STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. Building B. Wing	07/02/2025

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 - Some	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** Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R25) who was referred to as a feeder.Findings include:R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had severely impaired cognitive skills for daily decision making. R25 was dependent on staff for eating.R203's entry tracking record indicated R203 admitted to the facility on [DATE].R203's care plan printed 6/29/25, indicated R203 required setup assistance by one staff member to eat.During meal service on 6/29/25 at 12:14 p.m., dietary aide (DA)-A plated and served food to residents in the dining area. There were approximately eight residents in the dining area, both from the memory care area and non-memory care area. DA-A went to serve R25 when nursing assistant (NA)-E stated she was a feeder out loud, and DA-A placed the plate on top of the steam table instead of serving to the resident. During interview on 6/29/25 at 1:31 p.m., DA-A stated a person who was a feeder needed one to one support to eat. DA-A stated feeder was not a humane term for a human with emotions and could hear what was said. DA-A stated the term was hurtful, belittling, and may make a resident feel less human.During interview on 7/1/25 at 1:14 p.m., R203 stated the staff called residents feeders all the time and it probably made residents feel bad.During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff should call residents by their name and not their situation. RN-A stated staff cannot call a resident feeder.During interview on 7/2/25 at 1:58 p.m., the director of nursing stated staff should not refer to residents who needed assistance with eating as feeders. The DON stated the term would not make a resident feel good.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, before giving psychotropic medications for 2 of 5 residents (R24, R25) reviewed for unnecessary medication use. Findings include: R24 R24's admission Minimum Data Set (MDS), dated [DATE], identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. The MDS recorded R24 as having severe cognitive impairment and consuming both antipsychotic and antidepressant medications. R24's Order Summary Report, signed 5/15/25, identified R24's current physician-ordered medications and treatments along with their respective start date(s). These included orders for duloxetine (antidepressant medication) 20 milligrams (mg) once daily, haloperidol (an antipsychotic medication) with multiple doses ordered daily, and mirtazapine (antidepressant medication) 7.5 mg every bedtime. These medications all had a start date recorded of, 04/29/2025. R24's Medication Administration Record (MAR), dated 6/2025, identified R24's medications along with staff initials to demonstrate their respective administration. The orders for duloxetine, haloperidol, and mirtazapine were listed and each of these medications were recorded as administered for the entire month period. On 7/1/25 at 12:28 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they were R24's financial guardian and were very involved in her (R24) care decisions, too. FM-G stated R24 had been on the antidepressant medication since she was hospitalized a few months prior due to being very combative with staff members there. FM-G stated there had been no discussion from the care center about the duloxetine or mirtazapine medications thus far to their recall and then abruptly asked the surveyor aloud, What are the side effects?! R24's medical record was reviewed and lacked evidence a signed or verbal consent for use of the medication was obtained prior to them being provided. Further, the record lacked evidence the risks or expected benefits of the medication regimen had been reviewed or discussed with R24 or their responsible family member prior to initiation of the medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/1/25 at 12:41 p.m., licensed practical nurse (LPN)-B explained the admitting nurse was the person who typically obtained consent for psychotropic medications from the resident or family upon admission. LPN-B stated this was done with a form we have them sign about the medications, and there should be a separate one for each psychotropic ordered. The forms were then scanned into the electronic medical record (EMR). LPN-B reviewed R24's medical record, including hard chart and EMR, and expressed they were unable to locate any consents for the mirtazapine or duloxetine adding, We're missing those two. LPN-B stated R24 had family members who were involved with her care and mentioned FM-G by name as the person who helped R24 sign paperwork and make decisions. LPN-B verified they were unable to locate evidence of a signed, informed consent being obtained for the two psychotropic medications adding they'd looked everywhere that I would know to look [for them]. LPN-B stated mirtazapine and duloxetine both should have had a signed consent due to their potential side effects adding, Those medications just have to have consent. When interviewed on 7/1/25 at 12:56 p.m., social worker (SW)-A stated nursing was responsible to get medication consents. SW-A added, Nursing will do that. On 7/1/25 at 3:43 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R24's medical record for the consents. DON stated the admitting nurse should obtain all required consents and document them on paper before getting them scanned into the medical record. DON verified they were unable to locate any signed consents for R24's duloxetine or mirtazapine adding, I didn't [find them]. DON added, Something didn't get done. DON stated they would start education with the nurses to ensure consents were obtained moving forward adding obtaining consent was important so the patient understands the risk and benefits [of the medication]. DON added, It's part of the state regs [regulations]. R25R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had severely impaired cognitive skills for daily decision making. R25's diagnoses included aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medication.R25's Medication Administration Record dated June 2025, indicated R25 received risperidone (an antipsychotic medication) 1 milligram by mouth at bedtime for severe, recurrent major depressive disorder with psychotic symptoms with a start date of 6/10/25.R25's medical record lacked evidence of an informed consent for risperidone.During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated the admitting nurse obtained psychotropic medication consents for new admissions. RN-A stated if there was a change in psychotropic medication there was usually an associated clinic of psychology (ACP) provider involved who spoke with the resident or resident representative about the change in dosage first. If the ACP provider did not involve the responsible party, then nursing would obtain the consent for the psychotropic medication.During interview on 7/2/25 at 11:20 a.m., the director of nursing (DON) stated nursing obtained the consent for risperidone today, since they did not find a risperidone consent form in R25's medical record.During follow-up interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to obtain consents for psychotropic medications. The DON stated it was important to ensure the resident or responsible part were aware of the risks and benefits of the medication before administration.The facility Antipsychotic Medication Use policy dated December 2016, directed the attending physician and other staff to gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy did not specifically address informed consent to educate a resident or responsible party on the side effect/risks and benefits of antipsychotic medication.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure there was reasonable access to private phone use for 1 of 1 residents (R153) reviewed who utilized the facility phone.Findings include:R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on [DATE]. R153's profile dated 6/23/25, indicated R153 resided on the third floor. During an observation on 7/1/25 at 1:03 p.m., R153 was observed sitting in a wheelchair in front of a long desk with multiple staff members surrounding it, including trained medication aide (TMA)-B and licensed practical nurse (LPN)-A. The long desk at the nursing station was observed at the middle of two parallel hallways on the third floor with resident's rooms and in front of an elevator. R153 was observed talking on a corded phone and asking someone to get me out of here.During an interview at 7/1/25 at 1:12 p.m., R153 stated that he did not have his own phone so had asked the facility staff if there was one he could use. R153 stated the only phone offered to him was the phone at the nursing station. R153 stated he asked staff to bring the phone to his room, but they said they couldn't, so he had argued with them about it as he didn't want to talk with his wife in front of all the staff members. R153 stated he felt like he did not have enough privacy when he had to make his phone calls at the nurse's station. During an interview on 7/1/25 at 1:14 p.m. with TMA-B and LPN-A, LPN-A stated most residents had their own phone to use but if they did not, they offered them the phone at the nurse's station. TMA-B confirmed that they had neither a cordless phone nor a private area for residents to use the phone if they wanted. During an interview on 7/1/25 at 1:16 p.m., LPN-E, the third-floor nurse manager, stated the only phone that they had to offer residents on the third floor was a phone that could be utilized at the nurse's station and a more private option was not available. During an interview at 7/2/25 at 10:04 a.m., the administrator stated if a resident was able to pay for it, facility staff would install a phone in a resident's room, otherwise residents were able to use the phone at the nursing stations. The facility's Resident Use of Telephones policy dated 3/17, indicated designated telephones were available for residents to make and receive private telephone calls. The policy indicated telephones will be in areas that offer privacy and accommodate wheelchair bound residents.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure the most recent State agency (SA) were posted in a prominent location and readily accessible at all times of the inspection reports within the campus. This had the potential to affect all 51 residents and any visitors who wanted to review this informationFindings include: The CMS CASPER Report 0003D, dated 6/24/25, identified the completed recertification surveys for the previous three years, with the most recently completed recertification survey having exited on 2/13/25. On 7/1/25 at 11:30 a.m., an informal resident council meeting was held with R8, R13, and R1. The residents were asked, as part of the meeting, if the most recent survey results were readily posted within the facility for them to review at leisure. However, none of the residents voiced they knew the location or these results, nor had the results been discussed with them during the resident council meetings. Immediately following the council meeting, on 7/1/25 around 1:45 p.m., a tour of the nursing home was completed with the administrator. Administrator stated he was responsible along with the director of nursing for keeping the survey binder up to date. The main entrance had a 3-tiered black bookshelf to the right of the front desk which contained 4 three ring binders with 2022, 2023, 2024 and 2025 on the spine of the binders. Above the bookshelf hung a laminated sign Survey Results. Within the 2025 binder were the results from the survey exited on 4/8/25. The sign above lacked evidence that additional survey results were available upon request. Furthermore, the binder lacked results from standard abbreviated surveys (complaint) surveys which had been investigated since that last recertification survey. The administrator verified these findings during the tour. During the continued tour, on 2nd floor, there was a 3-tiered black bookshelf in the solarium on the backside of the wall, not in visible sight unless a person was in the solarium. Above the shelf was a sign Survey Results. The bookshelf contained 3 three ring binders. The front of the three binders were marked 2022, 2023 and 2024. Within the binders were the survey results. The most recent results were from the survey with an exit date of 10/7/24 (a follow up visit from the 8/30/24 survey). In addition, the binder lacked any complaint survey results. The sign above lacked evidence that additional survey results were available upon request. The administrator verified these findings during the tour. On 3rd floor, there was a 3-tiered black bookshelf that contained 3 three ring binders with a sign above it which identified Survey Results. The front of the three binders were marked 2022, 2023 and 2024. Within the binders were the survey results, the most recent results being from the survey with an exit date of 10/7/24 (a follow up visit from the 8/30/24 survey). In addition, the binder lacked any complaint survey results. The sign above lacked evidence that additional survey results were available upon request. The administrator verified these findings during the tour. During the tour and interview, administrator stated the survey binders were needed on each floor as some residents did not leave the floor and should have access to the results. Administrator stated the binders should include the complaint and recertification survey results. During an interview on 7/1/25 at 1:41 p.m., activities director (AD)-A stated that she helped coordinate resident council. AD-A stated they had never talked about survey results during resident council meetings since she had been helping coordinate resident council, which had been about 5 months. A facility policy titled Resident Right to Examine Survey Results, dated 1/30/17, identified the resident has a right to examine the three most recent annual survey results and any plan of correction. Furthermore, Information concerning the location of our facility's three most recent survey reports will be posted on the resident bulletin board and at each nurses' station.

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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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to promptly notify the provider consistently of high blood sugars for 1 of 1 residents (R36) of reviewed for notification of change. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). Section N-Medications indicated R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas). During an interview on 6/29/25 at 10:45 a.m., R36 stated she had diabetes and had been told she was a pretty fragile diabetic. R36 stated her blood sugars went up and down and sometimes she required insulin and sometimes she did not. R36's care plan, printed 7/2/25, included R36 had diabetes mellitus with the following interventions: monitor for signs and symptoms of hyperglycemia (high blood sugar); monitor for signs and symptoms of hypoglycemia (low blood sugar); obtain blood sugars per MD order; resident has an order for Dexcom (a continuous glucose monitoring system that is wearable that provides continual real-time blood sugar level reading without the need for frequent fingerstick), sensor to change every 10 days; diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. R36's June 2025 Medication Administration Record (MAR), printed 7/2/25, included the following orders: - Insulin NPH (Neutral Protamine [NAME]-Human -Isophane) (an intermediate-acting insulin that helps manage blood sugar level in individuals with diabetes) Subcutaneous Suspension 100 unit/milliliter(ml) - Inject 11 units subcutaneously in the evening related to diabetes with a start date of 5/31/25. The record identified it was given all days except 6/14, 6/17, 6/18, and 6/17 which were marked with a 2 indicating drug refused. The date 6/1 was marked with a 3 indicating absent from home with meds. - Insulin NPH Subcutaneous Suspension 100 unit/ml - Inject 7 units subcutaneously in the morning related to diabetes with a start date of 6/1/25. The record indicated it was administered all days. - Novolog (rapid acting insulin used to control blood sugar) Injection Solution 100 unit/ml - Inject as per sliding scale:if blood sugar is 151 - 225 = 1 unit;226 - 300 = 2 units;301 - 375 = 3 units;376 - 450 = 4 units;451+ = 5 units, subcutaneously with meals related to diabetes at mealtime only (give even if you skip meal) - Do not give correction dose if blood sugar is less than 150. Check blood glucose at bedtime and do not give correction insulin if blood glucose is less than 200. Start date 5/31/25. - Glucagon Nasal Powder 3 milligram(mg)/dose (dry nasal spray that helps raise blood sugar level in an emergency) 1 spray in nostril as needed for low blood sugar- unsupervised self-administration -In the event of unconscious hypoglycemia or hypoglycemic seizure. May repeat dose if no response after 15 minutes with a start date of 5/18/25. The record identified it was documented every day as U-SA which indicated unsupervised self-administration. - Glucose Oral Tablet Chewable (tablet used to quickly raise your blood sugar when it is low) 4 grams (gm), Give 1 tablet by mouth every 6 hours as needed with a start date of 4/16/25. The record indicated it was given on 6/1/25 at 10:32 p.m. and marked as effective and administered on 7/3/25 at 1:34 p.m. and marked as effective. - Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 2:49 a.m.- Novolog Pen Subcutaneous Solution 100 unit/ml - Inject 5 unit subcutaneously one time only for diabetes with a start date of 6/1/25 with a one-time administration on 6/1/25 at 3:31 a.m.- Dexcom CGM G6 - Use to obtain glucose level three times daily before meals and at hs (bedtime) for diabetes with a start date of 6/14/24. - Emergency department to evaluate and treat blood glucose level of 833 and patient is symptomatic. One time only for diabetes with a start date of 6/1/25. Record indicated it was documented with a 9 which indicated other/progress note on 6/1/25 at 2:48 a.m.- Encourage patient to drink ice water and extra movement to help lower sugar. One time only for diabetes with a start date of 6/1/25 and was completed on 6/1/25 at 10:36 a.m. R36's orders lacked specific parameters on when to notify the provider regarding blood sugars. R36's Blood Sugar Summary Report, from 5/31/25 to 6/30/25, included the following blood sugar readings in milligrams per deciliter (mg/dL): 6/29/25 at 5:00 p.m. was 443 mg/dL 6/28/25 at 1:39 p.m., was 449 mg/dL 6/28/25 at 9:30 a.m., was 500 mg/dL 6/28/25 at 8:54 a.m., was 500 mg/dL 6/27/25 at 12:25 a.m., was 444 mg/dL 6/27/25 at 12:22 p.m., was 444 mg/dL 6/27/25 at 11:46 a.m., was 444 mg/dL 6/27/25 at 8:42 a.m., was 500 mg/dL 6/27/25 at 8:41 a.m., was 500 mg/dL 6/27/25 at 8:40 a.m., was 500 mg/dL 6/26/25 at 8:30 a.m., was 492 mg/dL 6/24/25 at 9:58 a.m., was 600 mg/dL 6/24/25 at 9:19 a.m., was

