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	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 3 residents (R48) who utilized a urinary catheter, and (R55) who utilized an open plastic container to urinate in visible to the hall, nursing station and elevator. Findings include: R48 R48's admissions MDS dated [DATE], R48 identified with severe cognitive impairment, had impairment of lower extremities, was dependent on staff for all toileting and personal hygiene and required substantial assistance with dressing. In addition, R48 had a urostomy (surgical opening in the abdominal wall for urine to drain outside the body into a urine drainage bag), and a feeding tube (for nutrition). Also, R48 had medical diagnoses of a stroke, kidney disease, diabetes, bladder cancer, and depression. Review of R48's physician orders, care plan and kardex (nursing assistant care sheet) downloaded 2/13/25, fail to mention providing a privacy cover to urine drainage bag. During observation and interview on 2/12/25 at 9:51 a.m., R48 and roommate (R27) were in bedroom with door to hallway open. R48's bed was aligned with wall perpendicular and next to door. R48 was sleeping and lying in bed with large urine drainage bag attached to frame of bed facing hallway. Yellow fluid noted to be in the large urine drainage bag which was not covered. Licensed practical nurse (LPN)-C walked into the room past R48 and began to speak to his roommate. Surveyor asked LPN-C about the uncovered urine drainage bag and she stated, It should be covered. It is not covered and it is visible from the hall and left the room. -At 9:54 a.m., two staff members walked past the room. -At 10:02 a.m., nursing assistant (NA)-B knocked on the door and entered the room and walked past R48 to roommate with breakfast tray and walked out of the room past R48. During interview with NA-B on 2/12/25 at 10:05 a.m., NA-B looked at R48's uncovered urine drainage bag and stated, [It's] supposed to be covered. I am not sure if there is a cover. We need to hide it. (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 02/13/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview with director of nursing on 2/12/25 at 10:24 a.m., DON observed R48's uncovered urine drainage bag and stated, we need to put a cover on that bag. Safe to say it should be on for privacy. DON walked out of R48's room and to a supply room and obtained a privacy cover for the urine drainage bag. During interview with family member (FM)-A on 2/13/25 at 9:25 a.m., FM-A stated, that catheter bag thing should be covered. No one wants to see that. [R48] would be ticked off if it were visible to anyone. He is a private man and does not want something like that to be visible. R55 R55's admissions MDS dated [DATE] identified R55 with no indicators of cognitive impairment, utilized a wheelchair, required substantial assistance for toileting, showering, and dressing. R55's medical diagnoses include morbid obesity with a breathing disorder impacting lung function, diabetes, depression, chronic pain, and lymphedema. In addition, R55 required continuous oxygen therapy. R55's care plan (CP) downloaded on 2/10/25 with a start date of 11/11/24 indicated, TOILET USE: The resident does not always use the toilet, urinates in a bowl and then staff to empty it. During observation and interview on 2/9/25 at 10:34 a.m., R55 sitting in electric wheelchair in his room and a large opaque plastic container with urine in it was placed in the middle of a larger basin just inside the door of room, which was visible to the hall, nursing station, and elevator. R55 stated, I pee in it. Container had 500 milliliters (mL) of urine it. The container that held the urine had dried white flakes along the inside and outside of the container and a gelatinous yellow substance along the entire top ridge of the container. Container did not have a date or label on it and R55 stated no one has emptied it since last night. During observation and interview on 2/10/25 at 1:49 p.m., the container that held the urine had dried white flakes along the inside and outside of the container and a gelatinous yellow substance along the entire top ridge of the container. The container was just inside the door of room, which was visible to the hall, nursing station, and elevator. Staff and visitors walked past the room. Container did not have a date or label on it. R55 stated, Staff never wipe it out or clean it when they empty the urine. I think it looks gross. R55 stated he did not like the container to be so visible. During observation on 2/11/25 at 2:55 p.m., the container that held the urine had dried white flakes along the inside and outside of the container and a gelatinous yellow substance along the entire top ridge of the container. The container was just inside the door of room, which was visible to the hall, nursing station, and elevator. Staff and visitors walked past the room. Container did not have a date or label on it. R55 stated, nope they did not empty it yet and it's been there since this morning. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview with nursing assistant (NA)-A on 2/12/25 at 8:04 a.m., the container that held the urine had dried white flakes along the inside and outside of the container and a gelatinous yellow substance along the entire top ridge of the container. The container was just inside the door of room, which was visible to the hall, nursing station, and elevator. The container did not have a date or label on it. NA-A stated she was familiar with R55 and stated, [R55] pees in a cup. I empty it. NA-A looked at urine container and stated, looks dirty and needs to be changed. I don't know when it was replaced. I don't know. It looks awful. It should be washed and rinsed and it does not look like it has been done for many days or weeks. NA-A stated she had never wiped or cleaned the urine container. During interview with licensed practical nurse (LPN)-A on 2/12/25 at 8:12 a.m., LPN-A looked at R55's urine container and stated, it should be rinsed out. He brought it from home. It is not labeled or dated and we do not have a process to determine when it was replaced or cleaned. It is definitely an infection control concern. It has a lot of debris dried to it. LPN-A verified R55 admitted to facility on 11/6/24. LPN-A stated the location of the urine container was not ideal. Anyone can see that from the hall. [It] should not be visible for privacy. During interview with infection control preventionist (IPCP) on 2/12/25 at 8:26 a.m., IPCP looked at R55's urine container and stated, It should be cleaned daily. That is a concern for infection control. IPCP pointed to urine container and stated, we do not have this type of container here. I am just seeing this for the first time. No one told me about him using his own container for urine. There is white and yellow residue on the top and sides of that container. Facility policy titled Dignity reviewed November 2022 state, Residents are treated with dignity and respect at all times. And 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents: for example: a. Helping the resident to keep urinary catheter bags covered;

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure a functioning call light, or acceptable alternative, was provided or implemented to promote safety and allow for means of notification for 1 of 1 resident (R173) observed whose call light was not kept within reach. Findings include: R173's entry tracking record Minimum Assessment Data (MDS) dated [DATE], indicated R173 was admitted on [DATE]. R173's Clinical Diagnosis report printed 2/10/25, indicated diagnoses of lumbar spinal stenosis with neurogenic claudication (narrowing of the spinal canal of the lower back pressuring the spinal cord causing pain, weakness), polyneuropathies (simultaneous malfunction of many peripheral nerves throughout the body), cerebral infarction (area of damaged tissue on the brain), left side weakness due to cerebral infarction, aphasia (language disorder that affects a person's ability to communicate), adjustment disorder with anxiety, and depression. R173's Fall Risk care plan printed on 2/10/25, indicated R173 was at risk for falls related to weakness, pain, and recent back surgery. The fall risk's care plan interventions directed staff to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During interview on 2/10/25 at 12:18 p.m., R173 stated he had two strokes during recent back surgery and his left side was paralyzed. During observation and interview on 2/11/25 at 9:16 a.m., R173 was in his room and could be heard from the hallway about 150 feet from his room, calling out for help. R173 was in bed and said he didn't press his call light because he couldn't find it. R173's call light was on the floor by the foot of the bed, and he was unable to reach it. R173 stated he didn't like oatmeal and instead he wanted cold cereal. During observation on 2/11/25 at 9:36 a.m., nursing assistant (NA)-D answered R173's verbal call for help. R173 requested cold cereal and asked NA-D to empty his urinal, as he needed to void. During observation and interview on 2/11/25 at 9:48 a.m., R173's call light was observed at the foot of the bed. NA-D brought a bowl of cold cereal, juice, milk and a cup of coffee to the resident. When asked about the call light, NA-D stated, he can reach it. R173 tried to reach with his left hand. R173 also used his left foot and tried to get the call light within his reach but he was unable to do it. At this time, NA-D placed R173's call light over his abdomen and left the room. During interview on 2/11/25 at 9:51 a.m., the licensed practical nurse, infection preventionist and control program (ICPC) stated the call lights needed to be within residents' reach to call for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/13/25 at 2:14 p.m., director of nursing (DON) stated her expectation was for staff to leave call lights within residents' reach. The undated facility's policy and procedure titled, Answering the Call Light, indicated when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48065 Based on interview and document review, the facility failed to assist the resident council in setting up regular meetings. This had the potential to affect 10 of 10 residents (R45, R59, R8, R29, R13, R3, R2, R9, R21, R35) who had attended the last 3 resident council meetings in the facility, an additional 2 residents (R42, R56) who met to discuss resident council, and any other residents who wished to participate. Findings include: Facility provided documentation of the resident council meetings held in the last 6 months. The October 2024 and November 2024 resident council meetings were not scheduled. Meetings were held in September 2024 and December 2024. A meeting was scheduled in January 2025 but was cancelled due to a COVID outbreak. A resident council meeting had not been scheduled for the month of February 2025. During interview on 2/11/25 at 11:58 a.m., director of social services (SS)-A stated the resident council didn't have a president. SS-A stated the previous recreational therapist used to coordinate monthly resident council meetings. On 2/12/25 at 10 a.m., three of the six residents, invited to a resident council meeting with the surveyor, were in attendance. R42, R56 and R35 stated the resident council had not met on a regular basis, and so far, they heard nothing about a February 2025 meeting. The residents described the decline in residents' attendance to the resident council meetings. The residents stated the decline was caused by management and line staff turnover. Residents stated management staff doesn't stay long enough to work on their concerns. During interview on 2/14/25 at 11:00 a.m., administrator stated facility recently hired a new recreational therapist and resident council meetings will be resumed. Facility's policy titled Resident Council dated 2/2021 indicated, council meetings are scheduled monthly or more frequently if requested by residents. The date, time and location of the meetings are noted in the activities calendar.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49339 Based on interview and document review, the facility failed to promptly notify the emergency contact (FM-B) of medication changes, refusals of cares, and change of treatment for 1 of 1 residents (R51) of reviewed for notification of change. Findings Include: R51's admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated R51's admitted was 1/13/25. R51 had moderately impaired cognition without hallucinations or delusions present with no behaviors, rejection of care, or wandering present. R51 was dependent on staff for all activities of daily living (ADL's) including toileting, oral hygiene, personal hygiene, dressing, and bed mobility. Furthermore, R51 was incontinent of bowel and bladder. R51's admission record, printed 2/12/25, identified FM-B as the contact. Pertinent diagnoses included: Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain tissue to die), and epilepsy (seizure disorder). On 2/10/25 at 12:38 p.m., R51 was observed sitting in a Broda chair (a type of positioning chair) in the common area. R51 stated she was terrible, but was unable to elaborate. R51 was sipping on ice water. R51's hair was matted in back and appears greasy. R51 does repeat self and has some nonsensical responses. On 2/10/25 at 12:54 p.m., FM-B stated he went to visit R51 on 2/6/25 and found R51 almost dead. FM-B stated he notified nursing staff and R51 was transferred to the hospital after I had to nudge them to get her vitals and call 911. FM-B stated after asking many questions, he was told R51 had started on a new medication, Buprenorphine, on 2/5/25 and had received 2 doses. FM-B stated he was not notified or asked about starting this medication prior. FM-B stated they are the representative/power of attorney (POA) for R51 as R51 cannot make decisions. Furthermore, FM-B indicated I haven't gotten much communication from the facility. FM-B stated he has not been notified of any medication changes since R51 has been admitted to the facility, has not had a care conference, has tried to reach the doctor with no success and was frustrated. FM-B stated he understands that R51 can be difficult but had not been notified of refusals of cares. FM-B stated R51 does not have a foley catheter. FM-B stated R51 transfers with staff assistance and does not need a Hoyer (medical device used to safely lift and transfer people with limited mobility). R51's January Medication and Treatment Administration Record (MAR/TAR), printed 2/11/25, identified the following orders that had changed since admission: -Celebrex (used to treat pain) 100 milligram (mg) capsule: give 1 capsule vial G-tube (a thin flexible tube inserted through a small incision in the abdomen and into the stomach) at bedtime for pain for 14 days with a start day of 1/13/25 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Quetiapine Fumarate (antipsychotic medication used to treat mood/mental health disease) tablet: give 6.25 mg by mouth every 6 hours as needed for anxiety, agitation with a start date of 1/14/25 and end date of 1/29/25 with a total of 3 administration during that time period. - Quetiapine Fumarate tablet: give 6.25 mg by mouth every 6 hours as needed for anxiety, agitation with a start date of 1/29/25. R51's February MAR/TAR, printed 2/12/25, identified the following orders that changed: -Buprenorphine HCL (opioid pain medication used to treat pain) sublingual tablet: give 2 mg sublingually one time a day for pain with a start day of 2/6/25 and discontinued on 2/9/25. Administered on 2/6/25 and 2/7/25, coded as a 6 for 2/8/25 and 2/9/25 indicating hospitalized . -Celebrex (used to treat pain) 100 milligram (mg) capsule: give 1 capsule vial G-tube (a thin flexible tube inserted through a small incision in the abdomen and into the stomach) at bedtime for pain for 14 days with a start day of 1/13/25 with an end date of 2/13/25 -D/C (discontinue) foley catheter completed on 2/10/25. - Quetiapine Fumarate tablet: give 6.25 mg by mouth every 6 hours as needed for anxiety, agitation with a start date of 1/29/25 and end date of 2/12/25. R51's Task Log for bathing, printed 2/12/25, was reviewed for the past 30 days (1/13/25 to 2/12/25) and indicated no data found. The document lacked indication that a shower/bath was offered, given, or refused. R51's progress notes, dated 1/13/25 to 2/12/25, were reviewed and identified the following: -On 1/15/25: spoke with resident husband, he is ok with moving rooms Progress notes lacked evidence of notification to POA of and medication changes, refusals of cares or changes to treatments (catheter). R51's care plan, printed 2/10/25, indicated the following: -ADL self care needs Fatigue with the following interventions: -BATHING/SHOWERING: The resident requires (SPECIFY what assistance) by (X) staff with bathing/showering weekly and as necessary. -BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. -The resident is resistive to care r/t Dementia with the following interventions: -Allow the resident to make decisions about treatment regime, to provide sense of control. -Give clear explanation of all care activities prior to an as they occur during each contact. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time. Praise the resident when behavior is appropriate. The care plan lacked evidence of showering or bathing preference. Furthermore, lacked evidence of interventions that have been successful and unsuccessful in the past. It lacks R51's preferences time of day and what care R51 is resistive to. R51's care sheet, printed 2/9/25, indicated the following: -Shower Saturday PM -Toilet: Incontinent, Assist of 1-2 staff, Frequent check and change, upon rising, before and after each meal, at bedtime, NOC rounds and as needed. Transfer: Assist of 2 staffs and walker/Hoyer and medium sling when not able to stand/weak The care sheet lacks R51's preferences of shower/bath/bed bath, time of day, interventions that have been successful with cares. R51's electronic medical record (EMR) lacked evidence of notification to POA/family of medication changes, refusals of cares and changes in treatment (use of catheter). On 2/10/25 at 6:09 p.m., nursing assistant (NA)-J indicated they are familiar with R51. NA-J indicated they use the care plan and care sheets to obtain information about the residents. On 2/10/25 at 6:20 p.m., NA-I indicated they are familiar with R51. NA-I indicated R51 transfers with a Hoyer lift, needs total assistance with all cares, and has a catheter. On 2/11/25 at 11:29 a.m., licensed practical nurse (LPN)-G indicated they are familiar with R51. LPN-G stated when a new medication was started or current medication changes, we let the resident know but we don't update the family. LPN-G indicated they do not call families prior to starting a medication even if a resident does not have the capacity to make the decision. LPN-G indicated they were unsure if R51 had a catheter prior to going to the hospital but it had been removed. LPN-G indicated they had not updated R51's family/POA. On 2/12/25 at 8:55 a.m., registered nurse (RN)-B stated R51 refuses her showers frequently. RN-B indicated this would be documented in a progress note. RN-B stated, we try to wash her up when we get her dressed. On 2/12/25 at 10:46 a.m., LPN-E indicated a residents POA may not be notified of medications unless they request to be notified. LPN-E indicated even if the resident did not have the capacity to make the decision about medication changes, the POA may not be notified. LPN-E indicated any notifications to the POA, or family would be documented in a progress note. LPN-E reviewed EMR and indicated notifications were not completed for medication changes, catheter or care refusals. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 3:17 p.m., director of nursing (DON) stated the families should be notified of medication changes and changes in condition or care. DON stated, it shouldn't be a surprise. A facility policy titled Change in a Resident's Condition or Status, dated 2/2021, indicated Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure an allegation of potential harm was reported to the State Agency (SA) in the required timeframe for 1 of 1 residents (R1) whose facility reported incident (FRI) was reviewed. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] identified R1 with 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 history of fractures. R1 also took diuretics (medicine that increases urine production and help lower blood pressure and fluid retention). R1's progress note (PN) dated 1/24/25 at 3:15 a.m., indicated R1 was sent to the hospital for decreasing oxygen saturations and wheezing noted to left upper lobe of lung. A FRI submitted to the SA on 1/24/25 at 7:45 p.m., by the director of nursing (DON) stated a medication was never clarified, therefore never provided to R1 during her long-term care stay at facility since 1/8/25, to hospitalization on [DATE]. The facility failed to submit their 5-day report which included sufficient information to describe the results of their investigation and indicate any corrective actions taken. During interview with facility administrator and new DON on 2/11/25 at 1:04 p.m., administrator stated the facility's previous administrator did not provide information regarding R1's FRI to the current administrator therefore she was unaware of what was done or not done regarding it. In addition, the administrator and DON recalled a discussion with previous DON who filed the FRI for R1 and admitted there was no 5-day report filed. Administrator stated the 5-day report was supposed to be submitted and was not. Facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022, state Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure a significant change in status Minimum Data Set (MDS) was completed in a timely manner after hospice services were initiated for 1 of 1 resident (R5) reviewed for hospice care. Findings include: The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, identified a comprehensive MDS assessment included completion of the MDS along with the corresponding Care Area Assessment (CAA) and subsequent care planning. The manual outlined such MDS(s) included admission, annual, significant change in status (SCSA), and significant correction to prior comprehensive MDS(s). A table was provided to demonstrate the time periods allowed for such assessments to be completed. This identified an SCSA should have a reference date established within 14 days of determining a significant change has occurred. Further, a section labeled, Significant Change in Status Assessment (SCSA), outlined such assessment must be completed when the interdisciplinary team (IDT) has determined a resident meets the criteria for a major improvement or decline adding, A SCSA is required to be performed with a terminally ill resident enrolls in a hospice program . The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election . A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. R5's MDS listing printed 2/10/25, did not indicate a SCSA had been initiated or completed despite R5 starting hospice care on 8/28/24. R5's hospice consent for treatment dated 8/28/24, included a hospice admitted [DATE]. R5's census listing printed 2/13/25, indicated R5's primary payer source became Hospice Medicaid on 8/28/24. During an interview on 2/12/25 at 11:25 a.m., registered nurse (RN)-A stated she was the MDS coordinator for the facility but started a couple of weeks ago. RN-A confirmed she had reviewed R5's medical record and stated a SCSA should have been completed within 14 days of hospice enrollment, but it looked like that had not happened. The facility Resident Assessment policy dated 3/22, indicated the resident assessment coordinator was responsible for ensuring the timely and appropriate resident assessments and the RAI manual could be used to find detailed information on timing and submission of assessments.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening and Resident Review (PASARR) was completed prior to admission for 2 of 2 residents (R6, R61). Findings include: R6's admission Minimum Data Set (MDS) dated [DATE], indicated R6 had intact cognition and was diagnosed with schizophrenia. R6's PASARR dated 1/10/25, indicated the PAS [PASARR] is not final until the lead agency sends the documentation to the nursing facility. R6's medical record was reviewed and lacked evidence a final determination had been received by the county or managed care program as directed by the PAS. During an interview on 2/13/25 at 9:14 a.m., licensed social worker (SS)-A confirmed she had reviewed R6's medical record and had not been able to find a completed PASARR for R6. SS-A stated she had now contacted the county to receive it but did not find evidence that had been attempted before she started a couple of weeks ago. 48065 R61's quarterly Minimum Data Set (MDS) dated [DATE] indicated R61 had severe cognitive impairment and was diagnosed with dementia. R61's medical record was reviewed and lacked evidence of a PASSAR final determination from the county or managed care program. During interview on 2/11/25 at 10:05 a.m., SS-A verified R61's medical record did not have a final PASSAR determination letter. SS-A stated she called the Senior Linkage, and was told R61 didn't need a final letter. During interview on 2/11/25 at 1:48 a.m., Senior Linkage representative (SL) reviewed R61's information in their system and stated the screen was done in July 2024, they [facility] should have a copy. Those were preliminary results. Our records indicate we sent a final letter to the facility. If they [facility] didn't receive it or didn't have it in the chart, they needed to contact us and get a copy of the letter to have the final decision. The final decision will either indicate she [R61] needed or not a Level II. SL representative stated she will fax the final letter to the facility. During interview on 2/13/25 at 1:38 p.m., administrator stated their new social services director had started to review all the residents' charts to make sure the necessary PASSAR documentation was updated. Administrator stated, We know we need to get those on admission or if there is a change in status. A policy regarding completation of PASSAR was requested but not received.

