was obtained for the use of physical restraint, if the provider was informed of the use of physical restraint, and if an assessment of R1 was completed after the physical restraint. R1's Discharge summary dated [DATE] at 4:52 p.m., indicated R1 discharged due to non-compliance with facility policy. Discharge summary failed to indicate which policy. The Discharge Summary indicated the facility was unable to meet R1's needs, but failed to specify which of R1's needs the facility could not meet as well as the limitations R1 had in caring for himself. The Discharge Summary lacked indication of where R1 would reside when discharged . Additionally, the Discharge Summary also lacked mention if R1 had post-discharge appointments, medical or non-medical. R1's provider order dated 4/13/26 at 5:40 p.m., indicated, Okay to discharge resident to the community due to safety concerns for other residents. The order lacked indication which of of R1's needs the facility could not meet and the facility's efforts to meet those needs. The order lacked indication to discharge R1 with medications. R1's progress notes indicated the following:4/13/26 at 6:15 p.m., R1 returned to the facility from jail and was given the notice to discharge due to the safety concerns for other residents. R1 was educated in the presence of the director of nursing (DON) on how to take his medications and R1 verbalized understanding. R1 left the facility at 6:00 p.m., via Uber with all his medications and some of his personal belongings. 4/14/26 at 8:12 a.m., when R1 returned from jail the administrator informed R1 he was discharged for the safety and welfare of the other residents. The facility paid for a motel room, provided the resident with fifty dollars, and offered to send food with R1, which he declined. The administrator provided business cards for himself and the DON and instructed R1 to call the facility if he needed information or food. 4/14/26 at 8:12 a.m., R1 discharged from the facility with written instructions on how to take his medications, face sheet, order summary, provider notes, discharge order, and motel reservation slip. R1's progress notes dated 4/13/26 through 4/14/26, failed to indicate what specific needs the facility could not meet as well as the efforts made to provide those needs. Progress notes also lacked indication an assessment was completed to determine R1's needs upon return to the facility on 4/13/26.During an interview on 4/15/26 at 10:55 a.m., the administrator stated R1 was no longer in the facility for the safety of the (continued on next page)

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 04/16/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other residents. The administrator stated the facility did not perform assessments when R1 returned from the jail because R1 was discharged while he was in jail. The administrated stated R1's return from jail was not the time to complete new assessments. Facility staff instructed R1 in how to take his medications and provided the instructions in writing. R1 stated he understood how to take his medications as prescribed, but staff did not assess R1's ability nor request R1 provide a return demonstration. The administrator stated staff did not assess if R1 knew how to obtain medication refills but R1 could read and write and was alert and oriented. During an interview on 4/15/26 at 1:15 p.m., licensed practical nurse (LPN)-A stated one of R1's problems was alcohol dependence. R1 was a danger to others when he was drinking so the facility could not meet R1's needs. The facility offered R1 treatment for alcoholism but R1 declined the intervention. During an interview on 4/16/26 at 10:53 a.m., relocation worker (RW)-A stated R1 was accepted to an assisted living facility but because R1 was discharged from the facility, the RW-A could no longer assist R1 with relocation assistance. RW-A stated R1 would benefit from going where there were activities and 24- hour care, and was concerned about R1 living in a motel due to R1's dependency on alcohol which could impede R1's ability to care for himself. R1's alcohol dependency may have been the cause of R1's recent behaviors. The RW-A further stated R1 had recent memory changes and was concerned these were progressing quickly. R1 was losing things and did not recall the details of their meetings. During an interview on 4/16/26 at 4:19 p.m., the DON stated when R1 was admitted , R1 required nursing care for medication assistance. R1 had verbal and physical aggression and had been intoxicated at times. When residents discharged , they had to have a place to go, be deemed safe to leave, a care conference had to occur to discuss the discharge plan, and required an order to discharge. DON stated R1 had all of those in place. DON stated R1 was safe to discharge to a motel because R1 was cognately intact, could verbalize understanding of how to take his medications, and could read the instructions. DON stated there were progress notes which indicated when R1 was intoxicated he didn't care for himself well. Additionally, DON acknowledged the facility did not do an assessment of R1 when he returned from the jail to assure the facility could no longer care for R1 safely, the jail did not send updated information regarding R1's care needs, and DON had not requested an update. DON stated she was not aware RW-A's referral to another facility and was not aware RW-A had found R1 an assisted living facility in which to reside. During a subsequent interview on 4/16/26 at 5:37 p.m., the administrator stated R1 was referred to another care facility because R1 was unable to find an independent apartment, not because he could not be in an independent living setting. The administrator stated when R1 returned from jail, the facility staff did not assess if R1's needs had changed to determine if the facility could continue to meet R1's needs. The administrator stated he was unsure what information the discharge orders were supposed to include for an unplanned discharge but acknowledged R1's discharge orders did not include the needs the facility could not meet, nor the facility's efforts to meet those needs. The Discharge Summary and Plan policy dated December 2016 indicated the discharge summary will include a recapitulation of stay and final summary of the resident's status at the time of the discharge to include:Current diagnosesMedical historyCourse of illness, treatment and/ or therapy since entering the facilityCurrent laboratory, radiology, consultation, and diagnostic resultsPhysical and mental functional statusAbility to perform ADLsSensory and physical impairmentsNutritional status and requirementsSpecial treatments or proceduresMental and psychosocial statusDischarge potentialDental conditionActivities potentialRehabilitation potentialCognitive statusMedication therapy