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to appropriately follow up on continued and repeated voiced grievances of provided food for a diabetic diet for 1 of 2 residents (R31) reviewed for grievances who gained 35% of their weight since being admitted to the care facility. Findings include:R31's annual Minimal Data Set (MDS), dated [DATE], R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes. R31's weights, listed in the electronic medical record (EMR), indicated R31 weighed 165 pounds at admission to the care center and their most recent weight was listed as 231 pounds, a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet.R31's EMR lacked any progress notes from dietary or nutritional services and lacked any mention of R31's food concerns despite repeated vocal complaints. The facility's grievance log for the past six months was reviewed and also lacked any mention of R31's voiced complaints about the food she was receiving. During an interview on 6/29/25 at 10:35 a.m., R31 stated she had to buy her own fridge and food to ensure she had foods to eat that would work within her diabetic diet, stating she should be on a diabetic diet but feels the facility does not follow it. R31 stated she had told multiple people about her food concerns but had not worked with the dietician at the care facility. During an interview on 7/1/25 at 10:48 a.m., licensed practical nurse (LPN)-B stated the food at the facility had been an issue for over a year stating they don't offer R31diabetic options such as sugar free items or syrup. LPN-B confirmed R31 had voiced her complaints plenty of times and R31 would often say, they know I'm on a diabetic diet and give me all these carbs. LPN-B further stated many times R31 would make the decision not to eat the food that was served to her. LPN-B stated dietary was aware of the complaints. During an interview on 7/1/25 at 11:58 a.m., the certified dietary (district) manager (CDM) stated if a resident had an order for a diabetic diet, then the system would automatically push starch items to half portions or substitute out that item for a different item. The CDM stated they had started education with diabetic residents to help them understand that they might still see carbs on their plate even if they were on a diabetic diet and to help the residents understand where we [the facility] are coming from regarding diabetic diets. The CDM stated R31 was on a consistent carbohydrate diet, not a renal diet, which would include more carbs than a renal diet. The CDM further stated R31 was a vocal person so the assumption was that everyone had heard her concerns, however, sometimes word doesn't travel as well as we would like - we are working to have better communication between the floor staff and us. During an interview on 7/1/25 at 12:49 p.m., LPN-A stated R31 complained about the facility food all the time and voiced complaints about not getting food consistent with a diabetic diet. LPN-A stated she let the nurse manager know about R31's complaints but had not noticed any changes. During an interview on 7/2/25 at 8:57 a.m., the third-floor nurse manager, LPN-E, stated she had heard complaints from R31 about how terrible the food was but did not recall any complaints specific to her diabetic diet. During an interview on 7/2/25 at 10:15 a.m., licensed social worker (LSW)-A, who was the grievance officer at the facility, stated she would have expected to hear about repeated concerns relating to food or receiving proper diets, confirming she did not have any formal grievances for R31. A facility policy titled Grievances/Complaints - Staff Responsibility, revised 10/2017, indicated should a staff member overhear or be the recipient of a complaint voiced by a resident concerning care in the facility, including food, the staff member is encouraged to help, or guide, the resident to file a written complaint with the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 5 residents (R7) reviewed for unnecessary medication use and who consumed antipsychotic medication. 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, All antipsychotics carry some risk of orthostatic hypotension . [which can] lead to dizziness, syncope, falls . orthostatic hypotension should be evaluated by both history and measurement . Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age.R7's quarterly Minimum Data Set (MDS), dated [DATE], indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications. R7's electronic medical record (EMR) contained an order for orthostatic blood pressure once a month due to psych medication use. The order instructed the nursing staff to obtain a lying, sitting, and standing blood pressure five minutes apart. R7's EMR further contained on order, dated 3/8/24, for Olanzapine (an atypical antipsychotic medication) 10 milligrams (mg) by mouth at bedtime. R7's most recent fall risk screening, dated 5/6/26, indicated R7 was at high risk for falls. R7's EMR, including the medication and treatment administration records, vitals section, and progress notes, lacked evidence staff had obtained orthostatic blood pressure readings for the past 2 months that were reviewed. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated there were currently no residents on R31's floor who had orders for orthostatic blood pressures that she was aware of. TMA-B stated orders for any vital signs would pop up on their medication administration records. During an interview on 7/1/25 at 1:46 p.m., consultant pharmacist (CP)-A stated all antipsychotic medications pose a risk of causing orthostasis and residents who consumed antipsychotic medications should be monitored for orthostatic hypotension. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated if a resident needed to have orthostatic blood pressure readings it would show up, and be documented, in the residents' medication administration record. LPN-A confirmed currently no residents had any orthostatic blood pressure readings. During an interview on 7/2/25 at 8:57 a.m., third floor nurse manager and (LPN)-E stated the expectation was for orthostatic blood pressure readings to be obtained monthly if a resident was receiving an antipsychotic medication. LPN-E confirmed R7 had an order for orthostatic blood pressures to be obtained monthly, however was unable to find evidence they had been completed, confirming the information was not in R7's medication or treatment administration record or vital sign documentation, stating he has an order so it should be on the MAR [medication administration record]. A facility policy titled Antipsychotic Medication Use, revised 12/2016, indicated nursing staff would monitored for side effects and adverse consequences of antipsychotic medication including cardiovascular effects such as orthostatic hypotension.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set (MDS) was completed in a thorough manner to ensure all areas of resident performance and activities preference were evaluated for 1 of 4 residents (R24) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose of providing guidance with how to complete the Resident Assessment Instrument (RAI), and it outlined an admission MDS was considered a comprehensive assessment. The manual listed a section labeled, SECTION F: Preferences For Customary Routine and Activities, along with directions to complete the section. The directions outlined, The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities. The manual directed to interact with the resident or, if needed, complete the staff examination if the resident is unable to respond. On 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G stated they had not really seen R24 participate in any activities at the care center adding, She doesn't leave her bed. FM-G stated they were unsure if R24 would participate even, however, expressed they had never been asked or consulted on R24's activity preferences, either. R24's admission MDS, dated [DATE], identified R24 admitted to the care center on 4/28/25 from the acute care hospital and had multiple medical conditions including heart failure, dementia, and a history of stroke/transient ischemic attack (TIA). The MDS section labeled, Section F - Preferences for Customary Routine and Activities, provided spacing to record answers with gathered data including an Interview for Daily Preferences (F0400) and Interview for Activity Preferences (F0500). However, the entire section of the MDS (F0300 to F0800) was either left blank or marked, Not Assessed. R24's medical record was reviewed and lacked evidence R24 had been evaluated for their routine and/or activity preferences during the assessment reference date (ARD) period (See F679). On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas dashed with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was not acceptable. RN-O reviewed R24's medical record and verified the section of the MDS had been dashed and explained staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and gives us [staff] an opportunity to see if the resident is progressing or declining. A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, Timeframes for completion and submission of assessments is based on the current requirements published in the [RAI].

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the quarterly Minimum Data Set (MDS) was completed in a thorough manner to ensure areas of cognition and potential depressive symptoms were fully evaluated for 2 of 4 residents (R22, R23) reviewed for MDS accuracy and completion. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined a quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident' status between comprehensive assessments . to ensure critical indicators of gradual change in a resident's status are monitored. The manual included a section labeled, SECTION C: COGNITIVE PATTERNS, which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, These items are crucial factors in many care-planning decisions; with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, SECTION D: MOOD, which outlined the section would be used to help address mood distress and social isolation adding, Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity, and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R22R22's most recent quarterly MDS, dated [DATE], identified R22 had multiple medical conditions including high blood pressure, renal insufficiency or failure, and dementia. The MDS listed, Section C - Cognitive Patterns, with areas to record R22's Brief Interview for Mental Status (BIMS) and/or the Staff Assessment for Mental Status. However, nearly all of these responses were marked, Not Assessed. In total, section(s) C0100 to C1000 were marked, Not Assessed, or left blank. The MDS listed, Section D - Mood, with areas to record R22's Resident Mood Interview (PHQ-9) and/or a Staff Assessment of (the) Resident Mood, and potential social isolation symptoms. However, again, nearly all of these responses were marked, Not Assessed. In total, section(s) D0100 to D0700 were marked, Not Assessed, or left blank. R22's medical record was reviewed and lacked evidence either of these sections or corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the assessment reference date (ARD) to help determine what, if any, complications or issues R22 was demonstrating with these respective areas. R23R23's most recent quarterly MDS, dated [DATE], identified R23 had multiple medical conditions including a history of stroke and aphasia (language disorder; difficulty with words). The MDS listed, Section C - Cognitive Patterns, with areas to record R23's BIMS and/or the Staff Assessment for Mental Status. However, nearly all of these responses were marked, Not Assessed. In total, section(s) C0100 to C1310 were marked, Not Assessed, or left blank. The MDS listed, Section D - Mood, with areas to record R23's Resident Mood Interview (PHQ-9) and/or a Staff Assessment of (the) Resident Mood, and potential social isolation symptoms. However, again, nearly all of these responses were marked, Not Assessed. In total, section(s) D0100 to D0700 were marked, Not Assessed, or left blank. R23's medical record was reviewed and lacked evidence either of these sections or corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the ARD to help determine what, if any, complications or issues R23 was demonstrating with these respective areas.On 6/30/25 at 3:02 p.m., registered nurse (RN)-O was interviewed via telephone, and verified they were currently completing the MDS for the campus adding they had been involved with the care center for about a month now. RN-O stated they had noticed some MDS(s) having areas dashed with no data being completed during the ARD to record on the MDS which RN-O stated they explained to the facility was not acceptable. RN-O reviewed R22's medical record and verified the sections of the MDS were dashed and reiterated staff should be doing the corresponding assessments within the ARD so they could be coded on the MDS. RN-O reviewed R23's medical record and verified the sections of the MDS were dashed and, again, reiterated the dashing situation had been explained to the staff at the campus. RN-O stated getting the assessments and MDS fully completed were important as it impacts the care centers quality measures and gives us [staff] an opportunity to see if the resident is progressing or declining. A facility provided MDS Completion and Submission Timeframes policy, dated 7/2017, identified the care center would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy added, Timeframes for

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 residents (R50) reviewed for hospitalization.Findings include: R50's Discharge-return not anticipated Minimum Data Set (MDS) dated [DATE] identified discharge from facility was planned and R50 discharged to Short-Term General Hospital (acute hospital, IPPS).During record review, R50's nursing progress noted dated 4/13/25 identified Resident discharged from the facility to home with all her medication and instruction with her family members at 3:30 p.m.During interview with licensed practical nurse (LPN)-A on 6/30/25 at 5:01 p.m., LPN-A stated she recalled R50 and stated, She went home it was planned. During interview with R50 on 6/30/25 at 6:00 p.m., R50 stated, Yes I was there and discharged home.During interview with registered nurse and MDS facility liaison (RN)-MDS on 7/1/25 at 10:36 a.m., RN-MDS reviewed R50's electronic medical record (EMR) and stated R50 discharged home on 4/13/25. Further review of R50's Discharge-return not anticipated MDS dated [DATE], RN-MDS stated the MDS was coded incorrectly, it is not accurate. RN-MDS stated expectation for MDS to be coded accurately was it concerns payment sources. During interview with MDS clinician (MDS) on 7/1/25 at 12:13 p.m., MDS reviewed R50's 4/13/25 Discharge-return not anticipated MDS and confirmed, we have [R50] dc'd [discharged] to hospital. MDS stated that it looks like it was coded incorrectly and incorrectly coding will affect quality measures for the facility and impacts payment and reimbursement. Facility policy titled Certifying Accuracy of the Resident Assessment, revised 2019 state The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 2 residents (R37) reviewed for diet preferences/allergies. Findings include: R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood, and the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated the facility was aware of his food allergy. R37 stated he did not eat it, but it happened again just a few days ago and he had followed up with staff. R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: - Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up- Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -Administer medications as ordered. Monitor/Document for side effects and effectiveness. -Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc. -Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. -Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. - Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions. -Provide and serve supplements as ordered: Ensure TID -RD to evaluate and make diet change recommendations PRN.The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says no brown sugar on oatmeal per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions.R37's allergy list, printed 7/2/25, lacked indication of allergy to shellfish, seafood or fish. R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*. On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants used the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R37 and worked with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a no added salt diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic too. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated residents' food allergies and their food preferences should be listed on their care plan. DON verified R37's food allergies and food preferences were not listed and should be on the care plan. A facility policy titled Care Plan, Comprehensive Person-Centered, reviewed

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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** Based on interview and document review, the facility failed to provide routine care conferences to allow for resident participation and interdisciplinary review, and update, if necessary, of the care plan for 1 of 2 residents (R41) reviewed for care conferences. Findings include:R41's quarterly minimum data set (MDS), dated [DATE], indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. R41's electronic medical record (EMR) indicated R41 had one care conference since being admitted to the care facility. A progress note, dated 10/24/24, indicated R41 had her care conference today at 1:00pm. Pt [patient], SW [social worker], and Nurse Manager were in attendance.During an interview on 6/29/25 at 3:07 p.m., R41 stated she had been to maybe one care conference since being admitted to the facility and had concerns about her care. During an interview on 7/1/25 at 8:17 a.m., licensed social worker (LSW)-A stated the resident care conferences and care plan review should be held roughly every three months and generally coordinate with the MDS cycle. LSW-A stated she had not held a care conference for R41 as R41 had not been agreeable, however stated the interdisciplinary team should still meet quarterly to discuss the residents' care, even if the resident did not want to participate. LSW-A stated timely and routine care conferences were important to ensure there were no resident changes the team may have missed. During an interview on 7/2/25 at 12:06 p. m., the director of nursing stated it was expected that care conferences were held quarterly, even if the resident did not want to participate. A facility policy titled Care Plans, Comprehensive Person-Centered, revised 6/2023, indicated the interdisciplinary team would review and update the care plan at least quarterly, in conjunction with the required MDS assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide assistance to complete personal hygiene cares for 1 of 1 resident (R23) reviewed who needed assistance with fingernail care.Findings include:R23's quarterly Minimum Data Set, dated [DATE], indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). The MDS indicated R23 needed substantial/maximal assistance with person hygiene which included combing hair, shaving, washing/drying face and hands, etc R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). R23's care plan printed 6/30/25, directed staff to check nail length and trim and clean on bath day and as necessary and to report any changes to the nurse. The care plan indicated R23 required extensive assist of one staff for personal hygiene.R23's Treatment Administration Record (TAR) dated June 2025, directed staff to complete a weekly skin review and/or bath, and nursing staff to open a skin review assessment and complete. The order directed staff to chart all refusals in the evening every Wednesday. The order had a start date of 7/12/23 and discontinued date of 6/27/25.R23's Weekly Bath Audit dated 6/25/25, indicated R23 received a bed bath, did not have any new skin alterations, and was not resistive to or refused bathing. The audit did not reference nail care.R23's Point of Care (POC; an app which allows care staff to document ADLs) documentation, indicated R23 refused bathing on 6/25/25.R23's recent progress notes indicated R23 was seen by podiatry for foot care on 6/17/25. R23's progress notes did not indicate fingernail care or refusals of fingernail care.During observation and interview on 6/29/25 at 9:11 a.m., R23's nails were multiple millimeters (mm) in length with dark debris underneath them. R23 stated staff assisted him with nail care, and he would like his nails cut.During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his wheelchair and dressed. R23's nails were in the same condition as the previous observation. R23 reiterated he wanted his nails cut and cleaned.During interview on 7/1/25 at 12:04 p.m., nursing assistant (NA)-K stated R23 refused to have his nails cut at times and told the nurse when he refused. NA-K stated they would cut his nails after lunch.During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A stated residents nails were trimmed on bath days and refusals should be documented. LPN-A verified the condition of R23's nails and stated his nails needed to be trimmed.During interview on 7/2/25 at 1:58 p.m., the director of nursing expected nail care to be completed with weekly showers and as needed to prevent infection and maintain resident dignity.The facility policy Care of Fingernails/Toenails dated February 2018, indicated nail care included daily cleaning and regular trimming, and proper nail care aided in the prevention of skin problems around the nail bed and from accidental scratching and injury to residents' skin. The policy directed staff to document the reason why and intervention taken if a resident refused nail care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 1 of 2 residents (R24) reviewed for activities.Findings include: R24's admission Minimum Data Set (MDS), dated [DATE], identified R24 admitted to the care center in April 2025 from the acute care hospital, and she had multiple medical conditions including heart failure, dementia, and a history or stroke. However, the section to record R24's activity preferences and routines was left blank or marked, Not Assessed [See F636].On 6/29/25 at 10:46 a. m., R24 was observed lying in bed while in her room on the locked unit. R24's television was turned on and positioned along the opposite wall of her bed. R24 was interviewed and expressed aloud, I don't know, when asked how long they'd lived at the center. R24 was dressed in a hospital-type gown and her hair appeared with a light, greasy-looking shine. R24 was asked about what, if any, activities the floor staff involve her with and she abruptly responded, Would you leave me alone?! Following, on 6/29/25 at 1:45 p.m., R24's family member (FM)-G was interviewed via telephone. FM-G explained they had not really seen R24 participate in any activities at the care center adding, She doesn't leave her bed. FM-G stated R24 had been outside maybe once since admitting from their recall and expressed the staff may be offering them to her and she's declining them but was unsure. FM-G stated R24 had a television in her room which she needed help to operate and expressed they were unsure if staff knew that or not adding, I don't know they realize that. FM-G stated R24 enjoyed mystery and murder shows on the television. Further, FM-G reiterated they were unsure if R24 would participate in activities even, however, stated nobody from the care center had ever talked with them about her likes or dislikes for activities since she admitted . R24's medical record was reviewed and lacked evidence R24 had been comprehensively assessed for what, if any, individual or group-based activities she would like to attend; nor did the record have evidence of any other activities (i.e., 1:1) being provided. R24's care plan, printed 7/1/25, identified all R24's current or potential concerns the facility had identified and implemented interventions to address. The care plan was reviewed and lacked any recorded focus statements, goals, or interventions for leisure and/or activities despite R24 admitting to the care center months prior. Further, the entire electronic medical record (EMR) lacked any completed tasks or progress note(s) in the system to demonstrate R24 had been provided any activities since she admitted to the care center. On 6/30/25 at 1:33 p.m., R24 was again observed lying in bed while in her room. R24's television was turned on and a day-time drama television show was on. R24 was asked about the show or if she enjoyed it, however, R24 just mumbled a response which was not discernable. R24 was asked if she was able to use the remote or needed help and just stared at the surveyor with no audible response.When interviewed on 6/30/25 at 1:36 p.m., nursing assistant (NA)-A stated they had worked with R24 prior, and expressed R24 needed help with nearly all her cares. NA-A stated R24 would rarely get up from bed and expressed it all depends on her mood and what she'd allow each day. NA-A stated R24 would get up to the wheelchair maybe three to four times [week] and then added, She really likes to be in her room. NA-A stated they were aware of some activities happening at the back there on the unit, however, had only seen her at a few they could recall. NA-A stated R24 liked her criminal shows and would try to keep those on the television for her. NA-A stated they knew R24 enjoyed 'criminal shows' as I work with her a lot of times, adding nobody from the care center activities' staff had ever told them which channels or shows to play for R24 adding, I just found out on my own. NA-A verified R24 would, at times, not speak to staff and would remain silent adding R24 needed to be in a good mood to converse. When questioned how other staff, including pool staff, would know which shows or channels R24 enjoyed NA-A responded aloud, That's hard. NA-A stated the staff used a care guide which had all residents listed on it and reviewed this with the surveyor. R24's name was listed, however, the guide lacked any information on which channels, shows, or activities R24 enjoyed or wanted. NA-A verified the guide lacked this information and expressed aloud, It's not there. NA-A stated having it listed on the care guide would help others adding, Everybody works different with these people. When interviewed on 6/30/25 at 1:45 p.m., trained medication aide (TMA)-A stated they had worked with R24 prior and described her as needing a lot of help with cares. TMA-A explained R24 could be real mean sometimes and not too often would get up from bed. TMA-A stated physical therapy (PT) was working with her and even for them, R24 would still not too often get up from bed. TMA-A stated they had never seen R24 attend any activities prior and was unsure what, if any, in-room activities the staff were doing for her adding, I haven't