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate care was provided for 2 of 5 residents (R35 and R53) reviewed for comprehensive care plan. Findings include: R35 R35's quarterly Minimum Data Set (MDS) dated [DATE], indicated R35 had moderately impaired cognition and was independent with all activities of daily living (ADLs) except for showering/bathing which R35 required set up assistance from staff. R35's MDS indicated no hallucinations or delusion, no behaviors were present, and no rejection of care exhibited. R35's Oral/Dental Observation, dated 1/17/25, indicated no for dentures and had a note indicating resident has been going to dentist to have dentures made. During interview on 2/09/25 at 12:38 p.m., R35 stated that he had dentures and was getting used to them. R35 stated he has been getting sores in his mouth from them but has been working on getting them re-adjusted. R35's care plan, printed 2/9/25, identified the following: - ACTIVITES OF DAILY LIVING: ADL self-care needs with the following intervention: ORAL CARE: Remind resident to perform mouth care each shift and after meals. - ORAL/DENTAL: The resident has oral/dental health problems r/t [related to] edentulous (lacking teeth) status with the following interventions: - Coordinate arrangements for dental care, transportation as needed/as ordered. - Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted. - Monitor/document/report PRN [as needed] any s/sx of of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. R35's care plan lacked evidence of R35 having dentures. Furthermore, R35's care plan lacked evidence of needing continued support for readjustments for dentures. R35's care sheet, printed 2/9/25, indicated R35 was independent with most ADLs (activities of daily living) and assist per his request. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's care sheet lacked evidence of R35 having dentures. Review of R35's progress notes 10/1/24 thru 2/21/25 indicated the following: -1/22/25: pt. [patient] just got back from his dental appointment he got both lower and upper dentures, pt. demonstrates understanding on care for his denture. R35's progress notes lacked additional notes on follow up dental appointments. During interview on 2/09/25 at 10:39 a.m., nursing assistant (NA)-M stated they get residents' care needs information from the care sheets. During interview on 2/10/25 at 6:09 p.m., nursing assistant (NA)-J stated they use the care plan and care sheets to obtain information about the residents' care needs. During interview on 2/12/25 at 7:43 a.m., NA-A stated they are familiar with R35 and worked with him often. NA-A was unsure if R35 wore dentures. NA-A stated, I haven't noticed if he wears dentures. NA-A stated if a resident wore dentures, it would be on the care plan. During interview on 2/12/25 at 7:52 a.m., licensed practical nurse (LPN)-C stated they are familiar with R35. R35 wore dentures but did not wear them regularly. LPN-C stated was unsure the reason of why R35 did not wear them daily. If a resident wears dentures, whether they are independent or dependent with cares, it would be on the care plan. LPN-C stated they did not update the care plan, the nurse managers updated care plans. LPN-C reviewed R35's care plan and confirmed the care plan did not indicate R35 had dentures. During interview on 2/12/25 at 8:29 a.m., LPN-A stated R35 wore upper and lower dentures and had returned to the dentist for an adjustment. LPN-A stated they were responsible to update residents' care plans. LPN-A reviewed R35's care plan and confirmed R35's care plan did not indicate he wore dentures, and it should. LPN-A stated they were going to update the care plan. R53 R53's quarterly Minimum Data Set (MDS) assessment, dated 12/27/24, indicated R53 had severely impaired cognition with no hallucinations or delusions or behavioral symptoms. MDS indicated R53 required supervision for showering/bathing, set up for oral hygiene, toileting and personal hygiene (including shaving). Furthermore, MDS indicated no behaviors or rejection of care. R53's care plan, printed 2/9/25, identified the following: - BATHING/SHOWERING: The resident requires limited assist of one staff with bathing/showering weekly on Saturday mornings and as necessary. Resident prefers female caregiver, per spouse. Complete vitals and weight on shower days. - PERSONAL HYGIENE/ORAL CARE: The resident requires limited assist of one (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff with personal hygiene and oral care. Resident often refuses, prefers to complete tasks independently. Resident prefers female caregivers. - Encourage the resident to participate to the fullest extent possible with each interaction. R53's care plan lacked evidence of preference to have facial hair shaved and husband assisting with a shower weekly. R53's care sheet, printed 2/9/25, identified the following: -Shower: Saturday AM, prefer spouse to complete task -ADLS: Limited assist of 1 staff -Provide oral care R53's care sheet lacked evidence of preference to have facial hair shaved and plan for showering (husband and staff offering showers). R53's progress notes, dated 1/3/25 to 2/10/25, were reviewed. The progress notes lacked evidence of refusals of showers or cares. Furthermore, lacked notes of husband's assistance with showers. During observation on 2/10/25 at 12:45 p.m., R53 was ambulating with walker in the hallway. R53 had disheveled hair, appeared as though it was not combed as standing up in the back and on the side. R53 had chin hairs approximately half an inch long along with a mustache that was approximately the same length. Some of the hairs are longer. During observation on 2/11/25 at 8:40 a.m., R53 was in the dining room eating breakfast with other residents. R53's facial hair remained unchanged from previous observation along with hair appearing uncombed. During observation and interview on 2/11/25 at 10:30 a.m., family member (FM)-C stated R53 has an electric razor in the drawer and was unsure if staff assisted R53 with shaving. FM-C stated FM-C gives her a shower on Sunday's and staff does not assist with showers. R53 didn't like it when the razor didn't get the facial hair short enough. R53 stated she liked to be independent. She does prefer no facial hair. FM-C and R53 verified R53 had facial hair and preferred not to have facial hair. During interview on 2/10/25 at 6:09 p.m., nursing assistant (NA)-J stated they were familiar with R53 and verified working with R53. NA-J stated R53 needed stand by assistance for toileting needs, oral cares and personal hygiene. During interview on 2/10/25 at 6:20 p.m., NA-I confirmed they have worked with R53. NA-I stated R53 needed verbal reminders with cares and did not know of R53 refusing cares or assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/12/25 at 8:55 a.m., registered nurse (RN)-B stated if a resident refused a shower or cares, the nursing assistants were expected to notify the nurse and we reapproach. A progress note was to be put in the electronic medical record (EMR). RN-B stated R53 refused her showers and she wanted them done with her husband. RN-B expected shaving facial hair was done after a shower and when needed. During interview on 2/12/25 at 7:16 a.m., trained medication aide (TMA)-B confirmed they were familiar with R53 and worked with her often. TMA-B stated R53 did refuse cares at times. R53's family would help her. TMA-B stated if cares were refused, it was to be documented in the EMR. TMA-B stated shaving facial hair for females should be included with cares. During interview on 2/12/25 at 7:33 a.m., NA-H confirmed they were familiar with R53 and worked with her. NA-H stated they did not offer to shave female residents as they have a special person who shaves them. Furthermore, NA-H stated they have not offered to shave any facial hair for females. During interview on 2/12/25 at 10:52 a.m., licensed practical nurse manager (LPN)-E stated residents should be offered a shower weekly. LPN-E stated R53's husband assisted R53 with a shower but we should still offer a shower, and stated we schedule weekly skin checks to monitor a resident's skin for any changes during their showers. LPN-E was going to review R53's chart and care plan. During a follow up interview on 2/12/25 at 2:23 p.m., after LPN-E reviewed R53's EMR, LPN-E verified the last documented completed shower for R53 was on 1/18/25 and a shower was offered on 2/1/24 and 2/8/24 and documented as refused. LPN-E indicated R53's care plan did not include R53's husband assisted with a shower and indicated it should be on the care plan along with R53 preference to not have facial hair. During interview on 2/12/25 at 3:11 p.m., director of nursing (DON) stated she expected showers to be offered at least weekly by staff, if a family was providing showers, it would be in addition to the shower the staff offered and expected it to be on the care plan. DON stated the expectation would be to offer assistance to assist females with shaving facial hair if that was their preference. DON stated she expected if a resident had dentures, this would be on the care plan, even if the resident was independent. A facility titled policy Care Plans Comprehensive Person-Centered, dated 3/2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident and assessment of residents are ongoing, and care plan are revises as information about the residents and the residents' conditions change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and record review, the facility failed to ensure care conferences were conducted within 21 days of admission to the facility for 1 of 2 residents (R51) reviewed for care conferences. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated R51's admitted was 1/13/25. R51 had moderately impaired cognition without hallucinations or delusions present with no behaviors, rejection of care, or wandering present. R51 was dependent on staff for all activities of daily living (ADL's) including toileting, oral hygiene, personal hygiene, dressing, and bed mobility. R51's admission record, printed 2/12/25, identified FM-B as the contact. R51's progress notes, dated 1/13/25 thru 2/12/25, were reviewed. Progress notes lacked evidence of R51 having a care conference since admission on 1/13/24. Furthermore, lacked documentation of planning a care conference. R51's assessment tab in the electronic medical record (EMR), dated 2/12/25, were reviewed for a care conference note. Assessment for care conference lacked evidence of R51 having a care conference since admission on 1/13/25. During interview on 2/10/25 at 1:29 p.m., FM-B stated since R51 was at the facility there has not been a care conference. FM-B stated they asked about having one but had not heard anything. FM-B would like to have a care conference. Furthermore, FM-B stated I haven't gotten much communication from the facility. FM-B stated he was R51's POA. During interivew on 2/12/25 at 10:24 a.m., licensed practical nurse manager (LPN)-E stated an initial care conference was to be completed within the first 48 hours after admission. LPN-E stated social services set up the care conference. LPN-E stated they didn't think a care conference was done for R51 and requested follow up with social worker. During interivew on 2/12/25 at 11:37 a.m., director of social services (SS)-A stated care conferences were held within the first couple days of admission. SS-A stated, it does not appear as though there has been a care conference, and confirmed R51 admitted to the facility on [DATE]. SS-A requested to follow up. During follow up interview on 2/12/25 at 1:41 p.m., SS-A confirmed a care conference had not been completed for R51 since admission and should have been completed. SS-A added, I was not in this position when she first arrived. During interview on 2/12/25 at 3:14 p.m., director of nursing (DON) stated a care conference needed to be completed no later than 21 days after admission to the facility. A policy on care conferences was requested and not received.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49339 Based on observation, interview and record review, the facility failed to ensure routine personal hygiene assistance was provided to ensure abilities were maintained for 1 of 1 residents (R53) reviewed for activities of daily living (ADLs). Findings include: R53's quarterly Minimum Data Set (MDS) assessment, dated 12/27/24, indicated R53 had severely impaired cognition with no hallucinations,delusions or behavioral symptoms. MDS indicated R53 required supervision for showering/bathing, set up for oral hygiene, toileting and personal hygiene (including shaving). Furthermore, MDS indicated no behaviors or rejection of care. R53's care plan, printed 2/9/25, identified the following: - BATHING/SHOWERING: The resident requires limited assist of one staff with bathing/showering weekly on Saturday mornings and as necessary. Resident prefers female caregiver, per spouse. Complete vitals and weight on shower days. -PERSONAL HYGIENE/ORAL CARE: The resident requires limited assist of one staff with personal hygiene and oral care. Resident often refuses, prefers to complete tasks independently. Resident prefers female caregivers. -Encourage the resident to participate to the fullest extent possible with each interaction. R53's care plan lacked evidence of R53 needing assist with facial hair removal. R53's care sheet, printed 2/9/25, identified the following: -Shower: Saturday AM, prefer spouse to complete task -ADLS: Limited assist of 1 staff -Provide oral care R53's care sheet lacked evidence R53 needing assist with facial hair removal, and preference for female caregivers (as identified on care plan). R53's progress notes, dated 1/3/25 to 2/10/25, were reviewed. The progress notes lacked evidence of refusals of assistance with cares and/or showes. Furthermore, lacked notes of husband providing assistance with ADLs. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 2/10/25 at 12:45 p.m., R53 was observed ambulating with walker in the hallway. R53 was observed to have disheveled hair, appeared as though it was not combed as standing up in the back and on the side. R53 was observed to have chin hairs approximately half an inch long along with a mustache that was approximately the same length. Some of the hairs are longer. During an observation on 2/11/25 at 8:40 a.m., R53 was observed in the dining room eating breakfast with other residents. R53 was observed to continue to have a long facial hair (chin hair and mustache) and disheleved hair as hair appeared uncombed as it was standing up on the back of R53's head. During an observation and interview on 2/11/25 at 10:30 a.m FM-C stated R53 has an electric razor in the drawer. FM-C stated they were unsure if staff assisted R53 with shaving or provided R53 with the razor so R53 could shave her facial hair. FM-C stated he gives her a shower on Sunday's and staff does not assist with any showers. FM-C stated R53 doesn't like it when the razor doesn't get the facial hair short enough. R53 stated she likes to be independent. R53 indicated she prefers no facial hair. FM-C and R53 verified R53 had facial hair and preferred not to have facial hair. During an interview on 2/10/25 at 6:09 p.m., nursing assistant (NA)-J stated they are familiar with R53 and verified working with R53. NA-J indicated they need stand by assistance for toileting needs, oral cares and personal hygiene. NA-J stated they are not aware of R53 refusing assistance. NA-J stated if residents refuses cares and showers, you notify the nurse. During an interivew on 2/10/25 at 6:20 p.m., NA-I stated they have worked with R53. NA-I stated R53 needed verbal reminders, stand by assist and sometimes assist of 1 with cares Furthermore, NA-I was not awre of R53 refusing assistance. NA-I stated if a resident refused cares, you would notify the nurse. During interivew on 2/12/25 at 8:55 a.m., registered nurse (RN)-B stated if a resident refused cares or a shower, the nursing assistants notify the nurse and we reapproach. RN-B stated a progress note is put in the electronic medical record (EMR). RN-B stated R53 refused her showers and she wanted them done with her husband. RN-B indicated shaving facial hair would be done after a shower and when needed. During an interview on 2/12/25 at 7:16 a.m., trained medication aide (TMA)-B stated they are familiar with R53 and work with her often. TMA-B stated R53's will refuse cares at times. TMA-B stated R53's family comes and he'll help her. TMA-B stated if cares are refused, it is documented in the EMR by the nurse as the nurse was notified if residents refuse cares. TMA-B stated shaving facial hair for females should be included with cares. During an interivew on 2/12/25 at 7:33 a.m., NA-H stated they are familiar with R53 and work with her. NA-H stated they do not offer to shave females as they have a special person who shaves them. Furthermore, NA-H stated they have not offered to shave any facial hair for females. During an interivew on 2/12/25 at 10:52 a.m., licensed practical nurse manager (LPN)-E stated residents should be offered showers weekly along with a weekly skin check. LPN-E stated shaving of female facial hair was offered on shower days and as needed. LPN-E indicated R53's husband gives her a shower but we should still offer a shower. LPN-E was going to review R53's chart. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 2/12/25 at 2:23 p.m., after LPN-E reviewed R53's EMR, LPN-E verified the last documented completed shower for R53 was on 1/18/25. A shower was offered on 2/1/24 and 2/8/24 and documented as refused. LPN-E stated no reapproaches of cares or showers documented. Furthermore, LPN-E verified no documentation of showers being provided by R53's family. During an interivew on 2/12/25 at 3:11 p.m., director of nursing (DON) stated she would expect showers to be offered at least weekly. DON stated if a resident refuses a shower, this should be documented, and resident should be reapproached. DON stated it should be offered to female residents to shave facial hair or assist them in shaving facial hair on their shower days and as needed. A facility policy titled Activities of Daily Living (ADLs) Supporting, revision date 3/2018, indicated Residents will be provided with care, treatment and services as appropriate wot maintain or improve their ability to carry out activities of daily living (ADLs).