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	04/16/2026

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 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 1 of 1 resident (R1). reviewed for discharge. Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, no behaviors, and R1 was independent with activities of daily living (ADLs). R1's diagnoses included schizophrenia. R1's Discharge summary dated [DATE] at 4:52 p.m., indicated R1 discharged due to non-compliance with facility policy and the facility's inability to meet R1's needs. R1's discharge summary failed to indicate which facility policy R1 was non-compliant with, which of R1's needs the facility was unable to meet, the limitations R1 had in caring for himself at time of discharge, an indication of where R1 was discharging to, and if R1 had post-discharge appointments set-up, medical or non-medical.R1's medical record reviewed 4/11/26 through 4/15/26. R1 medical record failed to include a recapitulation of stay as well as reconciliation of all pre-discharge and post-discharge medications including prescribed medications as well as over-the-counter medications. During an interview on 4/15/26 at 2:49 p.m., licensed practical nurse (LPN)-B stated when a resident discharged , the plan had to be safe. LPN-B stated they heard administrative staff met R1 at the door with a discharge notice when R1 returned to the facility from jail. LPN-B stated with a typical discharge, the facility would find the resident a safe place with community supports. LPN-B did not feel R1 would have that in a motel. During an interview on 4/15/26 at 4:33 p.m., the social services designee (SSD)-A stated R1 had been looking for an apartment, and relocation services were trying to help R1. R1 was very specific about where he wanted to live and rejected a few apartments. SSD-A acknowledged she had not completed R1's Discharge Summary so was unsure if it met the Discharge Summary criteria. During an interview on 4/16/26 at 4:19 p.m., the director of nursing (DON) stated R1's discharged was involuntary. For involuntary discharge, a resident needed a place to go. R1 was a danger to others in the building, understood how to take his medications, was independent in cares and mobility, and was his own decision-maker. During an interview on 4/16/26 at 5:37 p.m., the administrator stated he was unsure what the documentation requirements were for an unplanned discharge but acknowledged R1 did not receive the information required according to federal regulations. The Discharge Summary and Plan policy dated December 2016 indicated the discharge summary will include a recapitulation of stay and final summary of the resident's status at the time of the discharge to include:Current diagnosesMedical historyCourse of illness, treatment and/ or therapy since entering the facilityCurrent laboratory, radiology, consultation, and diagnostic resultsPhysical and mental functional statusAbility to perform ADLsSensory and physical impairmentsNutritional status and requirementsSpecial treatments or proceduresMental and psychosocial statusDischarge potentialDental conditionActivities potentialRehabilitation potentialCognitive statusMedication therapy