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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** Based on observation, interview, and document review, the facility failed to ensure proper wheelchair positioning for eating was maintained to promote comfort for 1 of 1 resident (R22); and failed to ensure medical devices for edema management were consistently applied to reduce peripheral swelling for 1 of 2 residents (R258) reviewed for edema care. Findings include: R22 R22's quarterly Minimum Data Set (MDS), dated [DATE], identified R22 had dementia but demonstrated no delusional thinking, however, the section to record R22's cognition was dashed as, Not Assessed [see F638]. On 6/29/25 at 8:48 a.m., R22 was observed seated in the Broda-style wheelchair while in the dining room on the locked unit. R22 was positioned next to the table with his meal served on the table. R22's wheelchair back was in a reclined position at approximately 50 degrees and R22 was observed leaning forward approximately 12 to 14 inches from the wheelchair back to eat his meal. The seat of the wheelchair was approximately 12 to 14 inches from the ground and the table height was elevated, placing the meal plate at R22's chest level while he consumed the meal. Later, at 8:55 a.m., R22 continued to eat the meal from his plate in the same position, with several areas of spilled food on the table and R22's lap visible. There was no obvious attempt to correct R22's position during the observed meal service. R22's Physician Order, dated 12/12/24, outlined R22 was on hospice care and directed to continue consuming a regular diet with thin liquids, using a lipped plate for all meals, and, Ensure pt [patient] is at proper positioning for all PO [oral] intake. R22's care plan, printed 7/1/25, identified all R22's current and potential problems along with interventions to address them. The care plan outlined R22 was dependent on staff for mobility using a Broda chair and listed an intervention which read, Resident will have comfortable body alignment while in their chair. This intervention had an initiation date recorded, 01/06/2025. The plan continued and outlined R22 as being independent with eating after meal tray set-up, and listed R22 as having potential for inadequate oral intake due to dementia and being on hospice care. The plan directed, Assist at meals as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 at 5:24 p.m., the supper meal service on the locked unit was observed. R22 was pushed up to the table while seated in his Broda chair by nursing assistant (NA)-C and left there. R22's Broda chair was, again, in a reclined position and R22's buttock while seated in the chair was only 12-14 inches up from the ground. The table remained at the same height as prior with the table edge being even with R22's upper chest while he was seated in the Broda chair. NA-C returned to the table after a few moments and placed a lipped plate on the table in front of R22 before leaving the table again. R22 then, again, leaned forward nearly 12 to 14 inches or more from the reclined Broda chair and began eating his meal using the provided utensils. After several minutes, R22 was observed eating his meal and the Broda chair remained in a reclined position with R22 having to lean forward while eating to reach the cups and meal items. R22 then dropped his utensil on the ground with an audible noise to which NA-H responded to him from nearby, Did you drop anything? NA-H then retrieved the utensil and placed in onto the table, however, made no attempt to reposition R22 or improve his posture despite him leaning forward from the Broda chair-back to eat over 12 inches. Following, at 5:31 p.m., NA-H was interviewed and verified they had worked with R22 prior. NA-H explained R22 typically ate meals at the table in the dining room while seated in his Broda chair and, when asked to look at R22's posture, walked over and adjusted the back of the Broda chair to a more upright position which brought R22 to a more elevated position from which to eat his meal; however, the plate still was elevated and now appeared to be level with R22's mid-chest height. NA-H stated they keep the Broda chair in a reclined position so he can't fall from it. NA-H stated they had never seen or attempted to use any other tables, such as a bedside table, to provide a better posture for R22 to consume his meals. NA-H stated they were unsure why the Broda chair was left in the reclined position when R22 was provided his meal but reiterated the Broda chair-back should be raised to a vertical position while he's eating adding, That's how he eat [sic]. When interviewed on 6/30/25 at 5:39 p.m., trained medication aide (TMA)-A stated they had worked with R22 and observed him seated at the table in the dining room. TMA-A acknowledged the seat of the wheelchair being approximately 12 inches or so from the ground and R22's plate being positioned mid-chest level despite the chair-back being raised forward. TMA-A stated the table could likely be adjusted and expressed they were unsure who, if anyone, evaluates a resident' eating posture or position adding, I don't know that. TMA-A stated R22 had used the Broda chair for awhile and expressed they had never seen any other type of table used for him at meals to see if the positioning improved. TMA-A stated, at minimum, R22's Broda chair-back should be raised forward though at meals so he can sit up while he's eating. TMA-A added, How can you really enjoy your food [sitting back]? R22's medical record was reviewed and lacked evidence R22 had been comprehensively evaluated or assessed for what, if any, alternatives or interventions were needed for his posture while seated in the Broda chair at meals despite him having to lean significantly forward from that chair to consume his meals. On 6/30/25 at 5:44 p.m., registered nurse unit manger (RN)-A stated the speech therapist would typically evaluate someone for eating posture or positioning, if needed. RN-A stated they had never seen R22 use a bedside table or anything else to provide a better posture with eating adding, I've not observed that. RN-A stated they had not noticed R22's eating position while at the table prior and expressed no one of the floor staff had mentioned to them, either. RN-A verified R22's Broda chair-back should be moved forward for meals so he's not eating at a reclined position or having to lean forward while eating adding, That's not comfortable for him. RN-A stated they'd reviewed if a bedside (lower) table would possibly improve his posture, too, adding aloud, Thank you for catching that. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/1/25 at 9:38 a.m., the director of nursing (DON) verified they were able to review R22's medical record and provided the Physician Order (dated 12/2024) as the only evaluation or documentation of his eating posture. DON stated staff should be, at minimum, bringing the chair-back forward during meals so R22 would be sitting upright for meals. This was important to do to make sure he's able to reach his food and eat comfortably. DON stated they had never noticed R22 to sit in a poor posture while at eats prior and expressed the Broda chair itself could be raised up, if needed, too. A facility' policy on wheelchair positioning or posture was requested, however, none was received. R258's quarterly minimum data set (MDS), dated [DATE], indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. The MDS further indicated R258 was dependent on staff for toileting, bathing and lower extremity dressing. R258's physician orders sheet, printed 7/2/25, indicated R258 had several medical diagnoses including lymphedema (a condition that causes swelling, usually in the arms or legs, due to a buildup of lymph fluid in the body's tissues) and congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs which often causes swelling in the legs and ankles). R258's electronic medical record (EMR) contained two orders for lower extremity swelling: TEDs (specialized stockings designed to prevent blood clots and reduce swelling, particularly in the legs and feet, by applying graduated compression) to bilateral lower extremities on for 12 hours off for 12 hours, dated 10/23/24 and lymphedema wraps (specialized bandages used to manage swelling by providing graduated compression, which helps move lymph fluid out of the affected area) to bilateral lower extremities daily, dated 9/17/22. R258's June treatment administration record (TAR) indicated nursing staff applied R258's lymphedema wraps once in the month of June on 6/17/25 (all other days were marked as refused, sleeping or hospitalized). The TAR further indicated R258 TED stockikngs were applied just once on 6/6/25 (all other days were marked as refused, sleeping or hospitalized). R258 was hospitalized on [DATE] and 6/2/25. During observation and interview on 6/30/25 at 5:45 p.m., R258 was lying in bed with a sheet over her but her legs exposed. R258's bilateral legs appeared edematous and were without wraps or TED stockings. R258 stated she has not had her TED stockings on since she returned from the hospital in the beginning of June and has never worn lymphedema wraps. During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she thought R258 had wraps for her legs but that she only administered medications for R258 and the nurses would do the wraps if she had them. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated R258 would often sleep during the day and be up at night, so when staff went in to do her treatments (i.e. wound care and TEDs) she would tell staff to go away. (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 7/2/25 at 9:22 a.m., the director of rehab (DOR) stated prior to R258's hospitalization the rehab staff had attempted to fit R258 for custom lymphedema wraps but she had refused the fitting appointment. The DOR stated nursing staff should be assisting R258 to apply her TED stockings daily to be worn for 12 hours on then off for 12 hours, stressing their importance to help reduce R258's edema and promote skin integrity, even if R258 was spending more time in bed post hospitalization. During an interview on 7/2/25 at 8:57 a.m., the third-floor manager and LPN-E stated prior to her hospitalization, R258 was good about wearing her TED stockings. LPN-E had not assessed why nursing staff were not able to apply R258's TED stockings and not assessed whether R258 would rather wear them at night while she was awake. A facility policy on edema management was request but not received.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview, and record review the facility failed to identify, implement, monitor and modify interventions to provide timely treatment and services to heal and to prevent further worsening of wounds. This failure resulted in harm for R254 when his bilateral heel pressure ulcers were not identified and addressed by facility until they progressed to stage three.Findings include:According to the national pressure injury advisory panel (NPIAP), pressure injury is defined as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. In addition, the evolution of a deep tissue pressure injury (DTI) develops from an exerted pressure about 48 hours before visible signs of purple or maroon skin. Then, about 24 hours later, the epidermis (layer of skin) lifts and reveals a dark wound bed. A stage three pressure ulcer/injury is defined as a full thickness loss of skin.R254's admissions Minimum Data Set (MDS) dated [DATE], and quarterly MDS dated [DATE], identified risk for developing pressure ulcers, had no pressure ulcers, no unhealed pressure ulcers, no unstageable pressure ulcer/injuries, and no deep tissue injuries. In addition, R254 had intact cognition, no impairment of upper and lower extremities, and was independent with self-care and mobility. R254's significant change in status (SCSA) MDS dated [DATE], identified two stage three pressure ulcers, with none of them present upon his admission to facility. In addition, R254 had severe cognitive impairment and was dependent on staff for toileting, bathing, personal hygiene. Also, R254 required assistance with mobility including sit to lying and lying to sitting on side of the bed.R254's admission MDS care area assessments (CAA) dated [DATE], identified Potential risk factors for pressure ulcers. Section of form to identify Supporting Documentation. Provide the basis/reason for items being checked, including the location & date & source was left blank. R254's CAA for the [DATE], SCSA MDS identified Actual problem for Pressure Ulcer/Injury and, Skin breakdown with risk for further breakdown and impaired healing related to terminal condition. The Care Plan Considerations identified current pressure ulcer would be addressed in the care plan with overall objective to Slow or minimize decline.R254's medical diagnoses include diabetes, rheumatoid arthritis, depression, hypertension, and congestive heart failure (CHF).The Braden Scale for Predicting Pressure Ulcer Risk is an evidence-based assessment tool in health care used for predicting a patients' risk of developing pressure ulcers. It allows health care professional to implement preventive measures effectively. Scores of less than 9 indicate Severe Risk, scores of 10-12 indicate High Risk, scores of 13-14 indicate Moderate Risk, and scores of 15-18 indicate a Mild Risk.R254's Braden assessment scores (scale to assess patients' risk of developing pressure injuries) were:[DATE] score of 18, [DATE] score of 15,[DATE] score of 15,[DATE] score of 17,[DATE] score of 15, and[DATE] score of 16. R254's care plan with focus on Skin identified resident have actual wounds to both heels and potential for impairment to skin integrity fragile skin. Date initiated was [DATE]. CP Interventions identified Reposition Frequently and Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations was initiated [DATE]-four days before R254 expired.R254's provider progress notes (PN) dated [DATE], [DATE], [DATE], [DATE], [DATE] identified No rash, or lesions under Examination section of form. Provider PN dated [DATE] identified, No breakdown in hands or heels and to monitor for acute skin care breakdown.R254's hospital discharge summary (DC) dated [DATE], identified hospitalization from [DATE] to [DATE] for urinary retention and urinary tract infection. DC summary identified, no rashes, ulcerations on exposed skin surfaces. Upon admission to hospital R254 had bruising to coccyx which was identified [DATE], with no other skin issues identified.During review of PN dated [DATE] identified R254 readmitted to facility from hospitalization. PN failed to indicate any assessment or issues with skin integrity. PN dated [DATE] at 5:23 p.m., identified R254 felt like[sic] had an [sic] heart attack, and would like to go to the hospital for checkup. Orders were received to send to hospital. PN dated [DATE] at 11:07 p.m., stated R254 returned from hospital at 3:15 p.m. and failed to indicate any assessment or issues with skin integrity.R254's hospital DC summary dated [DATE], identified R254 hospitalized [DATE] to [DATE] for report of chest pain. During hospitalization on [DATE] a Pressure Injury: Suspected Deep Tissue Injury to left and right heels were first observed on [DATE] at 10:58 p.m., and both wounds were identified has being present Prior to Admission.R254's weekly bath audits (BA) dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], identified, no new alterations in skin. [NAME] were marked as, weekly wound assessment initiated and completed. R254's podiatry

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 resident (R23) reviewed for limited range of motion (ROM).Findings include:R23's quarterly Minimum Data Set, dated [DATE], indicated R23 had no behaviors or rejection of cares, unclear speech, and responded adequately to simple, direct communication. R23 had functional limitation in range of motion to one upper extremity and one lower extremity. R23 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R23's diagnoses included stroke, hypertension, and hemiplegia (severe or complete loss of strength to one side of the body) and hemiparesis (weakness on one side of the body). The MDS indicated R23 was not on a restorative nursing program during the look-back period (LBP). R23's care plan printed 6/30/25, indicated R23 required extensive assistance of two staff to turn and reposition in bed, extensive assistance of one staff to transfer between surfaces, encourage resident to participate to the fullest extent possible with each interaction, and physical and occupational therapy to evaluate and treat as per provider orders. A functional maintenance program directed nursing to assist patient with applying AFO (ankle-foot orthosis) foot brace to right foot and then ambulate 100 feet with CGA (contact guard assist) and quad cane (walking aid with a base which has four legs or prongs). The care plan identified R23 refused to walk and refused to wear the AFO brace with date of 1/4/25.R23's ROM and Mobility assessment dated [DATE], indicated had an impairment on onside of both upper and lower extremity and was not steady and only able to stabilize with staff assistance to move from a seated to standing position. The assessment indicated walking, moving on and off a toilet seat, and surface-to-surface transfer did not occur. R23 used a wheelchair. The assessment indicated direct care staff believed R23 was capable of increased independence in at least some ADLs and did not include interventions/exercises to ensure R23 maintained his ROM if needed.R23's physician order dated 11/16/21, included nurse to ensure resident wore AFO brace to his right foot when out of bed every shift with start date of 11/16/21.R23's Treatment Administration Record (TAR) dated June 2025, directed nurses to ensure R23 was wearing his AFO brace to right foot when out of bed every shift. All three shifts were marked as completed every day except for three morning shifts. R23's progress notes dated 12/13/25 to 7/1/25, indicated one refusal to wear AFO brace.R23's medical record did not indicate interventions/exercises for R23's right upper extremity.During observation and interview on 6/29/25 at 9:14 a.m., R23's right arm was in a sling and right-hand fingers were curled towards his palm. R23's right foot was on the wheelchair pedal and left foot was on the ground. R23 did not have a leg brace on. R23 stated staff did not complete exercises with him.During observation on 7/1/25 at 7:42 a.m., R23 was dressed and in his wheelchair. R23 had a sling on and no brace on his legs.During observation and interview on 7/1/25 at 11:59 a.m., R23 was in his room in his wheelchair. R23 stated yes when asked if staff completed exercises with him today. R23 did not have a brace on his legs. When asked about the leg brace, R23 used his left foot to propel in his wheelchair to his closet and opened the closet. A leg brace was not found in his closet. During interview on 7/1/25 at 12:04 p. m., nursing assistant (NA)-K stated they were unaware of any boot or brace for R23. NA-K stated he used to have a brace for his leg and was unsure if nursing stopped the brace. NA-K stated they completed range of motion with R23 but did not document the range of motion they completed. NA-K stated approximately four days ago they opened R23's right hand to clean it.During observation and interview on 7/1/25 at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R23's care sheet, which indicated R23 did not walk and AFO [right] foot when out of bed which is refused by resident. LPN-A stated staff should notify them if R23 refused the AFO brace, so LPN-A could write a progress note and let the provider or therapy know if needed. LPN-A observed R23's right hand and stated nursing could recommend therapy for R23.During interview on 7/1/25 at 12:30 p.m., NA-J stated R23's hand condition was unchanged since previous and had never seen a brace for his legs.During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapy had not been recently involved with R23's right upper extremity or AFO brace. DOR expected to be notified of a change in AFO brace, and occupational therapy addressed concerns with residents' hand mobility. DOR stated R23 had MA (medical assistance) pending for insurance coverage, and the business office was involved with setting R23 up with a guardian since R23 was nonverbal. DOR reviewed R23's therapy file which included:-R23's Functional Maintenance/Restorative Nursing Program form undated (copy provided had bottom part cut off), indicated treatment recommendations to assist R23 with right foot AFO brace and