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview and document review, the facility failed to ensure routine bathing, nail care, and grooming was provided for 5 of 5 residents (R173, R16, R43, R5 and R51). In addition, the facility failed to assist with hearing aids for 1 of 5 resident (R43) reviewed for activities of daily living (ADLs) for dependent residents. Findings include: R173 R173's entry tracking record Minimum Assessment Data (MDS) dated [DATE], indicated R173 was admitted on [DATE]. R173's Clinical Diagnosis report printed 2/10/25 indicated diagnoses of lumbar spinal stenosis with neurogenic claudication (narrowing of the spinal canal of the lower back pressuring the spinal cord causing pain, weakness), polyneuropathies (simultaneous malfunction of many peripheral nerves throughout the body), cerebral infarction (area of damaged tissue on the brain), left side weakness due to cerebral infarction, aphasia (language disorder that affects a person's ability to communicate), adjustment disorder with anxiety and depression. R173's ADLs care plan printed 2/10/25, indicated resident requires assistance with ADL's due to impaired mobility secondary to recent back surgery and left side residual weakness due to CVA [cerebral vascular accident]. Care plan interventions indicated R173 preferred showers and needed extensive assistance of two staff members with weekly showers given on Sunday afternoon and as necessary. R173's electronic medical record lacked documentation about receiving or refusing a shower since he was admitted to the facility. During interview on 2/11/25 at 9:31 a.m., R173 stated he had not received a shower since his admission to the facility on [DATE] in almost 2 weeks. R173 denied getting a sponge bath and added staff have not washed my back, legs, feet, hair, nothing. During interview on 2/11/25 at 12:41 p.m., LPN-C stated she didn't know how showers were assigned and verified the lack of documentation about R173 receiving a shower. During interview on 2/11/25 at 12:53 p.m., nurse manager, LPN-A stated the showers were assigned based on their room numbers and/or residents' preference. LPN-A state R173 should have a shower every Sunday. LPN-A verified bathing had not been assigned on POC (point of care, computer program used by staff to document ADLS, including bathing), and was not able to find documentation about R173 either receiving or refusing a shower. LPN-A added, it seems he hasn't had a shower. I can't understand how I missed that. I will have to fix it. During interview on 2/13/25 at 2:15 p.m., DON stated showers should be done weekly so people can feel clean and good about themselves. (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 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	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16 R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated R16 didn't have delusions, hallucinations and didn't refuse personal cares. MDS indicated R16 was dependent on staff for oral hygiene, toileting and putting socks and shoes on/off. MDS indicated R16 needed substantial assistance with bathing, dressing, and personal hygiene. R16's Clinical Diagnosis report printed on 2/10/25, indicated diagnoses of encephalopathy (brain dysfunction can appear as confusion, memory loss, personality changes and/or coma), history of malignant neoplasm of prostate (prostate cancer) and essential hypertension (abnormally high blood pressure that's not the result of a medical condition). R16's ADLs care plan indicated R16 needed assistance of 2 staff with showers and dressing. The care plan did not address R16's needs for grooming or nail care. During observation on 2/10/25 at 1:51 p.m., R16's pants had food stains on the legs, his fingernails were long, jagged and had black debris underneath. During observation on 2/12/25 at 11:44 a.m., R16 was in the TV room seated in his Broda chair (padded reclining wheelchair). R16's pants had small dry light beige crusted matter on both legs, and a 15 by 15-centimeter (cm) area on the pants' right leg. R16's fingernails were long and had black debris underneath. During observation and interview on 2/12/25 at 3:03 p.m., R16 was in the TV room seated in his Broda chair. R16 was awake and was wearing the same pair of stained pants observed at 11:44 a.m. Licensed practical nurse (LPN)-C stated his pants were dirty with what appeared to be dry oatmeal from breakfast. R16 was scratching his private parts with his right hand. LPN-C verified R16's fingernails were at least 1 cm long, were jagged, and had black debris underneath. LPN-C stated R16 needed to be changed so he was presentable and clean. LPN-C stated the nursing assistants were supposed to trim R16's nails on shower days. LPN-C added his [R16] nails are too long, jagged and he can scratch himself. During interview on 2/13/25 at 2:20 p.m., director of nursing (DON) stated long jagged fingernails was an infection control issue. DON stated long dirty nails and wearing dirty clothes were dignity issues. 49339 R5 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's significant change Minimum Data Set (MDS) assessment, dated 2/5/25, documented an admitted to the facility on [DATE]. The Section C-Cognitive Patterns, was not complete for either the resident assessment or staff assessment. MDS indicated no hallucinations or delusions, behavioral symptoms and had rejection of care that occurred 1 to 3 days during the look back period. R5 was dependent on staff activities of living (ADLs) including showering. R5's diagnoses included: adult failure to thrive, coronary artery disease (damage or disease in the heart's major blood vessels), hypertension (high blood pressure) diabetes (chronic disease where the body doesn't produce enough insulin or can't use insulin properly), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning), schizophrenia (a severe and lifeline brain disorder), and generalized weakness. R5's care plan, printed 2/9/25, identified the following: - ACTIVITIES OF DAILY LIVING: The resident has an ADL self-care performance deficit r/t Alzheimer's and weakness, with the following interventions: - DRESSING: The resident requires extensive assist of one staff for dressing. - PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist of one staff for personal hygiene/oral care. - Encourage the resident to participate to the fullest extent possible with each interaction. -BATHING/SHOWERING: The resident requires extensive assist of one staff with bathing/showering. Check vital signs weekly every Monday morning. The care plan lacked identification R5 refusing/declining cares, preference of shower, bath or bed bath. Furthermore, care plan lacked interventions that have been attempted. R5's care sheet, printed 2/9/25, identified the following: -Shower: Monday AM -ADLs: Assist of 1 staff -Toilet: Assist of 1 staff, Frequent check and change, upon rising, before and after each meal, at bedtime, NOC round and as needed. -Transfer: Assist of 1 with 4 wheeled walker -Ambulation: Assist of 1 staff -Provide oral care -Offer repositioning every 2-3 hours -Hospice (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care sheet lacked identification of R5 refusing/declining showers, preference of bed bath/bath or shower, approaches that have been attempted. R5's Task Log for bathing, printed 2/11/25, report for the past 30 days (1/12/25 to 2/11/25) indicated the following: -1/14/25: activity itself did not occur -1/17/25: activity itself did not occur R5's task log for bathing lacked evidence of a shower/bed bath/bath being offered, completed or refused in the past 30 days. During an observation on 2/09/25 at 9:54 a.m., R5 was observed in bed with hospital gown on and appeared to have greasy, uncombed hair. During an observation on 2/09/25 at 3:10 p.m., R5 was observed lying in bed with hospital gown on and R5's hair appeared to be greasy and uncombed. R5 declined to talk as R5 pulled the blanket over her head. During an observation on 2/10/25 at 12:34 p.m., R5 was observed in bed with eyes closed. R5 does not respond when talked to and closed her eyes tighter. R5's hair appeared to be uncombed and greasy. During an observation on 2/10/25 at 5:46 p.m., R5 was observed in bed and R5's hair continued to appear greasy and uncombed. During an observation on 2/11/25 at 8:38 a.m., R5 was observed lying in bed with a hospital gown on. R5 pulls the blankets up over her head when spoken with and declined to engage. R5's hair continued to appear greasy and disheveled. During an interview on 2/10/25 at 6:09 p.m., nursing assistant (NA)-J indicated they were familiar with R5. NA-J stated they use the care plan and care sheets to know resident preferences and the assistance they need. During an interview on 2/12/25 at 7:18 a.m., trained medication aid (TMA)-B indicated they were familiar with R5. TMA-B indicated, (R5) fights when you try to give to give her a shower and stated, don't know for sure the last time she got one. During an interview on 2/12/25 at 7:33 a.m., NA-H stated they were familiar with R5 and were working with R5. NA-H stated they use the care sheets and care plan to know what residents need. NA-H stated R5 was dependent on staff for ADLs. NA-H stated, we just change her, wipe her, monitor her and watch her eat, and stated they have not given R5 a shower or bed bath. On 2/12/25 at 8:55 a.m., registered nurse (RN)-B stated if a resident refuses a shower, it would be documented in a progress note. RN-B indicated R5 refuses showers but did get one about 2 weeks ago. RN-B stated, R5 probably hasn't had one since. RN-B verified R5 was dependent on staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 9:25 a.m., registered nurse (RN)-C stated they recently started working with R5. RN-C indicated they are in the process of getting to know R5 and were unsure of R5's preferences. RN-C indicated they heard that R5 had a history of refusing assistance. RN-C stated R5 does not get services from a hospice aid due to refusal of cares. On 2/12/25 at 2:21 p.m., licensed practical nurse manager (LPN)-E stated residents receive showers weekly along with a skin check to monitor skin for any changes. LPN-E reviewed R5's electronic medical record (EMR). LPN-E indicated R5's EMR lacked evidence of R5 having a shower/bath/bed bath in the last 30 days. Furthermore, LPN-E stated R5's EMR lacked evidence of documentation of any refusals of showers. R51 R51's admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated R51's admitted was 1/13/25. R51 had moderately impaired cognition without hallucinations or delusions present with no behaviors, or rejection of care. R51 was dependent on staff for all activities of daily living (ADL's) including showering. Furthermore, R51 was incontinent of bowel and bladder. R51's admission record, printed 2/12/25, included the following pertinent diagnoses: Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain tissue to die), and epilepsy (seizure disorder). During observation and interview on 2/10/25 at 12:38 p.m., R51 was observed seated in a Broda chair (a type of positioning chair) in the common area. R51 stated she was terrible, but was unable to elaborate. R51 was sipping on ice water. R51's hair was matted in back and appeared greasy. R51 did repeat self with responses that did not make sense. R51's Task Log for bathing, printed 2/12/25, was reviewed for the past 30 days (1/13/25 to 2/12/25) and indicated no data found. The document lacked indication a shower/bath was offered, given or refused. R51's progress notes, dated 1/13/25 to 2/12/25, were reviewed. Progress notes lacked evidence of refusals of showers or cares. R51's care plan, printed 2/10/25, indicated the following: -ADL self care needs Fatigue with the following interventions: -BATHING/SHOWERING: The resident requires (SPECIFY what assistance) by (X) staff with bathing/showering weekly and as necessary. -BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. -The resident is resistive to care r/t Dementia with the following interventions: -Allow the resident to make decisions about treatment regime, to provide sense of control. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Give clear explanation of all care activities prior to an as they occur during each contact. -If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time. Praise the resident when behavior is appropriate. The care plan lacked evidence of showering or bathing preference. Furthermore, lacked evidence of interventions that have been successful and unsuccessful in the past. It lacks R51's preferences time of day and what care R51 was resistive to. R51's care sheet, printed 2/9/25, indicated the following: -Shower Saturday PM -Toilet: Incontinent, Assist of 1-2 staff, Frequent check and change, upon rising, before and after each meal, at bedtime, NOC rounds and as needed. The care sheet lacks R51's preferences of shower/bath/bed bath, time of day, interventions that have been successful with cares. During an interview on 2/12/25 at 8:55 a.m., registered nurse (RN)-B stated R51 refused her showers frequently. RN-B indicated refusals would be documented in a progress note. RN-B stated, we try to wash her up when we get her dressed. Furthermore, RN-B indicated R51 gets washed up when she is incontinent. During an interview on 2/12/25 at 7:15 a.m., trained medication aid (TMA)-B stated when R51 gets dressed, we try to wash her up. TMA-B stated this would be incontinent cares (washing of the peri-area after a person was incontinent of bowel or bladder). Incontinent cares do not include washing of a resident's hair. TMA-B stated she will refuse showers. TMA-B stated, if a resident refused a shower, then you notify the nurse. During an interview on 2/12/25 at 7:30 a.m., nursing assistant (NA)-H stated R51 refused her shower the last time NA-H offered her a shower and cannot recall when that was. NA-H stated they have never offered her a bed bath instead of a shower. NA-H stated they notified the nurse. During an interview on 2/12/25 at 2:19 p.m., licensed practical nurse manager (LPN)-E indicated R51's shower day is on Friday's. LPN-E indicated a shower was not offered last Friday since R51 was in the hospital. LPN-E reviewed R51's EMR. LPN-E indicated the medical record lacks evidence that a shower/bed bath/bath was offered, completed or refused to/by R51 in the past 30 days. LPN-E indicated residents should be offered showers weekly. Furthermore, LPN-E stated the expectation was a weekly skin check was to be completed on shower days to assess the skin for any changes or concerns. On 2/12/25 at 3:11 p.m., director of nursing (DON) stated it was expected that residents are offered showers at least weekly, refusals are documents and residents are reapproached. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Activities of Daily Living (ADLs), Supporting policy dated 11/2022, indicated staff would provide assistance to residents based on their plan of care including bathing, dressing, grooming, and any function communication devices. The policy indicated if a resident with a cognitive impairment or dementia resist care, staff would attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. The staff are then to approach the resident in a different way, a different time, or have another staff member speak with the resident. 49034 R43 R43's quarterly MDS dated [DATE], indicated R43 had severely impaired cognition and had no rejection of care behaviors. R43's care plan dated 6/13/24, indicated R43 required extensive assistance of one person with bathing and dressing and limited assistance of one person with personal hygiene. The care plan did not indicate R43 had a history of refusing baths or correlating interventions to reduce bathing refusals. The care plan indicated R43 had a hearing deficit, and staff were to ensure R43 wore her hearing aids daily. R43's Follow Up Question report dated 1/1/25 through 2/10/25, indicated R43 refused her bath on 1/14/25 and 2/4/25 with no further bathing documentation on the report. R43's bath audit dated: - 1/6/25, asked Is this resident resistive to bathing? with the answer no. The report then indicated R43 had refused bathing, and it was offered to be rescheduled. - 1/7/25, asked Is this resident resistive to bathing? with the answer yes. The report then indicated R43 had refused bathing, and it was offered to be rescheduled. - 1/27/25, asked Is this resident resistive to bathing? with the answer yes. The report then indicated R43 had not refused bathing but indicated no bath/shower was received. - 1/28/25, asked Is this resident resistive to bathing with the answer yes. The report indicated that R43 had received a shower during the shift. R43's medical record was reviewed and no documentation if R43 was offered a bath/shower or refusals between 1/8/25 and 1/26/25. R43's provider note dated 1/16/25, indicated R43 was diagnosed with Alzheimer's dementia and remained appropriate to reside on the memory care unit. During an observation on 2/9/25 at 10:09 a.m., R43 was observed with no hearing aids, hair greasy, and white/grey hairs growing from her chin, mostly about 1/4 inch long with some hairs as long as 1/2 inch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/11/25 at 9:29 a.m., R43 was observed with no hearing aids, hair greasy, and white/grey hairs growing from her chin, mostly about 1/4 inch long with some hairs as long as 1/2 inch. When asked about her hearing aids, R43 stated, It is terrible to not have them. During the interview, R43 interrupted multiple times to state, I can't hear you. R43 stated No woman ever wants that when referring to the hair on her chin. During an interview on 2/11/25 at 10:08 a.m., nursing assistant (NA)-G stated she assisted R43 in completing her ADLs this morning. NA-G stated she had not noticed the hairs on R43's chin but they were supposed to assist the resident with shaving on bath days. NA-G stated R43 refused showers in the past the first time she was asked, but she does have dementia so normally when reapproached R43 will say yes to a shower, but she was unsure if other NA's knew that. NA-G stated she had not applied R43's hearing aids today because R43 had a history of taking them out and leaving them places. During an interview on 2/12/25 at 9:37 a.m., licensed practical nurse (LPN)-E, the second-floor nurse manager, stated she expected nursing staff to offer R43 bathes at least weekly and if R43 refused they should reapproach later. If R43 still refused bathing, they should reschedule the bath and document the refusals. LPN-E stated she did not think R43 had a history of refusing baths but if she did, she expected the floor staff to notify her of this so it could be further investigated, and a plan could be made to reduce this. LPN-E confirmed shaving should be offered weekly and as needed, if need was observed during daily cares. LPN-E stated she expected nursing staff to apply residents' hearing aids even if they had a history of losing them. The facility's Activities of Daily Living (ADLs), Supporting policy dated 11/2022, indicated staff would provide assistances to residents based on their plan of care including bathing, dressing, grooming, and any function communication devices. The policy indicated if a resident with a cognitive impairment or dementia resist care, staff would attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. The staff are then to approach the resident in a different way, a different time, or have another staff member speak with the resident.