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess and develop interventions as needed to reduce the risk of accidents or injury for 2 of 2 residents (R41, R38) reviewed with a history of substance abuse and suspected current use. In addition, the facility failed to implement interventions for 1 of 1 resident (R35) reviewed for falls.Findings include:R41's quarterly minimum data set (MDS), dated [DATE], indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact.R41's diagnoses list, dated 7/13/24, indicated R41 had several medical diagnoses including psychoactive substance dependence. R41's Associated Clinic of Psychology (ACP), dated 5/20/25, indicated facility staff informed the ACP practitioner of concerns of suspected substance use, which was also listed as a barrier to care on the ACP visit note. R41's electronic medical record (EMR) lacked any documented interventions, assessments, or monitoring protocols related to suspected substance use. Furthermore, there were no care plan elements or guidance in place outlining staff responsibilities or actions to take if substance use was suspected. The absence of such documentation and intervention planning presents a potential risk to R41's health and safety, as well as to the safety and well-being of other residents and staff in the facility.During an interview on 7/1/25 at 9:36 a.m., trained medication aide (TMA)-B stated she had not seen R41 using drugs but had suspected it on more than one occasion. TMA-B stated when she suspected R41 of substance use, R41 would be doubled over in her chair with glassy eyes, pinpoint pupils and slurred speech. TMA-B stated, you can tell she is on something confirming she has reported the concern to the nurse manager more than once but nothing is getting done. TMA-B stated something needed to be done because anything could happen. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and licensed practical nurse (LPN)-E stated she was aware R41 had a history of substance use and stated staff have reported smelling burning coming from R41's room at times. LPN-E confirmed there was no care planned interventions for suspected substance abuse, but should be, stating it would be expected that staff check on R41 every 15 minutes if they suspected she was using substances. R38's significant change Minimum Data Set (MDS) dated [DATE], indicated R38 had intact cognition with no delusions, hallucinations, or rejection of care behaviors. The MDS indicated R38 was independent with chair/bed-to-chair transfers and could wheel 150 feet in a wheelchair independently. The MDS indicated R38 was diagnosed with heart failure, kidney disease, diabetes, anxiety, and depression. R38's hospital note dated 1/4/25, indicated R38 was brought to the emergency department due to abnormal movements. The note indicated R38 had reported to hospital staff that he had smoked crack cocaine two days prior. R38's care plan dated 1/6/25, included a care plan titled substance use disorder and indicated R38 had tardive dyskinesia (involuntary muscle movements) related to cocaine use, with the sole intervention being that the resident will be offered chemical use counseling as appropriate. During an interview on 7/1/25 at 9:50 a.m., R38 stated he had used methamphetamine (meth) once, but he didn't like it so did not plan to use it again. R38 stated he had smoked crack cocaine in the past but could not recall the last time this had occurred and claimed he had never smoked crack while residing at the facility. R38 stated he was trying to get himself completely healthy so he wasn't using anymore and only gets 98 bucks a month, so he couldn't buy crack now even if he wanted to. R38 confirmed he had been offered chemical use counseling, but did not want the services. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/29/25 at 8:58 a.m., R153 stated R38 does crack at night. R153 stated he hears the click, click, click, of the lighter but has not seen R153 use crack cocaine. R153 stated he hadn't told staff about it, but they should know. On 6/30/25 at 1:33 p.m., R153 stated that in the last week, R38 had asked him for money to buy crack. R153 stated R38 would barricade the door with a dresser when he was smoking crack, and R38 told him he would hurt him if he put his call light on while he was smoking. R38 stated the last time this happened was on either Friday (6/27/25) or Saturday (6/28/25) night. During an interview on 6/29/25 at 12:55 p.m., licensed practical nurse (LPN)-B confirmed she was the nurse in charge of R38's care this shift. LPN-B stated that facility staff had suspected that R38 was using illicit drugs, but she had never observed signs or symptoms of this herself. When asked what monitoring was in place regarding R38's suspected illicit substance use, LPN-B stated they probably should but did not currently have any monitoring in place or a plan for if illicit substance use was suspected. During an interview on 6/30/25 at 1:57 p.m. with the administrator and director of nursing (DON), the administrator stated they had not been notified of any allegations of R153's using crack cocaine, and the DON confirmed she had also not been aware of these allegations and had not seen any symptoms of intoxication or been notified of anyone finding any drug paraphernalia, and was unsure if further assessments had been completed regarding R38's illicit substance use. During an interview on 7/2/25 at 10:01 a.m., the DON stated if a resident had a known history of illicit substance use, she would expect this to be care planned and assessed for, as well as implementing monitoring for signs or symptoms of substance abuse as well as collaborating with the provider for any additional orders if needed. The DON stated this monitoring would be outlined in either the care plan or orders. R38's medical record was reviewed, and it did not indicate that monitoring for illicit substance use was in place or that a comprehensive assessment of R38's substance abuse disorder had been completed. The facility's Substance Abuse Policy dated 6/29/25, indicated if a resident had a substance abuse disorder or displayed the potential for a substance abuse disorder, the facility would assess the residents to determine substance abuse disorder triggers, therapies/support available, and the resident's willingness to participate in substance use disorder services. The policy indicated that facility staff would assess for substance abuse disorders and triggers upon admission, readmission, and quarterly. The policy indicated that, based on assessment outcomes, an individual care plan would be developed and provide approaches for reducing triggers for substance use. The policy indicated it was essential to monitor if a resident who was suspected of illegal drug use was a danger to themselves, others, and /or staff. R35 Falls R35's annual assessment dated [DATE], indicated R35 had moderate cognitive impairment and diagnoses of osteoporosis, asthma, Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required staff assistance with most activities of daily living. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's care plan printed 6/29/25, indicated R35 was independent to turn and reposition in bed and transferred with staff supervision. R35 was at risk for fall related to Alzheimer's disease and safety awareness. The care plan indicated R35's last fall was 5/20/24. The care plan's fall interventions included:-Anticipate and meet the resident's needs dated 1/29/24.-Be sure call light within reach and encourage resident to use it for assistance as needed dated 5/16/24.-Physical therapy to evaluate dated 5/20/24.-Physical therapy to evaluate and treat as ordered or PRN (as needed) dated 10/16/24.-Obtain order for physical therapy to evaluate and treat for 12/16/24 fall dated 12/18/24.-Keep walker next to bed for fall on 12/1/24 dated 1/28/25. R35's Resident Fall Risk assessment dated [DATE], indicated R35 was at high risk for falls related to intermittent confusion, history of one to two fall in the past three months, ambulatory and incontinent, took one or two of the medications indicated in the assessment currently and/or within the last seven days, and had one or two of the indicated predisposing diseases. R35's progress notes indicated:-On 6/13/25 at 6:30 p.m., R35 was found on the floor next to the nursing station. R35 had her shoes on and stated she tried to stand up and twisted her leg and sat on the floor. R35's vital signs were noted, and R35 stated she did not have pain. R35 was able to move her upper and lower extremities without pain. R35 was helped to wheelchair with Hoyer lift and two nursing assistants. Family member (FM)-R, nurse manager, and provider were called. Neurological checks were started.-On 6/16/25 at 9:52 a.m., an interdisciplinary note indicated R35 was demented and forgot good body mechanics during movements. Physical therapy was requested to strengthen her mobility. R35's Un-witnessed Fall risk management assessment dated [DATE], indicated an incident description and immediate action taken which repeated information from the progress note dated 6/13/25. The assessment indicated no predisposing environmental factors, physiological factors including confusion and fear of falling, and situational factors of ambulating without assistance and using a walker. R35's electronic health record did not indicate therapy involvement after her fall. During interview on 06/29/25 at 10:56 a.m., FM-R stated R35 fell about a couple weeks ago, and R35 had no pain and did not need to be sent to the hospital. FM-R stated they did not know about any new intervention the facility implemented, and the facility continued with the current fall interventions. During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated staff stayed with residents who they found on the floor and called the nurse. NA-A stated the nurse assessed the resident and determined if 911 needed to be called or if staff could move residents using a Hoyer lift. NA-A stated fall interventions were noted in residents care plans and staff read the care plans every day. NA-A stated R35 was not really a fall risk but always made sure R35 had her walker and reminded R35 to lift her feet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses were called when a resident had an unwitnessed or witnessed fall. RN-A stated nurses took residents' vital signs, performed neurological checks, checked for injuries and range of motion. Nurses determined if the resident was safe to move or if 911 was needed. RN-A stated nurses notified the family, manager, and provider. A risk management assessment was completed of each fall to describe the situation and what interventions were implemented. RN-A stated R35 was a fall risk and stayed close to staff for monitoring. RN-A stated fall interventions prevented R35 from future falls. RN-A stated nurses obtained therapy orders if therapy was a fall intervention, so therapy could work on strengthening with residents. RN-A thought R35 was being seen by therapy. During interview on 7/2/25 at 9:48 a.m., the director of rehabilitation (DOR) stated therapies most recent encounter with R35 was in September of 2024 for speech therapy. DOR stated she was at a meeting where therapy was discussed after her last fall but did not see any orders come through to start therapy with R35. DOR stated therapy orders from the provider came through nursing or the health unit coordinator and they usually received a therapy order within a couple days after discussed, and indicated R35's fall risk management was signed on 6/17/25. During interview on 7/2/25 at 11:38 a.m., licensed practical nurse (LPN)-B reviewed R35's risk management assessment related to R35's fall on 6/13/25. LPN-B stated an immediate intervention should have been implemented and verified R35 had no current therapy orders. LPN-B stated nurses were able to obtain therapy orders within 24 hours unless the order was needed over the weekend. LPN-B stated fall interventions were important to prevent falls, and physical therapy would help strengthen R35. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to implement immediate fall interventions, review and discuss falls, and update the care plan. The DON stated staff were able to get therapy orders timely to give to the therapy department. The DON stated implementation of fall interventions were important to prevent residents from repeated falls. The facility Falls - Clinical Protocol dated November 2022, directed the staff and physician to assess residents at risk for falls and residents who have fallen to identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The facility Falls and Fall Risk, Managing policy dated November 2022, directed staff to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to recognize and respond to a resident's weight gain in the facility to ensure they maintained acceptable parameters of nutritional status, such as desirable body weight, for 1 of 2 residents (R31) reviewed for nutritional status who gained 35% of their weight since admittance to the care facility. Findings include:R31's annual Minimal Data Set (MDS), dated [DATE], R31 was admitted to the care facility on 4/29/25 and was cognitively intact. The MDS further indicated R31 had the following diagnoses; hypertension (high blood pressure), peripheral vascular disease, hyperlipidemia (high cholesterol), asthma and diabetes. R31's weights, listed in the electronic medical record (EMR), indicated R31 weight 165 pounds at admission to the care center and most recent weight was listed as 231 pounds, 66 pounds and a 35.8% increase. R31's EMR indicated an order, dated 4/29/24 for a diabetic, regular textured diet.R31's most recent Nutrition Data, dated 4/26/25, indicated R31's weight was up 62.8 pounds over 6 [six] months but lacked any interventions to address R31's significant weight gain indicating RD [registered dietician] to follow PRN [as needed]R31's EMR lacked any follow up from dietary or nutrition services regarding R31's weight gain. During an interview an on 6/29/25 at 10:35 a.m., R31 voiced concerns about the food quality she had been receiving at the care facility, stating it was not an appropriate diabetic diet and she had gained at least 35 pounds since being there. R31 voiced frustration at working hard to lose 60 pounds before coming to the care facility and had not had a dietician reach out about her weight gain or concerns about the food she had been receiving. During an interview on 7/1/25 at 1:02 p.m., the dietary manager (DM) stated she was aware of R31's concerns regarding the food but that R31 had chosen to exercise their resident rights to eat what [they] want confirming she had not spoken with R31 about their weight gain but will plan to now. During an interview on 7/2/25 at 8:57 a.m., third-floor manager and licensed practical nurse (LPN)-E confirmed she had heard complaints from R31 about the terrible food, and after review of R31's EMR, confirmed R31 had gained 66 pounds since admission. LPN-E stated the dietician was usually on top of nutritional status and should have recognized R31's significant weight gain and followed up with R31.A facility policy titled Weight Assessment and Intervention, revised 2/2022, indicated undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes:a. the resident's target weight range (including rationale if different from ideal body weight);b. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake;c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; andd. whether and to what extent weight stabilization or improvement can be anticipated.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a resident's pain was adequately controlled and failed to implement non-pharmacological pain interventions (i.e. heat, ice, massage, aromatherapy) if needed for adequate pain control for 1 of 2 residents (R41) reviewed for pain.Findings include: R41's quarterly Minimum Data Set (MDS), dated [DATE], indicated R41 was admitted to the care facility on 7/3/24 and was cognitively intact. The MDS lacked a pain assessment. R41's diagnoses, dated 7/3/24 indicated in R41 had several medical diagnoses including person injured in unspecified motor-vehicle accident, traffic, subsequent encounter; intervertebral disc degeneration lumbosacral region with discogenic back pain and lower extremity pain; and dorsalgia (back pain). R41's electronic medical record (EMR) contained several orders for medication and monitoring that included; oxycodone oral capsule 5 milligrams (mg) - Give 5 mg by mouth every four hours as needed for breakthrough knee pain - Max 2 doses per day, dated 6/11/25, Gabapentin Oral Capsule - Give 300 mg by mouth two times a day for pain, dated 11/25/24, and pain monitoring every shift. R41's EMR lacked any documented evidence of pain monitoring every shift. The EMR further lacked any documented evidence of staff offering R41 non-pharmacological interventions for pain including what, if any was offered, accepted or effective to help alleviate R41's pain. R41's Pain Assessment, dated 6/23/25, indicated R41 had moderate pain over the past five days however, the section for non-medication interventions for pain was left blank. R41's Associated Clinic of Psychology note, dated 4/23/25, indicated R41 let the clinician know she was struggling with pain with the clinician encouraging R41 to talk with her doctor abut pain to help mitigate. R41's care plan, dated 1/5/25, indicated R41 was at risk for pain related to previous lower extremities fractures second to motor vehicle accident. The care plan contained the following interventions, dated 7/8/24, anticipate R41's need for pain relief and respond immediately to any complaint of pain, pillows under legs when in bed, and pain meds as ordered. During observation and interview on 6/29/25 at 3:10 p.m., R41 was in visible pain and started to cry stating she struggled with pain before her car accident, in which she broke both her legs and an arm, which has exacerbated her pain, stating somedays the slightest movement is excruciating. R41 stated she can receive 5mg of oxycodone twice a day and tells staff it is not working to control her pain but staff look right through her. R41 further stated she cannot sleep because of her pain and choses to sleep in her wheelchair because it is more comfortable than sleeping in bed. During an interview on 7/1/25 at 9;36 a.m., trained medication aide (TMA)-B stated she had been working at the facility for approximately two years. TMA-B stated the nursing staff ask R41's pain level when they administer her as needed oxycodone but not routinely. TMA-B also stated she had not seen any non-pharmacological pain interventions being used, stating nursing staff just throw narcs [narcotics] at them [residents]. During an interview on 7/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated R41 was working with the pain doctor for her pain but that the facility did not attempt to use non-pharmacological interventions for pain. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated she had just recently started putting non-pharmacological pain interventions on the treatment administration records for residents who had pain. LPN-E confirmed R41 did have pain but did not currently have staff monitoring her pain every shift and was not receiving any non-pharmacological pain interventions. A facility policy titled Pain Assessment and Management, revised 3/2020, indicated non-pharmacological interventions maybe appropriate alone or in conjunction with medications and include environmental (i.e. room temperature), physical (i.e. ice or heat), and cognitive or behavioral interventions (i.e. relaxation, music).