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide activities to meet all resident's needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48065

Based on observation, interview and document review, the facility failed to ensure activities of interest were offered or provided to enhance quality of life for 4 of 4 residents (R10, R16, R5 and R51) reviewed for activities.

Findings include:

R10

R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 had no delusions, no behaviors and didn't refuse cares. MDS indicated, R10 needed max assistance with oral hygiene, eating, upper body and lower body dressing, putting on/off socks/shoes. MDS also indicated, R10 was dependent for transfers, bathing, and to propel his wheelchair.

R10's Clinical Diagnoses report printed 2/13/25, indicated diagnoses of multiple sclerosis with cerebral atrophy (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), essential hypertension (abnormally high blood pressure that's not the result of a medical condition), idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause cannot be determined) , and peripheral vascular disease(circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).

R10's Activity Interview for Daily and Activity Preferences dated 9/18/24, indicated R10 or a family member were not interviewed to determine R10's daily activities preferences. The summary of preferences for customary routine and activities reads: R10 doesn't talk but likes to eat. Needs help with everything.

R10's Activities Care Plan printed 2/13/25, indicated resident was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits, immobility and physical limitations. Care plan interventions indicated, resident preferred activities which do not involve overly demanding cognitive tasks. Intervention also directed staff to engage R10 in simple cognitive activities, music, religious events, and movies. Care plan also directed staff to escort resident to and from activities.

During observation on 2/10/25 at 4:46 p.m., R10 was in the hallway, close to the dining room, there were no other residents or staff members nearby. R10 was sitting in his Broda chair (a padded reclining chair), looking around, and was fidgeting with a blanket.

During observation on 2/10/25 at 5:29 p.m., R10 was in the television (TV) room seated in his Broda chair. R10 was awake, alone and his eyes wandered, looking around the room.

During observation on 2/11/25 at 12:42 p.m., R10 was in the TV room, and was sleeping, seated in his Broda chair. There was another resident sleeping in their Broda chair while the TV was on.

During observation on 2/11/25 at 12:59 p.m., R10 was sleeping in his Broda chair in the TV room.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 2/12/25 at 9:35 a.m., R10 was in the TV room, sleeping in his Broda chair. During observation on 2/13/25 at 10:10 a.m., R10 was sleeping in his Broda chair in the TV room. During interview on 1/13/25 at 9:39 a.m., the director of activities (A)-A stated she started to work in this position a month ago. A-A stated she had not assessed R10 and was not sure when she needed to do assessments or review care plans. A-A verified R10's records lacked documentation regarding participation in activities. A-A added, she didn't know if R10 participated in activities. A-A stated residents should get out of their rooms and learn new stuff because it was important for socialization. A-A added, I need to read my job description and work with the administrator to become more familiar with my job. R16 R16's quarterly Minimum Data Set (MDS) dated [DATE] indicated R16 didn't have delusions, hallucinations and didn't refuse personal cares. MDS indicated R16 was dependent to propel his Broda chair and be escorted to and from activities. R16's Clinical Diagnosis report printed on 2/10/25, indicated diagnoses of encephalopathy (brain dysfunction can appear as confusion, memory loss, personality changes and/or coma), history of malignant neoplasm of prostate (prostate cancer) and essential hypertension (abnormally high blood pressure that's not the result of a medical condition). R16's Activities care plan printed on 2/10/25, indicated resident had little activity involvement related to failure to thrive, cancer, and hospice. Care plan interventions directed staff to encourage R16's family members to attend activities with resident to support participation. The care plan also indicated, resident prefers leisure activities as TV, music, and pet visits. R16's Communication care plan printed on 2/10/25 indicated R16 was cognitively impaired. R16's POC (Plan of Care is a computer program used by staff to document various tasks, including activities) 30-day report from 1/12 to 2/12, had 3 entries. One of them indicated resident was not available and the other two entries were documented on 2/12/25. The entries on 2/12/25 at 2:59 p.m. were for crafts and group activity. R16's Activities Interview for Daily and Activity Preferences dated 9/23/24, indicated R16 was interviewed, and he only responded to one question. The Summary of this interview reads: Unable to fully talk on its own. Needs help with bathing, changing, eating and travel places. During observation on 2/10/25 at 1:51 p.m. R16 was in the TV room, seated in his Broda chair. R16 was awake, fidgeting in his chair and was by himself. During observation on 2/11/25 at 9:16 a.m., R16 was in the TV room, sleeping in his Broda chair which was reclined to about 65 degrees. During observation on 2/11/25 at 11:27 a.m., R16 was in the TV room and his Broda chair was in the same position observed at 9:16 a.m., R16 was awake, the TV was on, but he was not watching it and was by himself. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 2/11/25 at 12:20 p.m., R16 was in the dining room seated at a table by himself and eating without the help of a staff member. When asked if he liked his food, he said It's delicious. During observation and interview on 2/12/25 at 11:44 a.m., R16 was in the TV room, he was awake and seated by himself. The television was on, but resident was not watching the TV. Licensed practical nurse (LPN)-C stated R10 usually was in the TV room or dining room. LPN-C stated she had not seen an activities program provided to residents on the unit for a while. During observation on 2/12/25 at 3:16 p.m., R16 was in the TV room, sleeping in his Broda chair. During interview on 2/13/25 at 9:54 a.m., A-A stated she met with R16, but he doesn't like to talk. A-A stated she needed to review R16's documentation and assess him. A-A verified her staff had documented two activities within the last 30 days. A-A stated I would like residents to get out of their rooms to join activities and have fun. We need to start doing more activities. During interview on 2/13/25 at 2:16 p.m., director of nursing (DON) stated residents' activities preferences should be assessed and provide them with something to do to enhance their quality of life. A facility policy regarding Recreational Activities was requested, but not received. 49339 R5 R5's significant change Minimum Data Set (MDS) assessment, dated 2/5/25, documented an admitted to the facility on [DATE]. The Section C-Cognitive Patterns, was not complete for either the resident assessment or staff assessment. MDS indicated no hallucinations or delusions, behavioral symptoms and had rejection of care that occurred 1 to 3 days during the look back period. R5 was dependent on staff activities of living (ADLs) including toileting, showering, dressing, personal hygiene, bed mobility, and transfers. R5's diagnoses included: adult failure to thrive, coronary artery disease (damage or disease in the heart's major blood vessels), hypertension (high blood pressure) diabetes (chronic disease where the body doesn't produce enough insulin or can't use insulin properly), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of thinking and social symptoms that interferes with daily functioning), schizophrenia (a severe and lifeline brain disorder), and generalized weakness. R5's care plan, printed 2/9/25, identified the following: -ACTIVITIES: The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) Cognitive deficits with the following interventions: -Invite the resident to scheduled activities. -The resident's preferred activities are book reading, puzzle 1:1, musical programs and 1;1 interaction including planned programs and in room activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-ACTIVITES: The resident has impaired physical mobility r/t weakness with the following intervention: -ACTIVITIES: Invite The resident to activity programs that encourage physical activity, physical mobility, such as exercise group to promote mobility. -COGNITION: The resident has impaired cognitive function or impaired thought processes r/t Alzheimer's disease. The care plan lacked identification on the plan to meet R5's activity/social needs. R5's care sheet, printed 2/9/25, identified the following: -Transfer: Assist of 1 with 4 wheeled walker -Ambulation: Assist of 1 staff The care sheet lacked identification of R5's preference of activities, need for assistance to activities or offering 1:1 activity in room. During observation on 2/09/25 at 9:54 a.m., R5 was observed in bed. R5's room was quiet, no music or TV playing. During observation on 2/09/25 at 3:10 p.m., R5 was observed to be lying in bed with hospital gown on. R5 declined to talk as R5 pulled the blanket over her head. R5's room was quiet, no music or TV playing. During observation on 2/10/25 at 12:34 p.m., R5 was observed in bed with eyes closed. R5's lunch tray was uncovered and in front of her on tray table and appears on touched. R5 does not respond when talked to and closed her eyes tighter. R5's room was quiet, no music or TV playing. During observation on 2/10/25 at 5:46 p.m., R5 was observed in bed with a tray of food in front of her that appears untouched. R5's room was quiet, no music or TV playing. During observation on 2/11/25 at 8:38 a.m., R5 was observed lying in bed and pulled the blankets up over her head when spoken with. R5's room was quiet, no music or TV playing. During observation on 2/11/25 at 1:15 p.m., R5 was observed lying in bed with head of bed elevated with unidentified staff sitting in chair by the bed. Unidentified staff was not interactioning with R5. R5 was observed to be eating. R5's room was quiet, no music or TV playing. During interview on 2/10/25 at 6:09 p.m., nursing assistant (NA)-J stated they were familiar with R5. NA-J stated they use the care plan and care sheets to know a resident's preferences and the assistance they need. NA-J stated R5 doesn't like to get out of bed and was not sure of activities R5 enjoyed or participated in. NA-J stated R5 was in bed majority of the time. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/12/25 at 7:33 a.m., NA-H stated they were working with R5. NA-H stated they use the care sheets and care plan to know what residents need. NA-H stated R5 was dependent on staff for ADLs. During a follow up interview on 2/12/25 at 7:33 a.m., NA-H stated, I don't know any activities, that R5 enjoyed or participated in. Furthermore, NA-H stated, We just change her and wipe her, monitor her and watch her eat. NA-H stated R5 was in bed all day. NA-H did not respond when asked about activities in R5's room. During interview on 2/12/25 at 8:55 a.m., registered nurse (RN)-B stated they attempts have been made to get R5 out of bed. RN-B stated R5 doesn't get out of bed and was not sure of any activities that R5 participated in or was offered. During an interview on 2/12/25 at 2:19 p.m., LPN-E reviewed R5's activity log and verified it lacked documentation of any activities offered in the last 30 days. LPN-E stated they could not verify activities were offered to R5. R51 R51's admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated R51's admitted was 1/13/25. R51 had moderately impaired cognition without hallucinations or delusions present with no behaviors. R51 was dependent on staff for all activities of daily living (ADL's). R51's admission record, printed 2/12/25, indicated diagnoses included: Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain tissue to die), and epilepsy (seizure disorder). During interview and observation on 2/10/25 at 12:38 p.m., R51 was observed sitting in a Broda chair (a type of positioning chair) in the common area. R51 stated she was terrible, but was unable to elaborate. R51 was sipping on ice water. During observation on 2/10/25 at 4:42 p.m., R51 was observed lying in bed with the lights off, no tv on. R51's Task Log for activities, printed 2/12/25, report for last 14 day (1/29/25 to 2/12/25) indicated no data found. During an interview on 2/10/25 at 6:20 p.m., NA-I stated they use the care sheets and care plan for resident preferences. NA-I stated the activities department did the activities with the residents and was unsure what activities R51 participates in. During an interview on 2/12/25 at 7:30 a.m., NA-H stated R51 likes to chew on ice for an activity or sometimes we bring her out to watch tv. NA-H stated they are unaware of what R51's preferences are for activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 8:55 a.m., RN-B stated R51 liked to watch the news so we give her the remote. RN-B stated they are unaware of other activities R51 enjoys. During an interview on 2/12/25 at 2:19 p.m., LPN-E reviewed R51's activity log and verified it lacked documentation of activities offered in the last 30 days. LPN-E stated they could not verify activities were offered to R51. During an interview on 2/12/25 at 11:51 a.m., director of activities (A)-A stated all activities were documented in the electronic medical record (EMR) in the activities task log. A-A reviewed R5 and R51's EMR for documentation of activities in the last 30 days. A-A indicated even if a resident refused to attend an activity, it is documented. A-A indicated there was not documentation for activities for R5 and R51. A-A was going to look for documentation and follow up. No documentation was provided of attendance to activities or activities offered. During an interview on 2/12/25 at 3:09 p.m., director of nursing (DON) stated it was expected that residents are being offered activities, preferences of activities are documented, and if residents decline activities, it was documented. A facility policy titled Dignity, dated 11/2022, indicated resident are supported in exercising their resident residents are encouraged to attend activities of their choice, including religious, political, civic, recreations, or social activities.

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

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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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49339

Based on observation, interview and record review the facility failed to properly review and follow up on discharge orders in a timely manner for a resident who relied on nutritional support via gastronomy tube (G-tube: a thin flexible tube inserted through the abdomen and into the stomach) following hospitalization for 1 of 1 resident (R51) reviewed for quality of care. In addition, the facility failed to timely initiate heart failure management orders and to monitor daily weights as ordered for 1 or 1 resident (R15) reviewed for edema.

Findings Include:

R51's admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated R51's admitted was 1/13/25. R51 had moderately impaired cognition without hallucinations or delusions present with no behaviors, or rejection of care present. R51 was dependent on staff for all activities of daily living (ADL's). Furthermore, Section K: Swallowing/Nutritional Status identified R51 had a feeding tube and recieved more thant 51% of total calories through tube feeding.

R51's admission record, printed 2/12/25, identified FM-B as the contact. Pertinent diagnoses included: Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain tissue to die), and epilepsy (seizure disorder).

During interview and observation on 2/10/25 at 12:38 p.m., R51 was observed sitting in a Broda chair (a type of positioning chair) in the common area. R51 stated she was terrible, but was unable to elaborate. R51 was sipping on ice water. R51's hair was matted in back and appeared greasy. R51 ddid repeat self and responsed with answers that do not make sense.

During interview on 2/10/25 at 12:54 p.m., FM-B stated he went to visit R51 on 2/6/25 and found R51 almost dead. FM-B stated he notified nursing staff and R51 was transferred to the hospital after I had to nudge them to get her vitals and call 911. FM-B stated they are the representative/power of attorney (POA) for R51 as R51 cannot make decisions. Furthermore, FM-B indicated I haven't gotten much communication from the facility. FM-B stated R51 has had a feeding tube for a long time and relies on it for nutrition and can have food by mouth for comfort.

R51's hospital discharge paperwork, dated 2/9/25, indentified the following:

-resident was hospitalized from 2/7/25 to 2/9/25 for pneumonia suspected bacterial and acute hypoxic respiratory failure

Orders:

-d/c buprenorphine

-diet pureed/thin liquids

(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The discharge paperwork lacked orders for tube feeding orders or catheter orders. R51's care plan, printed 2/10/25, identified the following: -The resident requires tube feeding r/t Dysphagia; severed esophageal stricture with the following interventions: -The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. -The resident needs the HOB elevated 30-45 degrees during and thirty minutes after tube feed. -Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than specified in orders -Provide local care to G-Tube site as ordered and monitor for s/sx of infection. -RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. R51's care sheet, printed 2/9/25, identified the following: -Diet: G-tube The care sheet lacked evidence R51 was able to have food orally. R51's progress notes, dated 1/13/25 to 2/12/25 were reviewed and identified the following: -2/11/25 at 9 p.m. new order received from provider, ordered entered and dietician notified -2/11/25 at 6:13 p.m. provider and dietician notified about residents' oral order being in addition to previous enteral feeding order and enteral feeding starting today. -2/10/25 at 8 p.m. received a call from hospital provider who gave telephone order to d/c catheter and informed writer that oral diet is in addition to current enteral feeding. -2/10/25 at 11:02 a.m. resident retuned from hospital with foley catheter in place and no information hospital d/c summary about it, call placed to hospital regarding catheter and diet order, awaiting call back from provider. -2/9/25 at 11:55 p.m. res fed in bed by mouth per order, ate 50% with 320cc (cubic centimeter) of fluids (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/9/25 at 1:17 p.m. resident returned from hospital stay. She was diagnosed with acute respiratory failure and Pneumonia, suspected bacterial. She has an order for pureed diet. Dietary is aware. Skin assessment is completed. There are no new areas of concern. The resident has no new orders. R51's February Medication Administration Record (MAR/TAR), printed 2/12/25, identified the following orders that changed in relation to nutritional supplements: -Enteral Feed Order one time a day Formula Isosource 1.5 Route of nutrition: G-tube 1.5 carton 325 ml flush with 60cc before and after feeding Bolus gravity bag feeding -Start date of 1/29/25 d/c'd 2/09/025: to be administered at 4 p.m. -Enteral Feed Order one time a day Formula: Isosource 1.5 Route of nutrition support: G-tube 1 carton 250 ml, flush with 60cc before and after feeding Bolus gravity bag feeding -Start date of 1/29/25 d/c'd 2/09/25: to be administered at 8 a.m. -Enteral Feed Order one time a day Formula: Isosource 1.5 Route of nutrition support: G-tube 1 carton 250 ml, flush with 60cc before and after feeding Bolus gravity bag feeding -Start date of 1/29/25 d/c'd 2/09/25: to be administered at 12 p.m. -Enteral Feed Order one time a day Formula: Isosource 1.5 Route of nutrition support: G-tube 1 carton 250 ml, flush with 60cc before and after feeding Bolus gravity bag feeding. Start Date 1/29/25 D/C'd 02/09/25: to be administered at 8 p.m. - Enteral Feed Order one time a day Offer oral intake first. If patient eats LESS than 50% of breakfast, then give 1 can of Isosource 1.5 bolus. Flush 30 mL water before and after feedings. Start date 2/12/25: to be administered at 8:30 a.m. - Enteral Feed Order one time a day Offer oral intake first. If patient eats LESS than 50% of breakfast, then give 1 can of Isosource 1.5 bolus. Flush 30 mL water before and after feedings. Start date 2/12/25: to be administered at 5:30 p.m. - Enteral Feed Order one time a day Offer oral intake first. If patient eats LESS than 50% of breakfast, then give 1 can of Isosource 1.5 bolus. Flush 30 mL water before and after feedings. Start date 2/12/25: to be administered at 12:30 p.m. During an interview on 2/11/25 at 12:53 p.m. registered dietician (RD)-A stated they complete residents' nutritional admission, quarterly, annual and change of condition assessments in relation to their nutrional needs. RD-A stated they keep a list of high risk residents to monitor closely and stated R51 was on the list due to R51's reliance on tube feeding. RD-A stated they were not notified of R51's recent hospitalization and stated they were working on a new process to increase communication with the facility. Furthermore, RD-A stated prior to R51's hospitalization , R51 was 100% dependent on tube feeding for nutritional needs. RD-A reviewed R51's chart and stated currently there are no orders for tube feedings, an order for an oral diet and water flushes for G-tube. RD-A stated typically a person that was 100% reliant on tube feedings does not get them discontinued totally. RD-A stated the discharge paperwork was not in R51's electronic medical record for them to review. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 2:07 p.m., registered nurse (RN)-B stated R51 currently has a G-tube. RN-B stated currently was only an order for water flushes and R51 was not receiving any nutritional support through R5's G-tube. RN-B indicated prior to going to the hospital, R51 did not take any food by mouth and relied solely on her tube feeding for nutritional intake. RN-B stated she had not provided any nutritional supplement to R51 since returning from the hospital through her G-tube. During an interview on 2/12/25 at 10:25 a.m., licensed practical nurse manager (LPN)-E stated when a resident returned from the hospital, the process was to review the orders as soon as possible and get clarification if needed. LPN-E it was important to be process orders as efficient and fast as able, but a nurse may have to pass it on to the next shift. LPN-E indicated R51 came back from the hospital on 2/9/25 with a catheter that R51 previously did not have and did not have any orders for care of the catheter. LPN-E stated R51 returned with orders for a pureed diet but did not have orders for tube feedings via G-tube. LPN-E stated R51 was reliant solely on tube feedings prior to hospitalization and did not get any nutrition by mouth. LPN-E stated on 2/10/24, the hospital provider was called for clarification on the orders and received an order to discontinue the catheter and recieved clarification the orders for the pureed diet were to be in addition to the tube feedings. LPN-E verified an order for tube feeding was not started until 2/12/25 (2 days after clarification was recieved), and R51 went without tube feedings, which was her main source of nutrition, for over 2 days. LPN-E stated R51 was offered food via mouth since returning and reviewed documentation. During an interivew on 2/12/25 at 11:04 a.m., nurse practitioner (NP)-A stated they were notified of R51's recent hospitalization . NP-A stated they were asked for clarification regarding the tube feeding on 2/11/25 and notified that R51 had not been receiving the tube feedings since returning to the facility. NP-A stated, I am not concerned about it, as she is eating something by mouth, she has also gained 5 pounds since admission to the facility. During an interivew on 2/12/25 at 3:10 p.m., director of nursing (DON) stated the expectation would be orders are clarified fast as possible. DON expressed the importance of the accuracy of orders. 49877 R15 R15's admission Minimum Data set (MDS) dated [DATE], identified R15 was admitted to the facility on [DATE], cognitively intact, had no rejection of cares, was dependent on staff for transfers, and diagnoses included heart failure, hypertension, and depression. R15's diagnosis report printed 2/13/25, identified primary diagnosis on admission was acute on chronic right heart failure. R15's order summary reported printed on 2/12/25, identified daily weights starting on 1/30/25 and contact provider if weekly weights increase more than 5 pounds starting on 12/30/24. Orders lacked assessment of lung sounds, peripheral edema, and respiratory effort. R15's treatment administration record (TAR) dated 1/25 to 2/10/25, identified daily weights were not recorded on 1/31/25, 2/1/25, 2/9/25, 2/10/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's weight and vitals summary printed on 2/12/25, listed weights obtained since admission and prior to daily weight order occurred on 1/6/25 and 1/7/25. R15's record review had no documented refusals of weights. During interview on 2/13/25 at 10:35 a.m., licensed practical nurse (LPN)-E identified when a resident was admitted orders were entered by the admitting nurse and double checked by a second nurse. If the resident was admitted with a diagnosis of congestive heart failure the standing orders for heart failure management were added unless otherwise directed. During interview on 2/13/25 at 11:30 a.m., director of nursing (DON) identified any resident admitted with a primary diagnosis of congestive heart failure should have the standing orders for heart failure management included in their orders unless otherwise directed. The DON expects these orders to be added no later than the day after admission. If the resident was refusing daily weights, the DON expects a progress note made, and the provider notified if there was a pattern of refusals. Monitoring for changes in daily weights and shortness of breath was important for residents with congestive heart failure because it can indicate the condition was not well managed and other interventions may be needed. Facility Standing Orders for Skilled Nursing Facilities revised 2024, identified heart failure management orders include: -Daily weights for patients with heart failure unless directed otherwise. -Call for weight gain 3 pounds or greater in 24 hours 5 pounds in one week unless otherwise directed. -Assess lung sounds, peripheral edema, and respiratory effort daily unless directed otherwise. A facility policy on coordination of care/clarification of orders was requested and not received.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure interventions were used consistently for 1 of 1 resident (R10) at risk for pressure ulcers (PU). Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 had no delusions, no behaviors and didn't refuse cares. MDS indicated R10 needed maximal assistance with oral hygiene, eating, dressing, putting on/off socks/shoes, and was dependent for transfers, bathing, and to propel his wheelchair. The MDS indicated R10 had a surgical wound and was at risk for developing pressure areas. R10's Clinical Diagnoses report printed 2/13/25, indicated diagnoses of multiple sclerosis with cerebral atrophy (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), essential hypertension (abnormally high blood pressure that's not the result of a medical condition), idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause cannot be determined) , and peripheral vascular disease or PVD (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). R10's Skin Risk Care Plan (CP) printed on 2/13/25, indicated R10 had actual impairments to skin integrity related to PVD, immobility and history of contractures on his left foot. The CP interventions included bilateral foam boots and directions to lay down in bed after meals. The third-floor unit sheets which describe the resident's care needs, used by the nursing assistants, lacked information regarding the use of pressure relief interventions (i.e. boots or pillows). R10's Clinical Orders report printed on 2/13/25, indicated orders for wound care to the left foot dorsum area (top of the foot). Orders also included to use protective foam boots when sat in his wheelchair and the use of a pillow behind R10's feet when in his wheelchair. R10's Wound Care report dated 2/4/25, created by a wound specialist group, included left foot dorsum pressure areas wound measurements. Measurements were as follows: 11/15/24 2x1.75 centimeters (cm) 11/22/24 1.9x2.5 cm 11/29/24 2.26x1.69 cm 12/6/24 2x2 cm 12/10/24 2.1x1.9 cm 12/20/24 3.47x2.12 cm 12/27/24 6.9x3.7 cm (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/3/25 5.5x4.3 cm 1/14/25 5.9x3.8 cm 1/17/25 5.9x3.8 1/24/25 4.6x3.2 cm 1/31/25 4.8x3.2 cm 2/4/25 4.6x3.9 cm During observation on 2/10/25 at 1:04 p.m., R10 was seated in his Broda chair (a padded reclining chair). R10 was wearing a pressure relief boot on his left foot but not on his right foot. R10 had a pillow between his knees. During observation on 2/10/25 at 1:19 p.m., resident was seated in his Broda chair and was not wearing the pressure relief boots. R10 had a pillow between his knees. During observation and interview on 2/10/25 at 4:46 p.m., NA-C verified R10 was not wearing the pressure relief boots, the pillow used between his knees was on the floor, and didn't have a pillow behind his legs. NA-C stated R10 was supposed to wear boots when he was out of bed and needed a pillow between his knees and a pillow behind his legs. During observation and interview on 2/11/25 at 12:59 p.m., licensed practical nurse (LPN)-C verified R10 was not wearing the pressure relief boots and only had a pillow between his knees. LPN-C stated R10 was supposed to have boots on his feet and a pillow behind his legs, I think he has pressure areas, but I haven't seen his wounds for a while. During observation on 2/12/25 at 9:35 a.m., R10 was seated in his Broda chair and was only wearing a boot on his left foot. R10 had a pillow between his knees but not behind his legs. During interview on 2/13/25 at 2:19 p.m., director of nursing (DON) stated she expected nursing staff to follow up the care plan. DON stated following the care plan was important to maintain or improve residents skin integrity and to prevent further skin breakdown. The facility's policy titled Pressure Ulcers/Skin breakdown dated April 2018, indicated the physician will order pertinent wound treatments, including pressure reduction surfaces. The policy also indicated Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and record review the facility failed to ensure R55's respiratory equipment was properly maintained who was reviewed for respiratory care. Findings include: R55's admissions MDS dated [DATE] identified R55 with no indicators of cognitive impairment, utilized a wheelchair, required substantial assistance for toileting, showering, and dressing. R55's medical diagnoses include morbid obesity with a breathing disorder impacting lung function, diabetes, depression, chronic pain, and lymphedema. In addition, R55 required continuous oxygen therapy. R55's physician orders (PO) dated 1/4/25 state, Change oxygen tubing weekly. Date the tubing. PO indicated it was to be done every night shift every 7 days(s) for oxygen. R55's medication administration treatment administration record (MARTAR) for January 2025, identified R55's oxygen tubing was changed and dated on January 24th and January 31st with clinician initials. The MARTAR failed to indicate R55's oxygen tubing was changed and dated any other time of the month. Time slots for Friday January 3 was marked with an X and Fridays January 10 and January 17 were left blank. During observation on 2/9/25 at 10:34 a.m., R55 sitting in electric wheelchair in room with two portable oxygen containers attached to back of wheelchair. R55 receiving 6 liters of oxygen continuously and had nasal cannula in place. The oxygen tubing was not dated or labeled. Against the window of bedroom there were two tall oxygen concentrators turned off with a green oxygen tubing attached to one of the oxygen concentrators. The tubing was not dated or labeled and the end of the tubing was resting against the curtains of the window. The tubing had white flecks on the end of the tubing. The humidifier container also did not have a date or label on it to indicate when it was changed or replaced. During observation and interview on 2/10/25 at 12:57 p.m., R55's oxygen tubing and humidifier were not dated or labeled. R55 stated, I don't remember the last time it was replaced. The staff rarely date and label the tubing here. It's been at least a couple weeks. Tubing looks grimy to me. During observation and interview on 2/11/25 at 9:29 a.m., licensed practical nurse (LPN)-B pointed to R55's oxygen tubing and humidifier and stated, nope that is not dated or labeled. Should be though. Both the water thing there and the tubing. LPN-B looked in R55's electronic medical record (EMR) and stated, I don't know when it was changed if there is not[sic] documentation on it to tell us. During an observation and interview with infection control preventionist (ICP) on 2/12/25 at 8:06 a.m., ICP pointed to R55's oxygen tubing and humidifier and stated, Those should be dated and labeled. Documentation shows it was only done twice in January 2025 and that is not good. And If it is not dated or labeled then we would not know if and when it was done. I will have to do more training to the staff. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with director of nursing (DON) 2/12/25 at 10:15 a.m., DON stated R55's EMR documentation for January 2025 shows that it was dated and labeled twice. That is a concern for infection control. [R55] is a high risk for respiratory compromise. During interview with nurse practitioner (NP)-A on 2/12/25 at 10:27 a.m., NP-A stated she was familiar with R55 and stated, It is important for infection control to ensure that all respiratory equipment is in[sic] clean and maintained. Standard practice is to ensure the oxygen tubing an everything attached to it is replaced when dirty and minimally weekly. [R55] is on a lot of oxygen so he is very high risk for pneumonia or infection if his equipment is not maintained. That humidifier should always be checked and maintained. If it is not dated or labeled, then we would never be able to tell when it was changed. Common sense if you ask me. Facility policy on respiratory care was requested and not received.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 49877 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. Findings Include: 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. 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. 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. 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. 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.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview, observation, and document review, the facility failed to ensure medically related social services were provided when 1 of 1 residents (R6) reviewed, request for clothing was not addressed. Findings include: R6's admission Minimum Data Set (MDS) dated [DATE], indicated R6 had intact cognition, was admitted to the facility on [DATE], and required moderate staff assistance with dressing. R6's medical record was reviewed and did not include what steps, if any, had been taken to obtain R6 clothing. During observation and interview on 2/9/25 at 10:44 a.m., R6 was observed from the hallway sitting in her wheelchair with the skin of her back visible between the sides of the open gown she was wearing. The skin of her backside between the bottom of the back of the chair and the seat was also exposed. R6 stated she had previously lived at a group home and her clothes were still there. She had been at the facility for a month and had to wear a gown every day as she was never given clothing. R6 stated a social worker had come by a couple of weeks ago and said they were going to pick up her clothing from the group home but never came back. R6 stated it bothered her that the gowns she was given did not adequately cover her body and she wanted her clothing back. During observation and interview on 2/10/25 at 12:39 p.m., R6 was observed from the hallway sitting in her wheelchair with the skin of her back visible between the sides of the gown she was wearing. Skin was also exposed between the bottom of the back of the chair and the seat. R6 stated she was cold as she only had a gown to wear, and she still had no clothing. During observation and interview on 2/12/25 at 12:35 p.m., R6 was observed from the hallway lying in bed wearing a gown, exposed from the right shoulder down to the right heel of her foot. R6 stated the gowns that they give her didn't fit her due to her size and the nurses knew this as they are the ones who helped her get dressed every morning. During interview on 2/12/25 at 12:52 p.m., nursing assistant (NA)-D stated she helped R6 get dressed this morning and she could not find any clothes for her so helped her into a gown. During interview on 2/12/25 at 12:55 p.m., registered nurse (RN)-B stated she thought R6 had only come with one pair of clothes but was unsure where they were and didn't know if anyone was getting her additional clothing. RN-B stated she feel[s] bad for R6 as the gowns the facility has don't quite cover her body. During interview on 2/12/25 at 1:43 p.m., the director of social services (SS)-A stated she had started a couple of weeks ago and had not been made aware that R6 did not have clothing to wear or that her clothing had been left at her group home. SS-A stated if she had been made aware she could have assisted in getting her clothing back or helping her get new clothing. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy regarding social services was requested but not received.

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F 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident's drug regimen must be free from unnecessary drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49034

Based on interview and document review, the facility failed to ensure adequate side effect monitoring for 1 of 5 residents (R34) reviewed for unnecessary medications. In addition, the facility failed to ensure medications were not given in excessive dose for 1 of 5 residents (R43) reviewed for unnecessary medications.

Findings include:

Side Effect Monitoring

BUTRANS- buprenorphine patch, extended-release prescribing information dated 12/23, indicated the most common adverse reactions of the medication included, but were not limited to: constipation, dizziness, and vomiting.

R34's quarterly Minimum Data Set (MDS) dated [DATE], indicated R34 had severely impaired cognition and was dependent on staff for all activities of daily living (ADLs).

R34's diagnosis report dated 11/1/24, indicated R34 was diagnosed chronic pain syndrome, a traumatic brain injury, and aphasia (difficulty communicating thoughts and ideas through words).

R34's medication/treatment administration record dated 1/1/25 through 2/13/25, indicated R34 received a weekly Butrans (buprenorphine) patch (an opioid patch placed on the skin to assist with pain management). The record indicated R34 had 17 grams(g) of polyethylene glycol (laxative) available daily as needed (PRN) medication that had not been given during the reviewed period.

R34's care plan dated 6/13/24, indicated R34 was receiving a Butrans patch related to chronic pain syndrome with a goal of being free of any discomfort or adverse side effects from the medication. The care plan indicated staff were to monitor and document the side effects and effectiveness of the medication. The care plan indicated possible adverse reactions to the medication included anxiety, constipation, nausea, etc., and if these reactions were noted they were to document them and report these symptoms. The care plan included a section bowel and indicated R34 had bowel incontinence and required frequent check and change but did not indicate what R34's usual bowel movement pattern/frequency was.

R34's Follow Up Question Report dated 1/1/25 through 2/13/25, indicated R35 had a bowel movement on 1/3/25, 1/9/25, 1/15/25, 1/16/25, 1/20/25, 1/26/25, 2/4/25, and 2/6/25 with the remaining days of the period documented as no bowel movement.

R34's progress notes dated 1/1/25, through 2/13/25, were reviewed and did not indicate R34's possible constipation had been noted, the provider had been notified, or an intervention for R34's possible constipation had been attempted.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/13/25 at 11:01 a.m., licensed practical nurse (LPN)-F stated she was R34's nurse for the day. LPN-F stated she had confirmed with the nursing assistants on shift, R34 had not had a bowel movement today and they were unsure the last time she had one. LPN-F stated she thought R34 usually had a bowel movement every day. LPN-F stated it was both the nurse manager and floor nurses' job to review the record and ensure R34 was having regular bowel movements, but she was unsure how to do this. LPN-F stated an alert had popped up to indicate it had been 72 hours since R34's last bowel movement but was unsure if this was the first day the alert had shown up, or how to check when the last bowel movement was. LPN-F stated after 72 hours of a resident not having a bowel movement the provider should be notified, and they should document it in the progress notes and then use the standing house orders to give a PRN laxative. LPN-F stated she was unsure if anyone had ever assessed her to see how often was normal for R34 to have bowel movements, and at what point they should intervene as she was not finding that information in R34's medical record. During interview on 2/13/25 at 11:11 a.m., LPN-E, the second-floor nurse manager, stated the aides were in charge of documenting R34's bowel movements, and the floor nurses were expected to following up every shift to see when the residents last bowel movement was and document any constipation noted in the progress notes. LPN-E stated she expected nursing staff to intervene after three days of a resident not having a bowel movement but was not seeing that this had happened for R34. LPN-E stated a bowel and bladder assessment was done for R34 and bowel care plan was started, but confirmed she could not find how often R34 normally had a bowel movement or if this was assessed. During interview on 2/13/25 at 11:48 p.m., consulting pharmacist (CP) stated a big side effect of Butrans use was constipation and expected nursing staff to monitor for this side effect. CP stated it was important to know what R34's normal bowel movement schedule was so they could determine when R34 was constipated. Excessive Dose R43's quarterly MDS dated [DATE], indicated R43 had severely impaired cognition and required staff supervision with dressing, personal hygiene, and bathing. R43's provider note dated 1/16/25, indicated R43 was diagnosed with Alzheimer's dementia, diabetes, heart failure, and bronchospasms (contraction of part of the lung causing difficulty breathing). R43's medication administration record dated 2/1/25 through 2/11/25, indicated R43 had received two puffs of Ventolin HFA (brand name of medication with generic name of albuterol sulfate HFA, used to treat bronchospasms) 108 micrograms/actuation (mcg/ACT) three times a day (expect for two instances where see progress notes was documented) with an order start date of 5/19/22. The record indicated R43 additionally received two puffs of albuterol sulfate HFA 108 mcg/ACT three times a day with an order start date of 12/26/24. R43's progress note dated 2/11/25 at 5:49 p.m., indicated LPN-F contacted the pharmacy regarding the duplicate order of the albuterol sulfate inhaler and was told they were both the same medications and insurance prefers the albuterol. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/11/25 at 10:51 a.m., LPN-F stated she was R43's nurse today and thought R43 used inhalers. LPN-F reviewed R43's orders and stated R43 used both albuterol sulfate and the Ventolin inhalers. When asked if they are different medications LPN-F stated, yes, and it looked like they both had been given previously but she had not had time yet today. During interview on 2/12/25 at 9:37 a.m., LPN-E, the second-floor nurse manager, stated the issue with R43's albuterol sulfate inhaler had been brought to her attention, so they had notified the pharmacy of the issue and discontinued the Ventolin HFA and were now only giving the medication under the generic name instead of both orders. LPN-E stated she thought the generic albuterol had been started related to insurance reasons, but the brand name medication, Ventolin HFA, had not been discontinued as it should have been. During interview on 2/13/25 at 11:46 a.m., the CP stated although R43 received twice as much of the Albuterol Sulfate inhaler as ordered, it did not go over the max amount the medication that can be given, however, it was still important R43 should not receive more of the medication than needed. The facility Medication Therapy policy dated 4/2007, indicated each resident's medication regimen should only include medications necessary to treat existing conditions. The policy indicated the resident's medication regimen would be reviewed for a clear indication for use an appropriate dosage and frequency of administration as well as monitoring for potential medication side effects.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

49339

Based on observation, interview, and document review the facility failed to monitor for resident specific target behaviors and ensure appropriate side effect monitoring was completed in accordance with the standard of care for antipsychotic medication (group of medications used to treat psychosis) use for 1 of 5 residents (R53) reviewed for unnecessary medications.