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to identify triggers or attempt to identify triggers to avoid potential re-traumatization, and failed to develop a care plan to include individualized trauma-informed approaches for 1 of 1 residents (R36) who had a history of trauma. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). R36's diagnosis report, printed 7/2/25, included the following pertinent medical diagnoses: post-traumatic stress disorder, alcohol dependence, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, unspecified affective mood disorder, and chronic pain. During an interview on 6/29/25 at 10:40 a.m., R36 stated she had PTSD and had known triggers. R36 stated no staff at the facility had ever talked to her about her triggers or her trauma. R36 stated her triggers included when the staff started getting loud outside the room, when the staff came in and poked her to wake her up, and when staff came in and talked loudly to her. R36 stated again that no staff had ever talked to her about this before or asked her if there aware certain things that triggered her, and stated she would be willing to talk to staff about triggers. R36's care plan, printed 7/2/25, indicated resident reports a history of trauma related to experiencing an abusive husband/relationship and vulnerability of not being able to take care of herself. Interventions included to assist resident with identifying her personal strengths, observe resident for isolation and seclusion, and provide comfort and reassurance for resident. The care plan lacked identification of any triggers, or plan to help identify any triggers to help better care for resident. R36's Social Service Primary Care PTSD Screen, dated 2/21/24, indicated R36 was asked four questions on the PTSD screening and responded yes to all four questions, indicating they have had nightmares about it/thought about when they didn't want to, went out of their way to avoid situations that remind them of it, were constantly on guard, watchful or easily startled, and felt numb or detached from others, activities or surroundings. R36's Social Service Trauma Informed Care History, dated 2/21/24, identified the following information. R36 was able to identify the most difficult time in their life and indicated they had been through a life threatening or traumatic event. The following questions had unknown as a response: what helped get you through those difficult times, and what are some things that you do now to help you manage consequences of have gone through tough times. When asked about triggers, the answer typed in the box was none. The electronic medical record (EMR) lacked follow-up assessments when R36 was readmitted to the facility, during quarterly, or annual assessment to help identify triggers. R36's care guide, printed 6/30/25, was reviewed and lacked evidence of any triggers or identification of possible triggers. During an interview on 6/30/25 at 5:16 p.m., nursing assistant (NA)-F stated they were familiar with R36. NA-F stated R36 did not have any mental health concerns, PTSD, or triggers, adding nothing like that. During an interview on 7/1/25 at 9:41 a.m., trained medication aid (TMA)-A stated if a resident had a history of PTSD and had triggers it would be important to know what their triggers were to better care for them. TMA-A stated their triggers would be on the care sheets if a resident had PTSD. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36 and worked with her often. LPN-A stated she was unsure if R36 had PTSD, proceeded to verify she did on the diagnosis list, and stated R36 did not have any triggers. LPN-A stated that if R36 had any triggers, they would document that in a progress note. During an interview on 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated she believed R36 had a diagnosis of PTSD, verified the diagnosis on R36's diagnosis list, and stated she was not aware of any triggers for R36. LPN-E stated she would think if she had any triggers, it would be on her care plan. LPN-E reviewed her care plan and stated there were no identified triggers on her care plan. LPN-E stated there was a section on the care plan for trauma informed care, but verified it did not identify triggers or plan to identify triggers to help better care for R36. LPN-E did not answer when asked about who assessed residents for triggers from PTSD. On 7/2/25 at 11:37 a.m., director of nursing (DON) stated if a resident had PTSD they needed to be assessed for triggers, and those triggers would be documented on the care plan to help better care for the resident. DON stated assessments for triggers were done upon admission, quarterly, annually, and as needed, and stated these assessments would help identify any triggers, and behaviors would also be monitored.A facility policy titled Trauma Informed Care, revised 3/19, identified nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complications for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 had intact cognition. R10's quarterly MDS dated [DATE], indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders:- 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25, and the evening dose on 6/19/25. The medication was documented as a 9 (other/see progress notes) for the first and second dose on 6/19/25, and then 6/20/25 through the second dose on 6/23/25.- Five mg of oxycodone three times a day starting on 2/20/25, and discontinued on 6/23/25. The order was documented as given 6/1/25, through the second dose on 6/23/25.- 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a 9 was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25.- Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25, and a 9 was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone:-dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was not available with no indication the medication had been re-ordered.-dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider.-dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider.-dated 6/20/25 at 9:02 p.m., indicated nursing staff were awaiting delivery of 2.5 mg of oxycodone.-dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription.-dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone.-dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given.-dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was on order.-dated 6/22/25 at 10:03 p.m., indicated there was no supply of the 2.5 mg of oxycodone.-dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was on order.-dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was on order.-dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given.-dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available.-dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available.-dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was on order. R10's progress note dated 6/20/25 at 4:19 p.m., indicated R10's provider had been contacted to request a new prescription for her 2.5 mg order of oxycodone. R10's progress note dated 6/30/25 at 9:56 a.m., indicated a call was placed to the provider to get a new prescription for her oxycodone. R10's progress note dated 6/30/25 at 11:58 a.m., indicated that a voicemail was received from the provider indicating a new prescription [did not indicate what medication] was sent to the pharmacy. R10's progress notes were reviewed dated 6/1/25 through 6/30/25, and did not indicate any further requests for oxycodone were made. R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain documented. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt shaky and her pain has been terrible since she started missing doses

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	245289	A. Building B. Wing	07/02/2025

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

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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 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** Based on interview and document review, the facility failed to ensure a resident was free from unnecessary medication by failing to attempt to decrease a resident's nicotine patch (a known psychotropic medication) despite the consulting pharmacist's and Centers for Disease Control and Prevention's recommendations for 1 of 5 residents (R7), and failed to monitor, assess, and clarify an antibiotic without an end date for 1 of 5 residents (R25) reviewed for unnecessary medications.Findings include: R7's quarterly Minimum Data Set (MDS), dated [DATE], indicated R7 was admitted to the care facility 7/18/22, and was cognitively intact. The MDS further indicated R7 had consumed the following medication during the seven-day look back period of the assessment; antipsychotic, antianxiety, antidepressant, and hypnotic medications. R7'S electronic medical record (EMR) contained an order, dated 3/8/24, for a Nicotine Transdermal Patch 24 Hour 21 milligrams (MG) per 24 hours (Nicotine) - Apply one patch transdermal (on the skin) every 24 hours for nicotine dependence in remission. R7's most recent smoking review, dated 5/6/25, indicated that R7 was currently smoking and intended to continue to smoke. R7 was also on the facility provided list of residents who smoke. R7's care plan, dated 5/12/25, indicated R7 was a current smoker, trying to quit, resident received Nicotine Patch each morning will sometimes refuse it. R7's monthly medication regiment reviews (MRR), dated 2/21/25, 3/24/25, 4/24/25, and 5/23/25 all indicated a pharmacist recommendation to decrease R7's nicotine patch and to discontinue it if resident was still choosing to smoke. The consultant pharmacist (CP)-A gave a rationale of nicotine being a psychotropic medication intended to help a person quit smoking by reducing nicotine dependence and manage withdrawal symptoms. CP-A further indicated the CDC advises nicotine patch doses should be lowered overtime (8-12 weeks) with a goal of stopping use of the nicotine patch completely. On the MRR dated 5/23/24, the provider had checked agree. A handwritten note on the MRR from LPN-E, dated 5/29/25, indicated resident [R7] refused to have patch decreased, stated that the patch keeps him from smoking, the he has not smoked in long time. Provider updated. During an interview on 6/30/25 at 5:41 p.m., trained medication aide (TMA)-C stated R7 was currently still smoking. During an interview on 6/30/25 at 5:47 p.m., trained medication aide (TMA)-D stated R7 was currently still smoking. During an interview on 7/1/25 at 8:06 a.m., R7 stated he has not smoked in a couple of months. During an interview on 7/1/25 at 9:36 a.m., TMA-B stated she had worked at the facility for a few years and stated R7 smoked heavily and would still go outside to smoke daily. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/1/25 at 1:46 p.m., CP-A stated she had issued the recommendation to decrease R7's nicotine patch and had received a response in June from her May recommendation that the provider had agreed to decrease the dose but R7 had refused. The CP stated the intent of a nicotine patch was to assist a resident to quit smoking and was safer than smoking however, staff or R7 would not know how effective the patch was in helping R7 quit if it was not reduced, stating ideally it would be nice to reduce the dose, and ideally R7 would not be on the patch forever. CP-A further stated there were alternatives to the nicotine patch that R7 could try such as nicotine gum or lozenges to attempt to decrease R7's nicotine patch. CP-A further stated the patch should be discontinued if R7 was still smoking. During an interview on 7/2/25 at 8:57 a.m., third-floor nurse manager and LPN-E stated R7 had told her he was not smoking however R7 was outside a lot, so she was unsure if R7 was still smoking or not. LPN-E stated they had tried to discontinue or reduce R7's nicotine patch but he refused and had been on the patch for a long time and demanded it. LPN-E stated she had sent the provider messages that R7 was still on the nicotine patch but did not know what the provider's response was. A facility policy titled Tapering Medications and Gradual Dose Reduction, revised 4/2007, indicated attempted tapering of psychopharmacological medications shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. R25 R25’s quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had severely impaired cognitive skills for daily decision making. R2’s diagnoses included hypertension, diabetes mellitus, neurogenic bladder, aphasia, traumatic brain injury, epilepsy, anxiety disorder, and depression. The MDS indicated R25 received an antibiotic medication. R25’s care plan printed 6/29/25, indicated R25 directed staff to administer antibiotic medications as ordered by physician, monitor/document side effects and effectiveness, monitor/document/report as needed adverse reactions to antibiotic therapy, and monitor/document/report as needed signs/symptoms of secondary infection related to antibiotic therapy. R25’s care plan indicated R25 had legal blindness from history of traumatic brain injury. The care plan directed staff to arrange consultation with eye care practitioner as required and monitor/document/report as needed any signs/symptoms of acute eye problems. R25’s current physician order, directed staff to give one drop of moxifloxacin hydrochloride (an antibiotic used to treat various bacterial infections) ophthalmic solution 0.5% (percent) in the right eye two times a day for bacterial conjunctivitis (also known as “pink eye”; inflammation or infection of the eyes) with a start date of 6/9/25. The order did not specify an end date. R25’s medication and treatment administration record (MAR and TAR), progress notes, and provider, clinic, and hospital notes were reviewed from April 2025 to July 2025 and indicated: -4/20/23, staff were directed to write a progress note per shift on any behaviors, change in condition or any other matters related to R25. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/11/25 to 6/3/25, staff were directed to assist R25 with a warm compress and gentle eye care to right eye twice a day to remove debris and drainage until resolved. -On 4/13/25 at 11:32 a.m., an order administration note indicated nursing waited for delivery for polymyxin B-Trimethoprim ophthalmic solution (an antibiotic combination used to treat bacterial infections of the eye) to instill one drop in right eye four times a day for conjunctivitis. Progress notes did not describe how the eye looked. At 11:47 a.m., an order administration note indicated the eye drop was administered with no other details about R25’s eye. -4/16/25, indicated R25 was sent to the emergency department for concern of cornea injury and was unable to open eyes and had severe pain. -R25’s After Visit Summary from Methodist Hospital dated 4/16/25, indicated R25 was seen for acute conjunctivitis of right eye and directed the facility to give moxifloxacin as prescribed. -4/17/25 to 4/18/25, staff were directed to apply one drop of moxifloxacin to right eye every hour while awake for seven days until 4/23/25 for conjunctivitis. -4/19/25 to 4/25/25, staff were directed to apply one drop of moxifloxacin to right eye twice a day for conjunctivitis. -5/2/25, R25 had an appointment at M Health Fairview Ophthalmology. -R25’s The Terrace at [NAME] – Clinical Referral dated 5/2/25, indicated R25 had a stable ocular exam from a physician. Orders listed included moxifloxacin twice a day and did not indicate an end date. A note with initials dated 5/2/25, indicated orders were already in R25’s electronic health record. A second check by a nurse was dated 5/2/25. -5/6/25 to 5/18/25, staff were directed to apply one drop of moxifloxacin to right eye two times a day for central corneal opacity (a condition where the clear front part of the eye becomes cloudy or scarred and causes vision loss and a milky appearance) of the right eye. -On 5/23/25, R25 had an appointment with M Health Fairview Ophthalmology and was in the hospital on 5/23/25. -R25’s Discharge Orders and paperwork dated 5/31/25, indicated R25 had bacterial keratitis (inflammation of the cornea, the clear, dome-shaped front surface of the eye) and to continue moxifloxacin. -5/31/25 to 6/2/25, staff were to apply one drop of moxifloxacin to right eye two times a day for central corneal opacity. -6/2/25 to 6/5/25, staff were directed to apply one drop of moxifloxacin to right eye two times a day for bacterial conjunctivitis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-R25's Methodist Hospital Discharge summary dated [DATE], indicated R25 had keratitis of the right eye due to bacteria and exposure keratitis. The discharge summary directed staff to continue previous ophthalmologic medications, which included moxifloxacin to the right eye twice a day for bacterial conjunctivitis. The order did not include an end date. -R25’s Twin Cities Physicians’ provider note dated 6/26/25, indicated R25 had diagnoses of dry eyes and traumatic blindness, did not list ophthalmology on a list of specialists, and had clear eyes with no drainage. The provider note did not address R25’s moxifloxacin. During observation on 6/29/25 at 10:13 a.m., R25 had a clear substance over her right eye. During observation on 6/30/25 at 5 p.m., R25’s right eye color had a lighter blue hue and no redness or inflammation to the whites of her eye. During interview on 7/1/25 at 9:30 a.m., nursing assistant (NA)-A stated R25’s eye looked the same and unchanged compared to previous observations, and the nurses placed drops in R25’s eye. NA-A stated the nurses, nurse manager, or health unit coordinator followed up on eye appointments. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated nurses transcribed given orders for antibiotics into the resident’s electronic health record, checked resident diagnoses and allergies, and sent the order to the pharmacy. RN-A stated antibiotic orders had a frequency and duration. RN-A stated nurses should contact the provider if an end date if not given. RN-A stated they checked the resident temperature until the end of an antibiotic course. RN-A stated R25’s eye was “bad” at some point and now improved. RN-A stated the facility had an infection control nurse who reviewed antibiotics and was the best person to ask about any antibiotics. During interview on 7/2/25 at 12:26 p.m., the infection preventionist (IP) stated staff monitored for side effects and effectiveness of antibiotics and looked for if symptoms resolved. The IP nurses monitored antibiotic use and infectious symptoms via progress notes until the antibiotic ended. The IP stated antibiotics should be stopped or discontinued if the provider assessed the resident and saw the resident did not need the antibiotic any longer. The IP stated the moxifloxacin order came from the hospital and would have to look at R25’s paperwork to see when R25’s next appointment was when asked about the lack of end date for the moxifloxacin. During interview on 7/2/25 at 1:23 p.m., nurse practitioner (NP)-A stated R25 followed an eye doctor who prescribed the moxifloxacin and directed surveyor to talk to nursing about R25’s visit with the eye doctor. During interview on 7/2/25 at 1:36 p.m., medical records/health unit coordinator (HUC) stated R25 did not have another appointment scheduled for the ophthalmologist. The HUC searched through R25’s medical record and was unsure if R23 went to the appointment on May 23rd, since R23 was in the hospital. The HUC called the clinic and clarified another appointment was only as needed and asked the clinic to fax the facility information from R25’s last appointment. (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 7/2/25 at 1:58 p.m., the director of nursing expected antibiotic orders to have a stop date or staff to update the provider to ensure if provider wanted the antibiotic continued or stopped. The DON stated residents on antibiotics should be monitored for sign and/or symptoms of infection, side effects, and medication effectiveness. The facility Antibiotic Stewardship – Orders for Antibiotics policy dated December 2016, directed antibiotic orders to include drug name, dose, frequency of administration, duration of treatment with start and stop date or number of days of therapy, route of administration, and indications for use. The policy indicated empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate, and staff and the practitioner would document the specific criteria to support the suspicion in the resident’s clinical record. The policy directed the admitting nurse to review discharge and transfer paperwork for current antibiotic orders and to ensure the orders included all drug and dosing elements.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors when a narcotic pain medication was not administered as ordered for 1 of 5 (R10) residents reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 had intact cognition. R10's quarterly MDS dated [DATE], indicated R10 was on a scheduled pain medication regimen and received opioids (narcotic pain medication) during the look-back period (LBP). The MDS indicated R10 was diagnosed with heart failure, kidney failure, and chronic low back pain. R10's Medication Administration Record (MAR) dated 6/1/25 through 6/30/25, indicated R10 had the following orders:- 2.5 milligrams (mg) of oxycodone (an opioid) three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given on 6/1/25 through 6/18/25 and the evening dose on 6/19/25. The medication was documented as a 9 (other/see progress notes) for the first and second dose on 6/19/25 and then 6/20/25 through the second dose on 6/23/25.- Five mg of oxycodone three times a day starting on 2/20/25 and discontinued on 6/23/25. The order was documented as given 6/1/25 through the second dose on 6/23/25.- 7.5 mg of oxycodone twice a day starting on 6/23/25. The medication was given on 6/24/25 through the first dose of 6/27/25, and a 9 was documented for the second dose on 6/27/25 through 6/30/25 and the second dose on 6/23/25.- Five mg of oxycodone daily starting on 6/24/25 that was given 6/24/25 through 6/28/25 and a 9 was documented for 6/29/25 through 6/30/25. R10's MAR progress notes dated 6/1/25 through 6/30/25 were reviewed and included the following administration notes related to oxycodone:-dated 6/19/25 at 8:08 a.m., 1:36 p.m., and 9:36 p.m., indicated 2.5 mg of oxycodone was not available with no indication the medication had been re-ordered.-dated 6/20/25 at 2:18 p.m., indicated 2.5 mg of oxycodone was not available and an order was unable to be placed with the pharmacy as a new prescription was needed, so a call was placed to the provider.-dated 6/20/25 at 2:20 p.m., indicated 2.5 mg of oxycodone was not available, and a call was out to the provider.-dated 6/20/25 at 9:02 p.m., indicated nursing staff were awaiting delivery of 2.5 mg of oxycodone.-dated 6/21/25 at 10:16 a.m., indicated 2.5 mg of oxycodone was unavailable as they were waiting for the provider to approve a new prescription.-dated 6/21/25 at 2:17 p.m., indicated nursing staff were waiting for a new prescription from the provider for the 2.5 mg of oxycodone.-dated 6/21/25 at 8:32 p.m., there was no medication supply, so the 2.5 mg of oxycodone was not given.-dated 6/22/25 at 9:39 a.m. and 3:06 p.m., indicated 2.5 mg of oxycodone was on order.-dated 6/22/25 at 10:03 p.m., indicated there was no supply of the 2.5 mg of oxycodone.-dated 6/23/25 at 10:06 a.m. and 2:26 p.m., indicated 2.5 mg of oxycodone was on order.-dated 6/23/25 at 9:33 p.m., indicated 7.5 mg of oxycodone was on order.-dated 6/24/25 at 7:33 a.m., indicated only five mg out of 7.5 mg of available and given.-dated 6/27/25 at 11:03 p.m. and 6/28/25 at 2:47 p.m. and 9:04 p.m., indicated 7.5 mg of oxycodone was not available.-dated 6/29/25 at 12:54 p.m. and 4:12 p.m., indicated 7.5 mg of oxycodone was on order. -dated 6/29/25 at 8:32 p.m., indicated 7.5 mg of oxycodone was not available.-dated 6/30/25 at 9:38 a.m. and 1:27 p.m., indicated 7.5 mg of oxycodone was on order. R10's progress notes and pain score record for 6/1/25 through 6/30/25 were reviewed, with no obvious increase in pain noted. R10's prescription summary dated 6/30/25, indicated R10 had an order dated 6/30/25 for five mg of oxycodone once a day and 7.5 mg twice a day for lumbar spondylosis (degeneration of the vertebrae and disks of the lower back, commonly causing low back pain) with myelopathy (compression of the spinal cord). During an observation and interview on 6/29/25 at 9:38 a.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated she did have a history of chronic pain in her back, but felt the facility was doing what they could to manage it and had no concerns regarding her pain. During an observation and interview on 6/30/25 at 5:36 p.m., R10 was observed sitting in her wheelchair with no facial grimacing, restlessness, moaning, or shaking noted. R10 stated they had run out of her oxycodone sometime last week, and she has felt shaky and her pain has been terrible since she started missing doses, and they still don't have the medication. During an interview on 6/30/25 at 5:38 p.m., licensed practical nurse (LPN)-E, the nurse manager for R10's floor, stated that R10's oxycodone had run out, and she had called the provider for a new prescription on 6/20/25. LPN-E stated nursing staff had used oxycodone from the emergency supply until they ran out, so R10 hadn't missed every dose. LPN-E stated she had not noticed an increase in R10's pain from baseline when she had been receiving less medication than what was ordered. On 7/1/25 at 1:09 p.m., LPN-E stated that when a nurse documented 9 on the MAR, it meant that the