Findings include:

A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, Tardive dyskinesia is one of the most dreaded complications of antipsychotic treatment it typically develops after months or years of exposure, and is characterized by involuntary athetoid (neurological disorder that causes slow, involuntary movements often in hands or feet) or choreiform (involuntary, brief, and irregular dance-like movements that can affect various parts of the body) movements of the lower face, extremities and/or trunk muscles. Most commonly, these present as grimacing, lip?smacking/puckering, tongue movements, and excessive blinking. Most distressingly, symptoms persist long after the offending medication is discontinued, and may be permanent in some cases (dyskinesia lasting less than a month after withdrawal is considered a separate clinical entity, withdrawal dyskinesia). Other tardive manifestations may include akathisia (compelling need to rock, move or pace, feeling or restlessness), stereotypies (repetitive or ritualistic movement, posture or utterance), dystonia (cramping or involuntary movements), parkinsonism (a broad term for a group of neurodegenerative conditions that cause similar movement symptoms including tremors, stiffness and slowness of movement), tremor, myoclonus (muscle jerks), and tourettism (refers to Tourette syndromes that occur dur to other conditions that causes involuntary tics or sudden movements or sounds).

R53's quarterly Minimum Data Set (MDS) assessment, dated 12/27/24, indicated R105 had severely impaired cognition with no hallucinations or delusions and no behavioral symptom,s including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further, it indicated R53 had received an antipsychotic medication during the seven-day look back period.

R53's Order Summary Report, dated 2/11/25, included the following orders: Olanzapine (antipsychotic medication used to treat mental/mood disorder) tablet give 2.5 milligrams (mg) by mouth every 24 hours as needed for agitation for two weeks with a start date of 1/29/25 and end date of 2/12/25. The document lacked evidence of side effect monitoring and target behavior monitoring.

R53's care plan, printed 2/9/25, lacked indication R53 was prescribed an antipsychotic medication. Furthermore, lacked indication to monitor for side effects or identification of target behaviors for antipsychotic use.

R53's January 2025 Medication and Treatment Administration Record (MAR/TAR), printed 2/11/25, was reviewed and identified the following:

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Olanzapine 2.5 tablet: give 5 mg by mouth in the afternoon for psychotic disorder with delusions due to known physiological condition with a start date of 6/27/24 and end date of 1/18/25. Medication was noted as administered 1/1/25 through 1/17/25. -Olanzapine 2.5 mg tablet: give 2.5 mg by mouth in the afternoon for psychotic disorder with delusion due to known physiological condition with a start date of 1/18/25 through 1/29/25. Medication was noted as administered during those dates. -Olanzapine 2.5 mg tablet: give 2.5 mg by mouth every 24 hours as needed for agitation for 2 weeks with a start date of 1/29/25. The document lacked evidence of side effect monitoring and target behavior monitoring. R53's February 2025 MAR/TAR, printed 2/11/25, was reviewed and identified the following: -Olanzapine 2.5 mg tablet: give 2.5 mg by mouth every 24 hours as needed for agitation for 2 weeks with a start date of 1/29/25 and end date of 2/13/25. The document lacked evidence of side effect monitoring and target behavior monitoring. On 2/09/25 at 11:22 a.m., R53 was observed sitting in the common area with walker beside her. R53 smiled. On 2/10/25 at 4:37 p.m., R53 was observed ambulating in the hallway without a walker. Unidentified staff approached R53 with her walker and reminded her to use it. On 2/10/25 at 6:02 p.m., R53 ambulated with walker, and was observed to be social with others. A Consultant Pharmacist Recommendation to Nursing, dated 10/10/24, indicated the following: -The resident is on an antipsychotic medication without a current AIMS (an assessment tool used to evaluate the severity of tardive dyskinesia) on the chart (in PCC-electronic medical record). AIMS should be done within the first 30 days of either admission or initiating therapy, then at least every 6 months after that. The most recent AIMS test was done 2/28/24. Please update the AIMS for this resident. Thank you. Review of electronic medical record (EMR) confirmed the most recent AIMs assessment was completed 2/28/24. During interview on 2/12/25 at 11:04 a.m., nurse practitioner (NP)-A stated target behaviors should be monitored when a resident was taking an antipsychotic medication. By monitoring the behaviors it helped determine whether it was necessary to continue the medication. NP-A stated it was important to complete AIMs assessments to monitor for side effects and should be done twice a year and with dosage adjustments. During interview on 2/12/25 at 10:48 a.m., licensed practical nurse manager (LPN)-E stated target behaviors should be monitored when a resident is on an antipsychotic medication. LPN-E stated AIMs assessments were completed quarterly. LPN-E was going to review R53's EMR. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During follow up interview on 2/12/25 at 2:30 p.m., LPN-E stated there was no monitoring completed for target behaviors for R53. LPN-E confirmed the last AIMs assessment was 2/28/24. LPN-E stated target behaviors should be monitored and R53 was overdue for an AIMs assessment. During interview on 2/12/25 at 3:21 p.m., director of nursing (DON) stated she expected target behaviors were monitored to assess the effectiveness of an antipsychotic medications. DON stated an AIMs assessments should be completed every six months. A facility policy titled Psychotropic Medication, dated July 2022, indicated resident receiving psychotropic medications are monitored for adverse consequences.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 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. Findings include: 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. 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. 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. 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. Review of R1's PN from 1/9/25 to 1/23/25 indicated no mention of follow up regarding Lasix order. 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. 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 . 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. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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]. 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. 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49877 Based on observation, interview, and policy review, the facility failed to ensure insulin pens were securely stored and under direct observation of authorized staff. This had the potential to affect residents, staff, and/or guests on the memory care unit who could access the medications. During continuous observation on 2/12/25 from 12:50 p.m. to 1:32 p.m., 12 insulin pens were stored on top of the counter at a nurses' station on the memory care unit in a gray wash basin. Within the basin, the pens were contained in either a clear plastic bag or case. Insulin needles were stored in an open plastic container behind the nurse's station. Access behind the nurse's station was closed off by a half door which could be opened by reaching over the door and turning the doorknob. The nurse's station counter was approximately 3 feet high and located directly adjacent to a resident activity/TV room and the main elevators to the unit. During observation, seven residents or guests and ten staff members walked past the basin containing insulin pens. From 1:21 p.m. to 1:32 p.m., the insulin pens remained on the counter of the nurse's station unsupervised by any staff member authorized to administer medications. During interview on 2/12/25 1:32 p.m., registered nurse (RN)-B confirmed having the responsibility of administering and storing insulin on the unit. Insulin pens and supplies were kept on the treatment cart when in use and should be locked inside the cart when not in use. Currently there was not enough room to store the insulin pens in the cart. RN-B stated the insulin pens should have been locked in the medication storage room when not in use because many of the residents on the unit were confused and may tamper with insulin pens and supplies if they were not properly stored or supervised. During interview on 2/13/25 at 11:23 a.m., director of nursing (DON) stated staff were expected to store all medications not currently in use in a locked medication room or cart, and to supervise all unlocked medication during use to prevent theft, tampering, or improper use of medications. DON identified insulin as high-risk medication that could have serious side effects if not taken properly. A facility policy Storage of Medications revised 11/2020, identified the facility stores all drugs and biological in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments when not in use and only persons authorized to prepare and administer medications have access to locked medications.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 49339 Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication (i.e., cavities, oral pain) for 1 of 1 residents (R51) reviewed for dental care and services. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated R51 had moderately impaired cognition without hallucinations or delusions present with no behaviors, rejection of care, or wandering present. Further, the MDS identified a section titled Section L-Oral/Dental Status which was not completed. This section would have identified broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissues, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums or loose natural teeth and/or mouth or facial pain, discomfort or difficulty with chewing or if unable to examine. The assessment was dashed meaning it was not completed. R51's Admission Record, printed 2/12/25, identified diagnosis include: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dysphagia (difficulty swallowing foods or liquids), dementia (group of thinking and social symptoms that interferes with daily functioning) and epilepsy (seizure disorder). On 2/10/25 at 12:38 p.m., R51 was observed sitting in a broda chair (a type of position chair) in the common area. R51 stated she was terrible, but was unable to elaborate. R51 was sipping on ice water. R51's hair was matted in back and appeared greasy. R51 did repeat self and had some nonsensical responses. On 2/10/25 01:03 p.m., family member (FM)-B stated they had not talked to the facility staff about any dental services available to R51 and they were the representative/power of attorney (POA) for R51. FM-B stated R51 complained of dental pain and the facility was aware of this. R51's care plan, printed 2/10/25, identified the following: -ADL (activities of daily living) self care needs Fatigue with the following interventions: -ORAL CARE ROUTINE (AM, PC, HS): SPECIFY brush teeth, clean with toothette, rinse mouth with wash -PERSONAL HYGIENCE/ORAL CARE: the resident it totally dependent on 1-2 staff for personal hygiene and oral care. -Encourage the resident to participate to the fullest extent possible with each interaction. R51's Kardex, printed 2/10/25, identified the following in relation to oral care: -Encourage good oral care daily and assist prn (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oral care routine (AM, PC, HS): SPECIFY brush teeth, clean with toothette, rinse mouth with wash. -PERSONAL HYGIENCE/ORAL CARE: The resident is totally dependently on 1-2 staff for personal hygiene and oral care. R51's care sheet, printed 2/9/25, indentified the following: -Oral care: Assit of 1. R51's Nurse Admission/Readmission assessment, dated 1/13/25, indicated the following: -Under section F: Oral status: Resident has own teeth, with no oral pain and no oral lesions. The assessment lacked indication of R51's last dental appointment. R51's progress notes, dated 1/13/25 to 2/12/25, were reviewed. Progress notes lacked dental services being offered to R51. Furthermore, progress notes lacked refusals of cares. During interview on 2/12/25 at 7:13 a.m., trained medication aid (TMA)-B stated they were familiar with R51 and had assisted with R51's cares. TMA-B stated R51 did not always allow staff to brush her teeth and always declines. TMA-B stated R51 was dependent on staff for ADLs. TMA-B stated R51 allowed her to brush her teeth once and her gums bled when TMA-B brushed her teeth. TMA-B stated they reported it to the nurse. On 2/12/25 at 7:30 a.m., nursing assistant (NA)-H stated they had worked with R51 previously, and indicated they were unaware of R51's dental needs as they did not assist R51 for oral hygiene when they have worked with them. NA-H stated they use the care sheets to know what the resident's needs were, and R51 needed assistance with ADLs. On 2/12/25 at 10:44 a.m., licensed practical nurse manager (LPN)-E stated dental needs were assessed on admission and during assessment periods. LPN-E stated residents were assisted with dental appointments if needed and it would be documented in the progress notes. LPN-E was going to look for documentation of dental services being offered to R51 during the admission process or after. No additional information was provided. On 2/12/25 at 3:15 p.m., director of nursing (DON) stated dental services should be offered and discussed to all residents upon admission and as needed. A facility policy titled Dental Services, revised 12/2016, routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Furthermore routine and 24-hour emergency dental services are provided to our resident through: a. A contract agreement with a licensed dentist that comes to the facility monthly; b. Referral to the resident's personal dentist; c. Referral to community dentists; or (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Referral to other health care organizations that provide dental services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R173) reviewed for EBP. In addition, the facility failed to ensure infection control practices were provided for 4 of 4 residents (R173, R223, R55, and R35) reviewed to reduce the risk of contamination and infection. Furthermore, the facility failed to transport residents' clothing without risk of contamination. These findings have the potential to affect all 69 residents, staff and visitors within the care center. Findings include: EBP R173's entry Minimum Assessment Data (MDS) assessment dated [DATE], indicated R173 was admitted on [DATE]. R173's Clinical Diagnosis report, indicated diagnoses of lumbar spinal stenosis with neurogenic claudication (narrowing of the spinal canal of the lower back pressuring the spinal cord causing pain, weakness), polyneuropathies ((simultaneous malfunction of many peripheral nerves throughout the body), cerebral infarction (area of damaged tissue on the brain), left side weakness due to cerebral infarction, aphasia (language disorder that affects a person's ability to communicate), adjustment disorder with anxiety, and depression. During observation on 02/10/25 at 12:52 p.m., an EBP sign for contact precaution was taped to R173's room door. A bin was located next to the door, containing personal protection equipment (PPE). During interview on 2/11/25 09:38 a.m., IPCP indicated R173 was on EBP due to an open wound on his chest. Infection preventionist and control program (IPCP) stated staff needed to use gloves and gown during personal cares including transfers. During observation on 2/13/25 at 10:10 a.m., NA-A, NA-C, and occupational therapist (OT)-A were transferring R173 without using a gown. During interview on 2/13/25 at 10: 20 a.m., OT-A verified an EBP sign was taped to R173's door and said, I needed to use a gown, I didn't look at the sign. OT-A stated not wearing a gown was an infection control concern. During interview on 2/13/25 at 10:22 a.m., NA-A stated she knew the staff needed to follow contact precautions when helping R173 with personal cares, but the other staff members needed her help, and she forgot to put it on. NA-A stated it was important to wear a gown to prevent infections. During interview on 2/13/25 at 10:23 a.m., NA-C verified there were 2 EBP signs taped to R173's door, and stated he was supposed to use a gown for infection control prevention. NA-C stated he received education about infection precautions but forgot to put on a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 2/13/25 at 11:11 a.m., IPCP stated all staff members caring for R173 needed to follow the precautions indicated on the EBP signs to decrease the risk of spreading infections. During interview on 2/13/25 at 1:50 p.m., DON stated it was concerning to know staff members were not following the posted precautions due to the risk of spreading infections. Facility policy titled Isolation- Initiating Transmission-Based Precautions dated 8/2019 indicated transmission-based precautions are utilized when a resident meets the criteria for a transmissible infection and the resident has risk factors that increase the likelihood of transmission. The policy also indicated when transmission-based precautions are implemented, the infection preventionist or designee, clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used. Infection Control Practices R173 R173's entry tracking record Minimum Assessment Data (MDS) dated [DATE], indicated R173 was admitted on [DATE]. R173's Bladder Function Care plan printed on 2/10/25 indicated R173 was continent of bladder and was able to use a urinal at the bedside. During observation and interview on 2/11/125 at 9:25 a.m., R173 was in bed and a bedside table was on the left side of the bed. The bed side table had multiple articles on top, including a dentures box, eyeglasses, a cellular phone, comb, hard candy, small notebook, a breakfast tray and a urinal containing urine. R173's call light was on, and he said he wanted cold cereal and needed to use his urinal. During observation on 2/11/25 at 9:36 a.m., NA-D entered the room and talked to R173. NA-D picked the urinal up, and a wet spot was observed on the table where the urinal was before. NA-D emptied the urinal in the toilet, and once empty, NA-D put the urinal on the left side bed rail. During interview on 2/11/25 at 9:51 a.m., IPCP stated keeping a urinal next to food and personal items was an infection control issue. ICPC stated the urinal should be kept on the bedside rail. During interview on 2/13/25 at 1:53 p.m., DON stated keeping a urinal on a bedside table among food and personal items was an infection control issue. R223 R223's entry tracking record dated 1/22/25, indicated R223 was admitted to the facility on [DATE]. R223's medication administration record for the month of February, indicated diagnoses of obstructive sleep apnea, respiratory disorders and morbid obesity. R223's Clinical Orders, dated 1/24/25 an order for C-pap on at bedtime two times a day. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R223's treatment administration records for the month of February, lacked orders to care for C-pap machine. During interview on 2/11/25 at 9:09 a.m., R223 stated my son comes everyday to take care of her C-pap machine. The staff have not touched my machine. Sometimes the staff helps me to put on my C-pap mask, but they have not filled the water container or washed my mask. During interview on 2/11/25 at 11:21 a.m. R223, family member (FM)-D stated he visited his mother everyday and helped her with her C-pap machine. FM-D stated he helped R223 to put her mask on, refilled and clean the water reservoir, and cleaned the mask in the mornings. FM-D said the staff had not provided any instructions about how to care for the machine. During interview on 2/11/25 at 11:32 a.m., licensed practical nurse (LPN)-C verified the facility didn't have orders directing the staff to care for R223's C-pap machine. LPN-C stated the lack of orders was concerning because the water reservoir could be empty, and if the mask is not cleaned it could get nasty, with germs and R223 can get sick. During interview on 2/13/25 at 11:18 a.m., IPCP stated the expectation was for staff to ensure the C-pap was cleaned to prevent buildup of germs, bacteria and prevent respiratory infections. IPCP stated, if a family member was taking care of a C-pap machine we need to educate the family to make sure they are doing it right. IPCP verified the lack of documentation about educating R223's family member. During interview on 2/13/25 at 1:55 p.m., DON stated the lack of orders, and documentation of education provided to the family was an infection control issue. R55 R55's admission MDS dated [DATE], indicated R55 was independently making decisions, needed setup for oral hygiene, eating, personal hygiene, and upper body dressing. R55 needed maximal assistance with bathing, and toileting hygiene. MDS indicated R55 was occasionally incontinent of bladder. Medical conditions included morbidly severe obesity, diabetes, depression, chronic pain, and lymphedema (swelling due to build-up of lymph fluid in the body). During observation and interview on 2/9/25 at 10:34 a.m., R55 stated he urinated in a large yellow plastic container and added he didn't use a urinal. The large container had white dry matter around the top edges and had 500 cubic centimeters (cc) of amber fluid. The plastic container was in the middle of a larger gray plastic container, on top of drawer unit, just inside R55's room, and visible from the hallway. Both containers were not dated or labeled. During observation on 2/10/25 at 1:49 p.m., a large amount of amber fluid was observed in the container resting in the center of the gray plastic container. The gray container was on top of the drawer unit just inside R55's room and visible from the hallway. [NAME] and yellow dried flaky debris was attached to top of the gray container and inside the container. During observation and interview on 2/11/25 at 2:55 p.m., it was observed a large amount of urine in the container inside the gray plastic container. Containers were still not dated or labeled. R55 stated they did not empty it yet and it's been there since this morning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 2/12/25 at 8:04 a.m., NA-A stated R55 urinated in a container, and we [staff] emptied it. NA-A looked at the containers and stated looks dirty and needs to be changed. I don't know when it was replaced. I don't know. It looks awful. It should be washed and rinsed, and it does not look like it has been done for a many days or weeks. During interview on 2/12/25 at 8:12 a.m., LPN-A looked at container and stated It should be rinsed out. He brought it from home. It is not labeled or dated, and we do not have a process to determine when it was replaced or cleaned. It is definitely an infection control concern. It has a lot of debris dried to it. During interview on 2/12/25 at 8:26 a.m., IPCP looked at containers and stated It should be cleaned daily. That is a concern for infection control. We can offer the use of a regular urinal. We do not have this type of container here R35 R35's quarterly MDS dated [DATE], indicated R35 had moderate cognitive impairment, was independent with most ADLs, and needed set up assistance with bathing. Active diagnoses included coronary artery disease (damage or disease in the heart's major blood vessels), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes (refers to a group of diseases that affect how the body uses blood sugar), and other orthopedic conditions. During observation and interview on 2/12/25 at 10:03 a.m., R35 was in the hallway with a food tray on his lap yelling loudly, My toilet overflowed at 6:00 this morning and it still ain't clean. It is still not cleaned my room. They said we will put a work order in, and nothing has happened. I am walking around with a dirty a$$ floor. During interview on 2/12/25 at 10:15 a.m., DON observed R55's room with floor staining and liquid on the floor where R35 was standing with foot uncovered. R35's right foot stump had dark scabs on the end of it. DON stated, this is an infection control problem. The DON asked R35 if he would like his stump covered. R35 answered while standing on the soiled floor, The nurse ain't coming here to wrap it. The DON added It is not sanitary to stand in that, and the floor should have been mopped up before now. Facility policy titled Cleaning and Disinfecting Resident's Rooms dated 2/2023, indicated environmental surfaces will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Laundry During observation on 2/12/25 at 12:02 p.m., laundry aid (H)-A was delivering clean clothes to residents' rooms. The clothes were uncovered, and a blouse and a pair of pants were hanging on the side of the cart and were dragging on the floor. H-A stated, I don't know nothing, I usually don't deliver clothes. HA-A said she had just delivered clothes and forgot to cover the clothes and didn't realize the clothes hanging on the side of the cart were dragging on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 2/12/25 at 2 p.m., maintenance manager (M)-A stated the laundry aid was not following the correct procedure to delivery clean clothes. M-A stated H-A failed to follow proper procedure and it was an infection control issue. During interview on 2/13/25 at 11:10 a.m., licensed practical nurse, IPCP stated the bed linen and personal clothes needed to be covered and never touch the floor. IPCP added failure to follow infection control practices represented a concern for contamination. During interview on 2/13/25 at 1:49 p.m., director of nursing (DON) stated uncovered and personal clothes touching the floor should no longer be considered clean. Facility policy title Infection Prevention and Control Program dated 10/2018 indicated an infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program with established monitoring to help reduce unnecessary antibiotic use and reduce potential drug resistance for 11 of 11 residents (R10, R15, R223, R48, R4, R54, R9, R56, R45, R173, and R7) reviewed for antibiotic use. The lack of a program had the potential to affect all 69 residents residing in the facility. Findings include: Review of the January and February 2025 facility infection surveillance tracking logs identified residents who had been having an infection and were administered an antibiotic. The log included resident name, admitted , infection type, body system of infection, symptoms, onset date, test date, result (organism colony counts for urine), antibiotic name, dose, frequency along with start and end dates, transmission-based precautions and date when infection symptoms are resolved. The surveillance logs documentation was incomplete, and consistently failed to indicate diagnostics performed, specimen source, diagnostic results, completion of antibiotic time out, or the date the infection had been resolved. Logs information as follows: 1. R10 was identified as having cellulitis/soft tissue/wound. He was prescribed the antibiotic cephalexin 1000 milligrams (mg)twice a day (BID) started on 1/6/25. The surveillance log lacked documentation on the date when the infection was resolved. R10 was identified as having a common cold, body system of infection indicated skin. R10 was prescribed the antibiotic cephalexin 500 mg four times a day started on 1/22/25. The surveillance log lacked a note if a 72-hour time out had been completed or when the infection had been resolved. 2. R15 was identified as having cellulitis/soft tissue/wound. She was prescribed the antibiotic doxycycline 100 mg BID, started on 1/1/25. The surveillance log lacked a note if a 72-hour time out had been completed or when the infection had been resolved. 3. R223 was identified as having cellulitis/soft tissue/wound. She was prescribed an unidentified topical antibiotic BID, started on 1/1/25. The surveillance log lacked a note if a 72-hour time out had been completed or when the infection had been resolved. 4. R48 was identified as having a urinary tract infection (UTI). He was prescribed the antibiotic levofloxacin 750 mg once a day started on 1/31/25. The surveillance log lacked documentation of culture results, a note if a 72-hour time out had been completed or when the infection had been resolved. 5. R4 was identified as having a UTI. She was prescribed the antibiotic nitrofurantoin 100 mg BID started on 1/24/25. The surveillance log lacked documentation of culture results, a note if a 72-hour time out had been completed or when the infection had been resolved. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. R54 was identified to have a UTI. She was prescribed an antibiotic nitrofurantoin 100 mg BID started on 1/16/25. The surveillance log lacked documentation of culture results, a note if a 72-hour time out had been completed or when the infection had been resolved. Once again, R54 was identified to have a UTI. She was prescribed an antibiotic ciprofloxacin 500 mg BID started on 1/27/25 mg BID. The surveillance log lacked documentation of culture results, a note if a 72-hour time out had been completed or when the infection had been resolved. 7. R9 was identified as having COVID. The log lacked documentation whether a test was completed, no treatment was identified, or a date when symptoms were resolved. 8. R56 was identified as having a UTI. He was prescribed the antibiotic ciprofloxacin 500 mg BID started on 1/14/25. The surveillance log lacked documentation of culture results, an indication a 72-hour time out had been completed or when the symptoms had been resolved. 9. R45 was identified as having cellulitis/soft tissue/wound. The surveillance log lacked documentation of treatment or when the infection had been resolved. 10. R173 was admitted on [DATE] from a hospital with a diagnosis of pneumonia. R173 had an order for the antibiotic cefuroxime 500 mg BID. The surveillance log lacked documentation of diagnostics test, culture results, and indication whether a 72-hour time out had been completed, or when the infection was resolved. 11. R7 was identified as having a UTI. She was prescribed an antibiotic cefdinir 300 mg once a day started on 2/3/25. The surveillance log lacked documentation of culture results, a note if a 72-hour time out had been completed or when the infection had been resolved. During interview on 2/13/25 at 11:52 a.m., the infection preventionist and control program (IPCP) stated he was using the Minnesota Department of Health tool to track infections. IPCP stated the facility did not use the MDH tool or any other tool to identify residents with potential symptoms of infections or trended organisms to prevent infections. IPCP stated he only used the MDH tool to track residents receiving antibiotics. IPCP shared the infections and tracking logs for the months of January and February 2025 and stated the logs had lots of documentation missing. IPCP stated the intention of this tool was to check infections throughout the building and take preventative actions. IPCP added Based on the information in these logs, we could not do prevention at this time. I will improve our systems to monitor infections and improve our system. During interview on 2/13/25 at 2:02 p.m., director of nursing (DON) stated the infections were not properly tracked. Facility policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes dated 10/2022, indicated antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. The policy also indicated, as part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An article by the National Institute of Medicine, titled Antimicrobial Stewardship - Can We Afford to do Without it? dated 1/20/2015, stated the risk of prescribing and using inappropriate antibiotics leads not only to poor clinical outcomes but an increase in the risk of antibiotic-resistant bacteria.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure 3 out of 4 (R10, R35, R55) resident rooms were kept in good repair and provide a safe, clean environment to reside in. Findings include: R10 R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 had severely impaired cognition and required staff assistance for all activities of daily living (ADLs). During interview and observation on 2/11/25 at 9:21 a.m., the wall behind R10's bed, closest to the window had a large hole of drywall missing close to the floor that extended towards the ceiling as it got narrower for about four feet. Nursing assistant (NA)-F stated she had noticed that the wall was crumbling behind R10's bed previously and it had been like that for sometime. NA-F stated the wall spot had further expanded since she last saw it but acknowledged she had not notified anyone of this . During interview and observation on 2/11/25 at 11:58 a.m., the wall behind R10's bed, closest to the window had a large hole of drywall missing close to the floor that extended towards the ceiling as it got narrower for approximately four feet. The director of maintenance (M)-A stated he had not been made aware of the disrepair of R10's wall as he examined it. M-A stated he expected staff to make a maintenance report for something like this, so his staff can assist in repairing it. R35 R35's quarterly MDS dated [DATE], indicated R35 had moderate cognition impairment, was independent with most ADLs, utilized a wheelchair, and had no refusal of care behaviors. R35's care plan dated 1/5/25, indicated R35 was at a risk for falls related to substance use. The care plan did not indicate he had a history of refusal for room cleaning. R35's progress note dated 12/25/24 at 12:12 a.m., indicated staff had observed R35 fall to the floor from his wheelchair after attempting to pick up one of his packages. During an observation on 2/9/25 at 12:20 p.m., R35's room was observed with various items such as cardboard boxes, bags, food wrappers etc. covering about 65 percent of the floor. The floor appeared to have an unknown brown film in various spots and a large portion of the floor by the entrance to R35's room was observed covered by small brown oblong seed like substance. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 2/11/24 at 9:02 a.m., R35 was lying in bed. R35's room was observed with various items such as cardboard boxes, bags, food wrappers etc. covering about 65 percent of the floor. The floor appeared to have an unknown brown film, in various spots and a large portion of the floor by the entrance to R35's room was observed covered by a small brown oblong seed like substance. R35 stated his room was dirty like this for at least a few days and it sometimes took staff a while to clean it. R35 stated no one offered to help clean his room recently and denied refusing to allow staff to assist with this. During interview on 2/11/25 at 9:08 a.m., housekeeping aide (H)-B stated she noticed that R35 had spilled bird seed on his floor sometime last weekend but did not have a chance to clean it yet as R35 did not have the boxes cleared off his floor and thought R35 was responsible for this. H-B stated they were supposed to clean rooms every day. During an interview on 2/13/25 at 12:36 p.m., the administrator stated she expected R35's room to be cleaned on a regular basis but believed he routinely refused to allow this to be completed. The adminsitrator stated she expected staff to assist R35, if he was willing, with moving boxes so the floor could be cleaned. The administrator stated if R35 was refusing, she expected staff to document these refusals and to develop and care plan an appropriate approach to ensure R35 resided in as clean and sanitary environment as possible but did not see that this was occurring. R55 R55's admission MDS dated [DATE], indicated R55 had intact cognition and required staff assistance with almost all ADLs. R55's Census report dated 2/1/25, indicated R55 resided in his current room since 11/7/24. During observation and interview on 2/9/25 at 10:34 a.m., the wall directly to the right of R55's bed was observed with seven patches of drywall spackling ranging in size from approximately one by one inch to two by three inches. R55 stated the he hated the way the wall looked as it looks shabby. During interview on 2/11/25 at 11:52 a.m., M-A stated he had noticed the wall spackling previous when he had done plumbing maintenance in the room two to three weeks ago but was unsure how long the wall was like that before then. M-A stated his staff did not have time to repaint the walls given other higher priority issues the building had, so repainting had not been completed. The facility Maintenance Service policy dated 12/2009, indicated the maintenance department was responsible for maintaining the building in good repair.