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and document review, the facility failed to ensure prescribed inhaled medications were stored in their correct packaging to prevent potential administration error for 1 of 5 residents (R3); and failed to ensure prescribed oral medications were labeled with minimum identifiers to ensure correct administration (i.e., right patient, right medication) for 1 of 5 residents (R3) observed to received medication during the survey. Findings include: INCORRECT STORAGE: R3's Medication Administration Record (MAR), dated 7/2025, identified R3's current physician ordered medications, directions for their use, and staff spaces to record their administration or refusal. The MAR included an order for Mometasone (a steroid medication) 50 micrograms (MCG) with directions to administer 2 sprays in each nostril once daily for a respiratory infection. The MAR listed a start date for this medication as, 06/13/2025, and scheduled administration time of 8:00 a.m. On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3. LPN-B removed various oral medications from the cart while comparing them to R3's MAR which was displayed on a laptop computer on the cart. LPN-B stated R3 had a steroid inhaler (Mometasone) scheduled to be given and then removed a clear bag with a pharmacy label attached which had R3's name listed and read, Nasal Decong Spr [spray] 0.05%, which had directions, 2 DROP IN BOTH NOSTRILS EVERY 12 HOURS AS NEEDED FOR CONGESTION. LPN-B continued to search the upper row of the medication cart before finding another clear bag with a pharmacy label attached which had R3's name listed and read, Mometasone [steroid medication; used for asthma] Spr 50 MCG [micrograms], with directions listed reading, INSTILL 2 SPRAYS IN EACH NOSTRIL ONCE DAILY. However, this bag was empty with no medication or inhaler inside. LPN-B reviewed R3's MAR and verified the Mometasone was scheduled to be given; however, the inhaler wasn't in the bag. LPN-B searched the drawer and then reviewed the nasal decongestant bag. LPN-B opened the bag and expressed the Mometasone inhaler had been placed in the wrong bag. The steroid medication was placed in the nasal decongestant bag and not the correct one. LPN-B stated they were unsure how long the medication had been stored like that and, when questioned how medications could end up stored in the wrong pharmacy labeled containers, responded aloud, Carelessness. LPN-B stated the medications should be stored in their correct pharmacy packaging so there's no confusion. LPN-B verified trained medication aide (TMA) staff worked on the medication carts within the building, and they reiterated correct storage of the medication was necessary to reduce the risk of residents getting the wrong medications. When interviewed on 7/1/25 at 9:42 a.m., the director of nursing (DON) stated nasal medications typically come in a little zippy bag from the pharmacy and should be kept in them. DON stated the correct medication should be kept inside the correct bag from the pharmacy to help ensure accurate administration and so staff were giving what they're supposed to be giving. DON acknowledged medications stored in the wrong bags could lead to a medication error as the two medications (i.e., nasal decongestant / Mometasone) were different medications for different purposes. On 7/1/25 at 1:16 p.m., the consultant pharmacist (CP)-A was interviewed via telephone, and they explained Mometasone was a longer acting medication and meant more for ongoing therapy versus a nasal decongestant medication. CP-A stated inhalers typically arrived to the care center in a plastic bag from the pharmacy and were usually kept inside the same bags once in the medication carts. CP-A stated staff should use one inhaler at a time to ensure they're placed back into the correct bags when done. CP-A stated having the correct inhaler stored in the correct bag helped the double checking when doing medication administration to ensure the right medication was being given at the right time. A facility provided Medication Storage In The Facility policy, dated 5/2022, identified the pharmacy dispenses medications in containers which meet regulatory requirements and, . Medications are kept in these containers. The policy added, All medications dispensed by the pharmacy are stored in the container with the pharmacy label. MEDICATION NOT LABELED: R3's Order Summary Report, signed 5/15/25, identified R3's physician orders along with their administration instructions. This included an order which read, Nicotine Polacrilex Mouth/Throat Gum . Give 4 mg [milligrams] by mouth every 1 hours as needed for withdrawal symptoms. The order had a start date recorded, 04/11/2025. On 7/1/25 at 8:02 a.m., medication administration was observed with licensed practical nurse (LPN)-B preparing medications at a mobile cart for R3 who was seated in their doorway. R3 stated they wanted their nicotine gum and LPN-B expressed they would get it. LPN-B opened the medication cart and removed a white-colored package which was labeled, Rubgy [brand name] Nicotine Gum , Stop Smoking Aid 4 mg, and provided it to the surveyor for

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 3 of 3 residents (R12, R8, R153) who complained about cold food at meals. This had potential to affect a total of 25 residents identified to reside on the unit where the meals were served and sample tray tested.Findings include:R12's quarterly Minimum Data Set (MDS), dated [DATE], identified R12 demonstrated no delusional thinking. However, the section to record R12's cognition was dashed with, Not Assessed [See F638]. On 6/29/25 at 10:53 a.m., R12 was interviewed about his quality of life at the care center. R12 complained about the food and described it as garbage, and nasty. R12 stated the meals were often served cold and he wanted warm food to eat. R8's quarterly MDS, dated [DATE], identified R8 demonstrated no delusional thinking. On 6/29/25 at 10:23 a.m., R8 was interviewed and expressed aloud, The food sucks. R8 explained the kitchen rarely seemed to have meat products but rather just carb-filled food items which he disliked due to having diabetes. R8 explained the food was often served cold adding this occurred, Most of the time. R8 stated most of the time the meals delivered via room tray were often served cold and the aides rarely would heat it up even if asked adding, The aides don't do [expletive] here. R8 reiterated his displeasure with the meal service and stated, This place just sucks.R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on [DATE], but a cognitive assessment had not yet been completed. During an interview on 6/29/25 at 8:50 a.m. , R153 stated the food was garbage, tasted like dog food, and was always freezing cold when it should be hot. On 6/29/25, the following observations and interviews occurred:-At 11:52 a.m., cook (CK)-A stated they already temped the food for lunch. CK-A stated the temped the pork loin which was above 170 degrees Fahrenheit and did not need to temp the cabbage, potatoes, or other items. CK-A was unsure of where to write down the food temperatures. Dietary aide (DA)-C stated the food carts were already brought upstairs for service. DA-A was still in the kitchen collecting serving items with food in pans and covered on their cart. -At 12:03 p.m., DA-A stated they went to the second floor as soon as possible to turn on the steam table and ensure serving items were stocked. DA-A started to scoop food onto plates and serve to residents in the dining area. DA-A was not observed to temp the food before service.-At 12:42 p.m., some room trays were set up and plated on the cart and others were not. DA-A was not in the dining area.-At 12:47 p.m., DA-A returned to the dining area with a sandwich.-At 12:55 p.m., DA-A stated they plated up the last room tray. A test tray was requested, plated, and placed on the cart. Some room trays were already brought to rooms and other rooms trays were still on the cart.-At 12:59 p.m., there were still room trays on the cart and DA-A went to the kitchen on the first floor to bring up a resident's alternative meal option.-At 1:02 p.m., DA-A plated a meal for a new resident.-At 1:05 p.m., the test tray was taken for another resident.-At 1:09 p.m., DA-A stated the last tray on the cart could be used as a test tray instead of the initial one which was taken for a resident. The director of nursing (DON) sampled the pork loin, potatoes, and cabbage. The DON stated the pork loin and cabbage could be a little warmer.During interview on 6/29/25 at 1:31 p.m., DA-A stated they heard about complaints of cold food. DA-A stated they asked others about temping food once on the steam trays and were told they did not need to temp the food.During interview on 7/1/25 at 2:20 p.m., CK-C stated they temped all the food to ensure the food was hot or cold and had a temperature log they filled in. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to temp and track all food and temp again after placed in the steam tables. CD stated temping food was important to ensure food was cooked appropriately and prevent food poisoning.During follow-up interview on 7/2/25 at 10:22 a.m., CD reviewed the temperature log and verified the pork loin and cabbage were not items listed as temped on 6/29/25 for lunch. CD expected food to be served at appropriate temperatures to avoid bacteria growth, and residents liked hot food.The facility Food: Quality and Palatability policy dated 2/2023, indicated food would be palatable, attractive, and served at a safe and appetizing temperature.The facility Time and Temperature Control and Recording policy undated, directed staff to record final cooking temperatures on the Cooking Temperature Log and check good temperatures when food was placed in steam table or hot holding unit and at least every two hours thereafter.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide the ordered diet texture for 1 of 2 residents (R35) reviewed for dietary texture.Findings include:R35's annual Minimum Data Set (MDS) dated [DATE], indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup.R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency.R35's Terrace at [NAME] Rehabilitation Screen/Update dated 9/11/24, indicated R35 was evaluated by a speech language pathologist (SLP) to assess possibility of upgrading diet texture. SLP reported R35 was unsafe to upgrade diet and remained on a dysphagia puree diet plan.During observation on 6/29/25 at 12:03 p.m., dietary aide (DA)-A scooped food onto plates from the steam table and brought meals to the residents seated in the dining area.During observation and interview on 6/29/25 at 12:17 p.m., nursing assistant (NA)-E stated R35 could not eat this. R35 was seated at a dining room table and had a full piece of uneaten pork loin on her plate. NA-E stated R35 was not able to chew the pork loin. R35's pork loin was replaced with minced meat with gravy over the meat. The staff returned to assisting other residents, and R35 ate independently with no difficulties.R35's meal ticket next to her plate indicated R35 had a regular diet and pureed texture.During interview on 6/29/25 at 12:51 p.m., DA-A stated they did not have pureed pork today and confirmed they served mechanical cut-up pork and no pureed pork, which included R35.During interview on 6/29/25 at 1:31 p.m., DA-A stated they served resident meals according to their meal tickets, which indicated what diet and texture of food the resident was ordered. DA-A stated sometimes they were not given pureed food to serve and only ground food.During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's diet but would reference the meal ticket. NA-A stated they would tell a server if they noticed a resident was not served the correct diet.During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets listed diet texture, allergies, and preferences. RN-A stated it was important to follow diet orders to prevent choking for residents with dysphagia.During interview on 7/1/25 at 2:20 p.m., cook (CK)-C stated managers explained to the cooks the diet and textures they needed to prepare for the residents. CK-C stated they had a spreadsheet which described which diets residents were on. When asked to see the spreadsheet, CK-C showed a book with dietary updates related to new residents or changes in diets. During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to serve residents the correct texture of food according to the meal tickets. CD stated food could be a choking hazard for a resident if not served the correct texture. During interview on 7/1/25 at 2:57 p.m., the culinary district manager (CDM) expected pureed food to be pudding consistency and not lumpy or too runny. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to follow diet orders.The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents.The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure food allergens and/or preferences were followed for 3 of 4 residents (R258, R35, and R37) reviewed for food allergens/preferences.Findings include:R258 R258's quarterly minimum data set (MDS), dated [DATE], indicated R258 was admitted to the care facility on 7/20/21 and was cognitively intact. R258's face sheet, printed 7/2/25, indicated R258 had several allergies including cornstarch, gluten, and soybean Oil.R258's care plan, dated 6/19/25, indicated resident [R258] has reported food intolerances that cause abdominal pain (corn starch, dairy (butter, American Cheese & Hard Cheeses ok), egg whites (ok if cooked into things), gluten, soy, soybean oil. The care plan contained an intervention, dated 2/10/25, that directed staff to not serve corn starch, dairy (butter, American Cheese & Hard Cheeses are ok per [NAME]), egg white (ok if cooked into something), gluten, soy, or soybean oil unless requested. R258's meal ticket, used by the kitchen staff to communicate allergies, preference, and diet type, also indicated R258's allergy/preference to not have foods cooked in soybean oil. During observation and interview on 6/29/25 at 10:14 a.m., R258 was in her room, lying in bed with her breakfast tray on the overbed table. On the tray were what appeared to be two, untouched fried eggs. R258 stated the food at the facility was a joke and that she had allergies that were still served to her, including gluten and soybean oil. R258 stated the eggs were the worst and always cooked in soybean oil and sometimes you lift them [the eggs] up and they are just greasy with oil. R258 stated if she eats things cooked in soybean oil it causes her to have extreme upset stomach and that if she didn't buy her own food, she would not get enough to eat. R258 confirmed the dietary manager was aware. During an interview on 6/29/25 at 3:08 p.m., cook (CK)-A stated they use an Arrezzio 90/10 Vegetable and Olive Pomace Oil Blend. The oil blend contains 90% soybean oil and 10% olive oil. During observation on 07/01/25 at 8:51 a.m., an Arrezzio oil container was sitting next to cracked eggs in the kitchen.During an interview on 7/1/25 at 2:20 p.m., (CK)-C stated they used the Arrezzio oil for cooking and did not know of any residents who needed a different kind of oil. CK-C stated they used the oil for frying eggs, deep frying foods, and chicken breasts. CK-C stated they used butter for frying eggs at times, to grease pans, and to make cookies.During interview on 7/2/25 at 7:23 a.m., CK-B stated they used the Arrezzio oil for food like eggs unless a resident specifically stated they wanted their eggs fried with butter. CK-B stated there were two residents who requested butter instead of oil for cooking but one of those residents passed away and the other resident did not reside in the facility anymore. CK-B stated they were not aware of any current residents for whom they should avoid cooking with the oil.During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated they knew of one resident, R258, who could not have soybean oil and expected staff to cook her meat and steam eggs without the soybean oil. R35 R35's annual Minimum Data Set (MDS) dated [DATE], indicated R35 had moderate cognitive impairment and diagnoses of gastro-esophageal reflux disease, hyperlipidemia, Alzheimer's disease, dementia, dysphagia, anxiety disorder, depression, and psychotic disorder. The MDS indicated R35 required setup or clean-up assistance to eat. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's care plan printed 6/29/25, directed staff to serve diet as ordered. R35 had a regular diet with pureed textures and thin liquids and was independent with eating after setup. The care plan indicated eggs caused R35 to have an upset stomach unless the eggs were cooked into food. The care plan indicated R35's preference to avoid strawberries and nuts, and R35 liked fish patties with tartar sauce, chicken, turkey porkchops, and applesauce. R35's physician order dated 3/13/24, indicated R35 had a regular diet with pureed texture and thin liquid consistency. During observation and interview on 7/1/25 at 8:32 a.m., R35 sat at a dining room table and ate breakfast. Dietary aide (DA)-E stated R35's plate had pureed biscuit, pureed scrambled eggs, and oatmeal. The meal ticket next to R35 indicated Allergies: *Strawberry Allergen*, Egg Yolk, Treenuts, Soy/Soybean Oil, *Peanut Allergen*. The meal ticket indicated No eggs at breakfast under the listed allergies and NO EGGS under the listed breakfast items. During interview on 7/1/25 at 9:30 a.m., NA-A stated they were not sure of R35's allergies but would reference the meal ticket. NA-A stated they would change a resident's plate if they noticed a resident was not served the correct meal. During interview on 7/1/25 at 1:23 p.m., registered nurse (RN)-A stated staff looked at meal tickets to know what to serve to residents and should intervene if not served the right food. RN-A stated meal tickets listed diet texture, allergies, and preferences. During interview on 7/2/25 at 10:22 a.m., the culinary director (CD) expected staff to follow residents' meal tickets and should not plate items listed as an allergy for a resident since staff may not know if the food item was an allergy or preference. During interview on 7/2/25 at 1:58 p.m., the director of nursing expected staff to not serve food listed as an allergy to residents for safety reasons. The facility Meal Distribution policy dated 9/2017, indicated all meals would be assembled in accordance with the individualized diet order, plan of care, and preferences. The policy indicated nursing staff were responsible for verifying meal accuracy and the timely delivery of meals to residents. R37 R37's quarterly Minimum Data Set (MDS) assessment, dated 5/17/25, indicated R37 had intact cognition with no hallucinations or delusions with no behaviors or rejection of care and was independent with eating after set-up assistance. Pertinent diagnoses include type 2 diabetes (long term condition in which body has trouble controlling blood sugars), morbid obesity and depression. During an interview on 6/29/25 at 1:05 p.m., R37 stated he had an allergy to fish and seafood. R37 stated the facility continued to serve him fish and seafood despite the meal tickets indicating an allergy to fish and seafood. R37 stated he did not eat it, but it happened again just a few days ago. R37 stated he had followed up with the social worker when this happened as it continued to happen. R37's allergy list, printed 7/2/25, lacked identification of allergy to shellfish, seafood, or fish. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's Care Guide, printed 6/30/25, indicated R37's diet was a regular diet with thin liquids and was independent with eating. The document lacked indication of food allergies or food preferences. R37's Care Plan, printed 7/2/25, included the following: -Resident requires assistance with activities of daily living (ADLs) with an intervention of resident is able to feed self after tray is set up- Resident has nutritional problem or potential nutritional problem related to type 2 diabetes, morbid obesity, hyperlipidemia and history of hypokalemia with the following interventions: -Administer medications as ordered. Monitor/Document for side effects and effectiveness. -Assist the resident with developing a support system to aid in wt loss efforts, including friends, family, other residents, volunteers, etc. -Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. -Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.- Provide and serve diet as ordered. 2 gram Na/CCD Small carb portion and large vegetable portions. -Provide and serve supplements as ordered: Ensure TID -RD to evaluate and make diet change recommendations PRN.The care plan lacked evidence of R37's food allergies or food preferences. R37's progress notes, dated 1/1/25 to 6/30/25, were reviewed and identified the following: -2/4/25 at 11:00 p.m.: RD [registered dietician] met with resident briefly today to discuss how meals have been going. Resident was not feeling very well today. He also expressed that he feels like the staff are not listening to what he has to say. His affect showed frustration. He stated he has not been getting a salad at lunch daily per his preference. He reported today was the first day staff served his brown sugar separate from his oatmeal. RD asked if if it was ok to come back and discuss food concerns next facility visit when he feels better. Resident agreed. Resident in our mealtracker system currently has a banana and orange juice for breakfast daily. In his diet note it says no brown sugar on oatmeal per residents preference. Dislikes are fish. Does not want to receive cinnamon rolls, white bread, and dinner rolls at meals d/t T2DM. Has small starch portions and large vegetable portions. R37's Dietary/Nutrition Assessment, dated 11/12/24, indicated R37 was on a cardiac diet, regular textures and thin liquids. The section on preferences for likes and dislikes was blank. The assessment lacked evidence of R37's food allergies or preferences. R37's meal ticket for 6/24/25 indicated Allergies: *Fish Allergen*, *Seafood Allergen*, Shellfish Allergen*. Grievance log for June 2025 indicated a grievance was filed by R37 on 6/24/25 regarding food concerns. On 6/30/25 at 1:54 p.m., licensed practical nurse manager (LPN)-E provided a copy of the care sheets. LPN-E stated the nursing assistants use the care sheets to help guide the care for the residents. During an interview on 6/30/25 at 5:12 p.m., nursing assistant (NA)-A stated they had worked with R37 previously and were familiar with him. NA-A stated they were unaware of any dietary restrictions, food allergies or preferences for R37. NA-A stated they would ask the nurse if they had any questions regarding R37's diet or what he could or could not have. During an interview on 7/01/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they are familiar with R37 and work with him often. LPN-A stated R37 was able to make his needs known. LPN-E reviewed his diet orders and stated he was on a no added salt diet. LPN-E stated that R37 had told them that he had an allergy to seafood. LPN-E verified seafood was not listed on R37's allergies or on R37's diet. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/01/25 at 1:36 p.m., regional culinary manager (CDM) stated R37's allergies to seafood and shellfish were added to the meal tickets when resident moved into the facility. CDM stated they added the fish allergy to the meal tickets about a month ago to help ensure R37 did not get any food products he was allergic to. CDM stated that he encouraged residents and staff to fill out grievances as this was a great way to track concerns. CDM reported R37 should not receive any sort of seafood or fish products as it was documented that he has an allergy to seafood, shellfish and fish. During an interview on 7/02/25 at 8:06 a.m., licensed social worker (LSW)-A stated she had met with R37 on 6/24/25 regarding concerns with R37's supper on 6/24/25. LSW-A stated R37 was served shrimp for dinner and verified R37 had an allergy to shellfish and should not have been served shrimp due to his allergy. LSW-A stated she had seen his dinner plate, reviewed his meal ticket, and he had not received the food that was on the meal ticket. LSW-A stated she filled out a grievance form regarding this and notified the administrator and director of nursing. LSW-A stated the grievance form was given to the dietary manager to address. LSW-A stated dinner was purchased for R37 on 6/24/25 as the kitchen was closed when R37 had come to talk to her about the meal that was given to him. During an interview on 7/02/25 at 8:20 a.m., culinary director (CD) stated she had received a grievance regarding R37 receiving a shrimp dinner on 6/24/25, which he should not have received. CD stated she followed up with R37 and staff involved. CD stated staff are to follow the meal tickets and verified in this instance they did not. R37 was to get the alternative meal, due to shellfish allergy, and R37 was served shrimp. CD stated she has provided education to dietary staff regarding the importance of following meal tickets upon receiving the grievance form. CD stated R37 has an allergy to shellfish, seafood and fish and when asked what type of allergy stated, probably his throat swells up, probably would need an epi-pen or something. CD verified the allergy was listed on the meal ticket. During an interview on 7/02/25 at 11:50 a.m. director of nursing (DON) stated that residents' food allergies should be listed under resident's allergies. DON verified R37's food allergies were not listed in his allergy list. The facility Food Allergies and Intolerances policy dated August 2017, directed staff to ensure residents with food intolerances and allergies were offered appropriate substitutions for foods they cannot eat. The facility Food and Nutrition Services policy dated October 2017, indicated food and nutrition services staff would inspect food trays to ensure the correct meal is provided to each resident. The facility Dining and Food Preferences policy dated 10/2022, indicated individual tray assembly tickets identified all food items appropriate for the resident based on diet order, allergies & intolerances, and preferences.

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The Terrace at Crystal LLC	3245 Vera Cruz Avenue North Crystal, MN 55422

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a therapeutic diet was ordered upon return to facility per orders on hospital discharge for 1 of 1 residents (R36) reviewed for therapeutic diets. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 4/24/25, indicated R36 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R36 was independent for all activities of daily living (ADLs). R36 received insulin 7 of 7 days during look back period of MDS assessment. Pertinent medical diagnoses included type 1 diabetes with other specified complication (a chronic condition that affects the insulin producing cells of the pancreas).R36's progress note dated 4/16/25 at 5:21 p.m., indicated resident was readmitted from the hospital and had new and changed orders and to see the facility electronic medical record (EMR). R36's Hospital Discharge summary, dated [DATE], indicated R36 required a consistent carbohydrate diet. During an interview on 6/29/25 at 10:37 a.m., R36 stated she was diabetic and when asked about the facility food, R36 stated I know it is not diabetic friendly. R36 stated I want to eat better so I don't have so many problems. R36's order summary, dated 6/30/25, indicated R36 was on a regular diet, regular texture with liquids with a start date of 4/18/25 (2 days after hospital discharge). Review of R36's paper chart or EMR did not contain an order for a regular diet. During an interview on 7/1/25 at 10:08 a.m., licensed practical nurse (LPN)-A stated they were familiar with R36. LPN-A stated when a resident came back from the hospital or admitted to the facility the floor nurse entered all the orders, including diet orders, and a second nurse verified all the orders. LPN-A verified R36 was diabetic, required insulin to manage blood sugar, and stated R36 was all over with her blood sugars. LPN-A stated R36 was on a regular diet and not a diabetic diet. On 7/1/25 at 2:40 p.m., licensed practical nurse manager (LPN)-E stated R36 was on a regular diet and as far as they were aware was not on a diabetic diet. LPN-E reviewed R36's EMR and verified she had many high blood sugars over 400 mg/dL (milligrams per deciliter) in June. During a follow up interview with LPN-E on 7/2/25 at 8:46 a.m., LPN-E verified the hospital discharge paperwork dated 4/16/25 included an order for a consistent carbohydrate diet, and R36 did not have any diet entered into the EMR when she returned from the hospital on 4/16/25 until a regular diet order was entered on 4/18/25. LPN-E was not able to find an order for a regular diet in the EMR.During an interview on 7/2/25 at 11:49 a.m., director of nursing (DON) stated the expectation when a resident admitted or readmitted to the facility was the orders were entered into the EMR, including diet orders, and then checked by another nurse. DON stated the unit managers should also be looking over all the orders to ensure accuracy. DON was unable to locate an order for a regular diet for R36. On 7/2/25 at 12:56 p.m., LPN-E stated they did not have an order for a regular diet for R36, and R36 should have been ordered the diabetic diet. LPN-E stated they followed up with the provider regarding this and the provider was going to put an order in for a consistent carbohydrate diet. During an interview on 7/2/25 at 1:03 p.m., nurse practitioner (NP)-A stated the facility spoke with her today upon her arrival to the facility about a diet order for R36. NP-A stated she was going to put an order in for a low carbohydrate diet for R36. NP-A stated, if she is compliant with the diet, it should help with her blood sugars. A facility policy titled Therapeutic Diets, revised 10/22, indicated a licensed nurse accepts the diet order form the authorized prescriber.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure opened dairy products (i.e. , milk) for resident' consumption was either consumed or discarded in a timely manner to reduce the risk of foodborne illness; and failed to ensure 1 of 2 unit refrigerators were adequately monitored for temperature and food quality to reduce the risk of complication or illness. In addition, the facility failed to ensure staff covered their hair during food preparation and service; failed to ensure dry baking and frozen foods were stored in a manner to reduce the risk of cross-contamination; failed to ensure food items were properly stored, labeled, dated, and discarded properly; failed to ensure metal pans were completely dry before stacking to prevent bacterial growth; failed to These findings had potential to affect all 51 residents within the care center.Findings include: UNDATED MILK: A USDA (United States Department of Agriculture) article labeled, How long can you keep dairy products like yogurt, milk, and cheese in the refrigerator[?], dated 5/2024, identified milk could be refrigerated for seven (7) days after being opened. On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A mobile cart was positioned in the middle of the dining room by a white-colored refrigerator which had a container on top and inside this container had pitchers of various juices along with one opened one-gallon container of skim milk. The milk had black-colored, hand-written markings on top which read, 06-19-25 [10 days prior]. The milk container had a commercial stamp along the collar which outlined a 'best by' date of, 06/29/25. DA-A was interviewed and expressed the nurses and nursing assistant (NA) staff pass the beverages from the mobile cart. DA-A stated the kitchen had sent up the cart just like that to be served to the residents. Following, NA-D and NA-E were observed preparing drinks from the mobile cart, including the same skim milk (dated 6/19). NA-D and NA-E were interviewed, and both expressed milk could be used three days after being opened. NA-D verified the milk they were serving was dated 6/19/25 (10 days prior) and expressed they were unsure why it was still being used adding aloud, I don't know. On 6/30/25 at 4:49 p.m., the supper meal service on the locked unit was observed. Residents were, again, seated at tables and a steam table was located along the far wall with DA-B present. A mobile cart was positioned by the refrigerator and, again, had a white-colored container on top which was filled with pitchers of juice and an opened single one-gallon container of skim milk. The milk had visible, handwritten black markings along the top, however, they were not legible and appeared to have been smeared away. The collar of the milk gallon had a commercially printed 'best by' date which read, 06-25-25 [five days prior]. DA-B was interviewed and explained they brought the mobile cart with drinks up from the kitchen adding it had likely been set-up and used for the earlier meals that same day. DA-B verified the best-by date was listed on the milk as 6/25/25, and expressed the black markings had been rubbed off by them just before they brought the cart up. DA-B stated the black writing read 6/9 before it was rubbed away accidentally. DA-B verified the marking had read 6/9 (over 20 days prior) when asked again. DA-B stated milk was good to be used until it expired but they were not sure how long this was after it was opened adding, I'm not sure. DA-B verified the milk was intended to be used for the supper meal service that evening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Following, on 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM observed and verified the milk sitting in the mobile cart for service was beyond the 'best by' date. CDM reiterated the milk should be used or discarded within seven days of being opened due to the number of diseases that come with it [using milk beyond that range], adding the repeated cycles of cooling and warming milk goes through for meal service increase the risk of foodborne illness if used beyond those dates. CDM then removed the milk from the mobile cart. On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all time/temperatures control for safety foods which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a use by date with added text reading, (Day 7). UNIT REFRIGERATOR: On 6/29/25 at 8:14 a.m., the breakfast meal service on the locked unit was observed. Residents were seated at multiple tables and a steam table was located along the far wall with dietary aide (DA)-A present. A single, white-colored refrigerator was along the wall and taped to the outside door was a white sheet labeled, Refrigerator Temperature Log, which was dated, June 2025. The sheet had a series of columns which included spaces to record the temperature of refrigerator and staff to record their initials. The last recorded temperature was on 6/11/25 (a.m.) when the refrigerator was recorded at 40 degrees (F). The remaining spaces (dated 6/12 through 6/31) were left blank. The refrigerator was opened and, inside, a few black-colored winged bugs were visible flying away from the inside (see F925). The shelving was packed nearly full of white, plastic bags which were tied, and a single one-gallon container of 2% milk was on the middle shelf which was approximately one-quarter full. The milk had a commercial stamp along the collar which listed the 'best by' date and read, 06-24-25. However, there was no other dates or markings on it to demonstrate when it had been opened. DA-A was asked about the refrigerator at this time and expressed aloud, I don't check this. DA-A verified the milk was beyond the 'best by' date and was not dated when opened, and they expressed there was enough milk in the container to serve seven or eight people they felt. Following, nursing assistant (NA)-D was interviewed, and they explained the refrigerator was a resident fridge used to store food for the residents. NA-D stated they had never checked it before for dates or temperature. A single thermometer was in the back of refrigerator behind stacked up plastic bags which had food inside. The temperature was 42 degrees (F), and NA-D stated the kitchen, not us was responsible to monitor and check the refrigerator for temperature and dated or expired items. The contents of the refrigerator were then removed and inspected with NA-D present. This found multiple items which were not dated upon opening and/or were expired including: One (1) small bowl, covered with foil which had black writing present which read, 05/23/25, and Gravy. The foil was removed, and the contents were nearly black and dried to the inner surface of the bowl. NA-D stated, I think it's gravy. NA-D verified the condition of the food product and dates on the tinfoil. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	One (1) plastic bag which had plastic containers inside. Both the containers and plastic bag lacked any visible names or dates on them. The plastic containers had stew with an unknown meat inside and various vegetables. NA-D verified these items and the lack of dates on them. One (1) plastic bag which had a large Styrofoam container inside. The container was undated and, upon being opened, had a light-green colored rice which had several growths of a blue and white-colored mold present on it. NA-D verified the mold and lack of date on the container. One (1) plastic bag which had a series of smaller containers inside. This included rice and several flour biscuits which all had visible mold on them. NA-D was asked about the food and laughed before saying aloud, Yea, when asked if the food had mold present on it. NA-D stated they would discard all the items from the refrigerator. Following, on 6/29/25 at 9:01 a.m., licensed practical nurse (LPN)-B was interviewed and asked about whom, if anyone, monitors the unit refrigerator or checks for dates and expired food items inside it. LPN-B responded, Obviously no one was doing it. LPN-B verified they had seen the food items removed from the refrigerator and expressed the items looked disgusting. LPN-B stated many of the food items in the plastic bags were a single resident's whose family brings items in for them often. LPN-B stated they were unsure who checked the refrigerator for temperature monitoring or food quality but added the night shift would likely be doing it moving forward. LPN-B verified the flow sheet attached to the refrigerator used to recorded the temperature checks had not been completed since 6/11/25, and expressed the refrigerator was for resident' use items and reiterated it should be checked for temperature and food quality inside adding, So things like that [surveyor findings] don't happen. On 6/30/25 at 5:04 p.m., the contracted group (dietary) district manager (CDM) was interviewed. They explained they helped to manage the dietary department since the facility' dietary manager was new to the role. CDM stated milk should be dated when it's opened and used within seven days or discarded. CDM stated the kitchen staff were supposed to be monitoring the temperature of the refrigerator and recording it on the flow sheet attached to the door. CDM stated getting a new dietary manager (DM) up and running would hopefully help provide more daily oversight of tasks like that to ensure they get done. CDM explained there was a monthly routine to check the unit refrigerators for food dates and expirations but added, Some people can be forgetful. CDM stated if food items were not dated when placed inside, they should have been discarded immediately. CDM stated having expired, moldy food items in the refrigerator could cause foodborne illness adding, Especially with the vulnerable base we have. On 7/2/25, a telephone call was placed to the facility' registered dietician (RD) with a request to call back. However, a return call was never received. A facility provided Labeling and Dating policy, dated 2017, identified all time/temperatures control for safety foods which were going to be held for over 24 hours at 40 degrees (F) or less would be labeled and dated with a prepared date and a use by date with added text reading, (Day 7). In addition, a facility provided Foods Brought by Family/Visitors policy, dated 1/2023, identified food brought in that is left with the resident to consume late would be labeled and stored in a manner that was distinguishable from facility-prepared food items. The policy added, The nursing staff will discard perishable foods on or before the 'use by' date, adding further, The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor .). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	INITIAL TOUR: During initial tour of the kitchen on 6/29/25 at 8:17 a.m., cook (CK)-A was in the kitchen and cut onions and prepared a salad and other food throughout the initial kitchen tour. CK-A had a hat on and no beard net to cover their beard which was approximately half an inch long. Dietary aide (DA)-C was in the kitchen with a long ponytail and no hair net. DA-C stated they were to serve the residents on the first floor as they appeared in the dining area. CK-A stated they did not know where the hairnets were. DA-C showed an empty holding rack and stated the hair nets were usually there, but they were out of hairnets and would let the manager know the next day. A metal scoop was observed in a bin with flour in it. CK-A stated they had not used the flour today, and the scoop was not supposed to be left in the flour bin. A smaller sized freezer across from the larger freezer had a frozen plastic water bottle and another unfrozen plastic water bottle. The freezer contained various bags of frozen vegetables. CK-A stated the water bottles should not be in the freezer and removed them. A larger sized refrigerator contained multiple unopened gallons of skim milk with a best by date of 6/25/25. CK-A stated they were not sure why the milk was still in there when they had milk which was not past the best by date. A package of provolone cheese was opened without an opened date and not secured closed. DA-C observed the cheese, removed from the refrigerator, wrapped, and dated the package. A smaller sized refrigerator close to the kitchen serving window contained a package of swish cheese which was opened without an opened date and not secured closed. DA-C stated they were unsure when the cheese was opened and needed an opened date. A drying rack and multiple different sizes of serving pans stacked with opened side down. Condensation dripped from the pans, and condensation was observed between the stacked pans. DA-D stated the pans were washed and then stacked to drip down and dry. MEAL SERVICE: During observation on 6/29/25 at 12:03 p.m., DA-A was behind the steam table on the second floor and dished up food onto plates for residents in the dining area and for room trays. DA-A did not have a hair net on. During interview on 6/29/25 at 1:31 p.m., DA-A stated they asked other staff in the kitchen about the hair nets and stated there were not any hair nets in the kitchen. DA-A stated they usually wore a hair net to serve food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) expected staff to wear hairnets and beard nets in the kitchen to prevent hair in the food. CD stated scoops should not be left in flour bins to prevent contamination and spreading of germs. CD stated there should be no personal items, like plastic water bottles, in the freezer with resident food items. CD stated staff needed to avoid carrying germs from outside the kitchen. CD expected opened food to be labeled, dated, and closed in a different container to prevent food contamination or serving expired food. CD expected staff to not keep items past the best by date to prevent serving expired items. CD expected dishes to be turned upside down and dry before stacking. The facility Labeling and Dating policy dated 2017, directed staff to label food with the food item name, date of preparation/receipt/removal from freezer, and use by date. The policy directed food to be properly stored, covered, and handled. The facility Staff Attire policy dated 9/2017, directed all staff to have hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The facility Warewashing policy dated 12/2024, indicated all dishware would be air dried and properly stored. The facility Food and Supply Storage Procedures for Dry Storage policy undated, indicated scoops were not to be stored in bins and needed to be hung.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure current infection control standards of practice were followed when performing resident personal care for 1 of 4 residents (R153) observed for personal care.Findings include: R153's entry tracking record dated 6/20/25, indicated R153 was admitted to the facility on [DATE].R153's Medical Diagnosis list dated 6/23/25, indicated R153 was diagnosed with diabetes, a stroke, and heart disease. R153's care plan dated 6/30/25, indicated R153 required the assistance of one to two staff members for bed mobility and dressing, and the assistance of two staff members for toileting and transferring. During an observation on 7/1/25 at 8:27 a.m., R153 was observed lying in bed. Nursing assistant (NA)-I and NA-J were observed assisting R153 with personal care. NA-I, with gloved hands, was observed to assist R153 with perineal care while R153 was lying on his back. NA-J was observed to assist the resident in rolling towards her, while NA-I completed perineal care on the backside. NA-I was observed, still with gloved hands, to assist the resident to apply a new pad and put on shorts. Then both aides assisted R153 to sit on the edge of the bed. NA-J was observed to position a motorized stand aide while NA-I, with gloved hands, assisted the resident to position his hand and feet on the machine. NA-J was observed to complete hand hygiene and then leave the room. NA-I with gloved hands, assisted R153 to position himself in the wheelchair and readjust his glasses. NA-I took off his gloves, gathered the trash, and left the room. NA-I was not observed to complete hand hygiene during this observation or to change gloves. During an interview on 7/1/25 at 8:50 a.m., NA-I stated he had completed hand hygiene and applied gloves before entering R153's room, taken off his gloves before leaving the room, and then, after he had thrown away the trash, he completed hand hygiene. NA-I confirmed he had otherwise not completed hand hygiene while completing R153's care. NA-I stated he was taught to complete hand hygiene before and after care but had not been told that he also needed to complete hand hygiene during care. During an interview on 7/2/25 at 9:58 a.m., the director of nursing (DON) stated staff were expected to complete hand hygiene before applying gloves, when changing gloves, after glove use, and after a task like perineal care to prevent cross-contamination.The facility Handwashing/Hand Hygiene policy dated 8/19, indicated staff were to complete hand hygiene before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, and after removing gloves.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair which had the potential to affect all 51 residents, staff, and visitors of the facility. In addition, the facility failed to ensure the dish machine in the main kitchen was kept in a clean and sanitary manner and free of debris.Findings include: Walls: During observation of R15 on 6/29/25 at 10:24 a.m., R15 in resident room on second floor sitting in hospital gown with brown substance streaked on the floor. During observation and interview with R31 on 6/29/25 at 10:35 a.m., R31 stated she was disappointed in her facility stay in part due to the environment is dirty pointing to ceiling in her room with yellowing stain on it and a gash in the wall with brown drip stains down the wall. During observation and interview with R12 on 6/29/25 at 10:52 a.m., R12 lying in bed which was horizontally against the wall. Wall had numerous black marks along it with a yellow-colored stained area that extended on the wall for approximately half the length of his bed. R12 stated he was unhappy with the condition of the walls and would like it addressed. R12 stated this whole place is f***ed up and that the facility had done nothing about it.During interview with R24 on 6/29/25 at 1:48 p.m., R24 stated cleanliness of the place [sic] run down R24 stated this place is a pit. During observation and interview on the second-floor secured memory care unit in the dining room on 6/30/25 at 2:07 p.m., a baseboard in east corner of room had broken wallboard above it. Portions of the baseboard was not attached to wall due to the hole in the area. The area was approximately 18 inches long. Blue laminate edging was missing from portion of nursing desk facing the hallway. Portion was 8 inches that spanned the corner of the nursing station desk. Knee wall attached to nursing station and wall across from the nursing station had numerous scrapes and missing pain including peeling. In the dining room above chair rail in corner of it there was white corner piece that did not match color of remaining wall. The corners that came together were pulling apart showing half an inches of empty space for eighteen inches. Area also had beige staining around it. Both dining room wall frames had peeling, stained, and chipped paint on both sides. Nursing assistant (NA)-A was seated at a dining room table with resident who was in a wheelchair. Two other residents were in the room at the time. NA-A stated expectation of staff to report any maintenance issues to the MT-D. NA-A stated she would tell the nurse who would then fill out a work order on the computer or verbally tell MT-D of any concerns. NA-A looked around and stated, [It] looks like [sic] needs to be repainted. Not looking good. During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:19 p.m., TMA-A stated, need to be fixed or done painting or repairing. TMA-A stated expectation of staff to notify maintenance of work order request for MD-T to address concerns with painting and repairing. TMA-A observed hole in the wall in dining room above the baseboard and stated, Oh wow. Needs to be repaired.During observation and interview with director of nursing (DON) on 6/30/25 at 2:34 p.m. , on the second-floor secured memory care unit pointing to the walls, baseboards, and door frames of resident rooms and also the two entrances to the dining room. DON stated, Needs repair. The door frames need to be repaired and replaced. DON stated, I would not like that at my home. DON stated expectation of staff to fill out a work order and submit it electronically or notify MD-T verbally. DON stated she had worked at facility for over two years and did not see any wall repairs or replacing of baseboards or painting of door frames during that time.During observation and interview with MD-T on 6/30/25 at 3:02 p.m., MD-T observed 2nd floor resident door frames, memory care security doors, baseboards, chipped, broken wallboards and stained ceiling tiles and walls and stated, It is not homelike. I would not like it in my home. We need to replace all of the baseboards and repaint the walls. The doors are really chipped and need to be repainted. MT-D stated expectation of staff to submit work orders or notify him of repair needs verbally. I have been working on them but was not aware of some of the issues. There is a lot.During observation on 6/30/25 at 5:08 p.m., in the 3rd floor dining room, two residents were eating supper at dining room table while television was on. Baseboards of dining room were beige in color with black markings all along them horizontally. Three rooms at end of hall had black markings along the walls, door frames to the dining room were chipped with stains and missing paint. All resident room door frames were chipped and missing paint. Walls with chair rails had wallpaper peeling or marked with nail holes visibly covered with white wallboard repair, sanded to reveal the nail heads resulting in white repair marks but nothing finished. Painted walls had visible nail holes which were never painted over to match. Section of cracked broken wallboard was visible outside two resident rooms ranging thirty inches horizontally above the baseboard. Broken wallboard that appears to be punched in running two feet above the baseboard outside a resident room During observation and interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. Building B. Wing	07/02/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dishmachine During initial tour of the kitchen on 6/29/25 at 8:17 a.m., several orangish blackish substances were observed on top of the dish machine. Dietary aide (DA)-D stated dishes which came through the dish machine were clean. DA-D stated staff washed the outside of the dish machine every one to two days.During interview on 7/1/25 at 2:30 p.m., the culinary director (CD) stated staff wiped the dish machine every day, and they were unsure of the orangish blackish substances on top of the dish machine.During interview on 7/1/25 at 2:57 p.m., the culinary district manager (CDM) stated the sediment on top of the dish machine came from the hood above the dish machine, and staff did their best to ensure the top of the dish machine was clean. CDM stated Ecolab did not assist with the hood or custom pieces, so the facility was trying to find a company who could fix the hood above. During interview on 7/2/25 at 2:24 p.m., the administrator stated maintenance was contacting vendors to install or replace the hood vent above the dish machine. The administrator stated Ecolab did not work on the hood above the dish machine and parts online or in a store would not fit.During interview on 7/2/25 at 2:42 p.m., the maintenance director (MT)-D stated hot steam rose from the dish machine fan and vent area and made the metal from the hood above rust and fall. MT-D stated they were aware of the issue for at least a few months, focused on higher priority facility needs, and were not aware how severe the rust fell from the hood. MT-D stated they discussed putting plastic over the dish machine when the machine was not running to scrape the hood above.The facility Warewashing policy dated 12/2024, did not indicate when to clean the dish machine.The Healthcare Services Group task descriptions for cooks and aides, indicated when staff were to complete their scheduled cleaning assignment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review the facility failed to ensure adequate pest control measures were in place to eliminate small black flies from the building. This had the potential to affect all 51 residents of the facility.Findings include:During observation and interview with R8 on 6/29/25 at 10:27 a.m., in second floor resident room, several small black flies were observed flying around the room during interview. R8 stated the facility is full of small black flies and they are all over the f***ing building. R8 stated the flies been issue for a while.last few months I guess. R8 stated he was disappointed with facility's lack of action to address the flies. R8 stated he was not sure what's being done about it.During observation and interview with R31 on 6/29/25 at 10:35 a.m., in third floor resident room R31 stated she occasionally sees fruit flies both in her room and out in hallway and dining room.During observation and interview with R36 on 6/29/25 at 10:43 a.m., in third floor resident room, R36 stated facility gets bugs in here and was not pleased with it.During observation in second floor dining room on 6/29/25 at 12:17 p.m., a dietary aide was serving food on meal tray to a table with R22 seated in a geriatric chair. Visible little black flies were flying above the table were observed.During interview with nursing assistant (NA)-E on 6/29/25 at 1:19 p.m., NA-E stated she had noticed flies on the second floor. NA-E stated expectation of staff to notify management of flies and Bring someone in to spray the place.During interview with culinary aide (DA)-A on 6/29/25 at 1:31 p.m., DA-A stated she had seen a lot more fruit flies now consistently [for] two or three weeks. DA-A stated she did not hear any meetings or information from management regarding fruit flies.During interview with R24 on 6/29/25 at 1:48 p.m., in second floor resident room, R24 stated she had seen some fruit flies in the past and that her sister had mentioned it to her also when visiting.During interview with maintenance director (MT)-D on 6/30/25 at 11:14 a.m., MT-D stated he was aware of the small black flies' issue in the facility through verbal reports by staff and residents and stated the pest management company comes out once a month. MT-D stated the monthly reports filled out by the pest service specialist (PS)-S were missing so he was unable to provide surveyor written reports. MT-D stated he knew nothing about what specific services PS-S provided to address the fly issue.During observation on 6/30/25 at 2:05 p.m., in the second-floor shower room a small black fly was buzzing around.During interview with nursing assistant (NA)-A on 6/30/25 at 2:15 p.m., NA-A stated she could see and was aware of small black flies in the facility. NA-A stated she noticed black flies when the weather started to get warmer. Looks like something needs to be done to get rid of them. They are everywhere. NA-A stated expectation of staff to notify the nurse so a report could be completed and sent to MT-D. Also, all staff had ability to email or verbally communicate to MT-D about maintenance concerns, including pests.During observation interview with trained medication aide (TMA)-A on the second-floor secured memory care unit on 6/30/25 at 2:22 p.m., TMA-A stated she was aware of the small black fly issues in the building from residents and other staff including her own observations. TMA-A stated MD-T was made aware by her via verbal means. TMA-A stated, [facility] need to do something better.During interview with director of nursing (DON) on 6/30/25 at 2:49 p.m., DON stated she was aware of the small black fly issues. I have seen it and reported to [MT-D] within this month. DON stated MT-D placed some traps out on resident units and it still [sic]an issue.During interview with MT-D on 6/30/25 at 3:02 p.m., MT-D stated expectation of staff to communicate facility maintenance needs including pest concerns through electronic Work Orders which can be done through the computer. MT-D stated he is also made aware of issues including pests through verbal communication also.During interview with PS-S on 7/1/25 at 9:55 a.m., PS-S stated he had been at facility in May and June of 2025 for the monthly pest control visits. [Facility] don't have a logbook there. PS-S stated, the main issue is that I noticed small flies in the kitchen [sic]. PS-S stated he spoke to administrator and just met [MT-D] over the phone the other day. During tour with PS-S on 7/1/25 at 1:51 p.m. , PS-S stated the facility contract with the pest control company provided, no service for the smaller flies that are going around here.During interview with dietary manager (D)-M on 7/1/25 at 10:10 a.m., D-M stated she was aware of the flies in the kitchen area and swatted a black fly as she exited the kitchen.During review of customer service report invoice with service date of 6/11/25, the Target Pest column identifies Flies-Large. During review of the facility's Pest Elimination Services Agreement dated 8/30/2022, the contracted services include Outside in Large Fly Program with frequency of Monthly-6 Month Program.During review of documents titled Work Orders with dates May. 1, 2025 -Jul. 1, 2025 failed to identify concerns with pests or small black flies.During review of Grievance Tracking logs from January 2025 to June 2025, no mention of pests for Types of Concern.During interview with administrator and regional director (RD) on 7/1/25 at 10:25