| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245289 | A. Building<br>B. Wing | 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents (R22, R53, R66 and R36) who exited the facility out of the front door after-hours had the ability to safely and timely reenter the building. This resulted in an immediate jeopardy situation for R22, R53, R66 and R36 who had to wait for an extended period of time in severe cold temperatures in order to get back into the building. This failure created a risk of serious harm, injury, impairment or death for any resident who may attempt to reenter the building after hours. The IJ began on 10/17/25 when the administrator had the after-hours door code to enter the facility changed without informing the residents it may affect and then did not provide the code or a consistently working system they could use to alert staff they needed reentry. The administrator and regional operations director (RM) for the facility were notified of the IJ on 12/4/25 at 4:35 p.m. The immediate jeopardy was removed on 12/5/25, but noncompliance remained at the lower scope and severity (level E), no actual harm with the potential for more than minimal harm that is not immediate jeopardy.As a result of the IDR review the start of IJ is changed from 10/17/25 to 11/28/25.<br><br>Findings include:<br><br>The facility's Grievance Tracking Log dated October 2025 included an entry with Date Received as 10/20 and identified Type of Concern as Door codes. The form lacked Actions Taken, Date of Solution, and Date Completed.<br><br>A Grievance form submitted 10/20/25 from the resident council president (R17) and attached Council Action Form to the Administrator dated 11/12/25, identified a concern as Code to the front door was changed so residents are locked out after 11:00 PM, The council did not request this, and Smokers are blocking door. The section of the form titled Recommendations/Solutions from R17 was, Give code to residents, There are no visiting hours for friends and family so they can have the code. The Administrators written response dated 11/28/25 stated, For the safety of our resident and staff, we do not share the door codes with resident, family or friends. They can call staff if they need to enter the building after 11pm, when the front desk staff leave. There is a phone in the middle room by the entrance, and nursing staff are now assigned to first floor overnights. Summary of pertinent findings: Door codes were changed for resident/staff safety during overnights when there is less staff supervision on the first floor. There is a phone outside the door than [sic] guests/staff/residents can use to call the facility to be let in. When the doors are locked, the handicap button will not open the door for safety. During the day the handicap button works.<br><br>The facility's October 2025 QAPI meeting minutes attended by RM and administrator identified Entrance door code change as an Customer Services Related Issue. The facility's November 2025 QAPI meeting minutes attended by RM and Administrator identified Entrance door code change as a<br>(continued on next page) |

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

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Customer Services Related Issue with notations on Audits Currently working for concern of, Family communication and satisfaction: Family continue to complain that phones are not being answered on the floors. A notation in margin indicated, Assign a nurse each shift.<br><br>During observation and interview with R16 on 12/2/25 at 7:17 a.m., R16 was outdoors on the front smoking patio. A garbage can was used to prop the door open between the unheated breezeway and the facility entrance to prevent it from closing. A sign on the door said, Please DO NOT prop this door open!!! There were no other staff, residents or visitors in the area. R17 stated he put the garbage can in the doorway every morning so I can get back in. Otherwise, it is locked and I can't get back inside. It is too cold to be stuck outside.<br><br>During interview with R17 on 12/2/25 at 1:00 p.m., R17 stated he was the current resident council president and stated the facility changed the after-hours door code and did not give it to the residents. R17 admitted to filing a grievance in October of 2025 and said, It is an accident waiting to happen [when staff] do not answer [phone] to let residents back in. R17 said, the front door locks [after-hours] and residents can't get back in.<br><br>During observation on 12/3/25 at 6:40 a.m., a state surveyor (SA) arrived at main entrance to building and was unable to enter. The door from unheated breezeway was locked. Four numbers were posted by the telephone in the unheated breezeway and none of the numbers were answered. The phone numbers were attempted multiple times with a consistent beep-beep sound that was heard when each number was dialed. At 6:48 a.m., an unknown staff member walked past the door and let the SA into the facility.<br><br>R3's Comprehensive Minimum Data Set (MDS) dated [DATE], identified R3 as cognitively intact, did not reject care, and was independent in self-care, and utilized a motorized wheelchair. Diagnoses include anemia, hypertension, peripheral vascular disease, amputation of left lower leg, diabetes, depression, bipolar, post-traumatic stress disorder (PTSD), tobacco use, and chronic lung disease.<br><br>During interview with R3 on 12/4/25 at 11:02 a.m., R3 stated she was a smoker and two of my friends got stuck outside last night and had to call me to get in. They [facility] won't give us the code [to unlock the door]. The phone [in the breezeway] did not work.<br><br>R22's quarterly MDS dated [DATE], identified R22 as cognitively intact, did not reject care, and was independent in self-care, and utilized cane/crutches, walker and wheelchair for mobility. Diagnoses include hypertension, diabetes, amputation of left lower leg, tobacco use and chronic lung disease.<br><br>R53's quarterly MDS dated [DATE], identified R53 as cognitively intact, did not reject care, and was independent in self-care, and utilized a wheelchair for mobility. Diagnoses include depression, bipolar, chronic back pain, and chronic lung disease.<br><br>During interview with R22 and R53 on 12/4/25 at 11:17 a.m., both confirmed they were outside smoking late the night of 12/3/25 to 12/4/25 and could not reenter the facility after hours because the door was locked and the phone [in the breezeway] did not work. R22 and R53 stated none of the residents were told about the after-hours door code being changed. R22 stated, this is our home and we live here. We are not in prison or probation. This is our home, and we should have that code. Both agreed that sometimes we will put the garbage can to block the door from closing so we can get back in. R22 and R53 stated they went to smoke during the night of 12/3/25 and tried to reenter the facility at 12:15 a.m., on 12/4/25 and the door was locked and all four phone numbers that were posted in the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | breezeway did not work. Both stated there were no staff around to see that they were outside in the unheated breezeway. R22 said, **** it was too cold out here to stay out there much longer. R22 had his cellphone with him, and he called the facility, but no one answered the phone. He then he called another resident, R3, who got out of bed and took the elevator down to let them in. R22 said that both R22 and R53 were stuck out there about 20-30 minutes. R53 stated, my fingers were still cold 20 minutes after we got back in. Both said facility staff were notified about them being stuck outside in the cold but did nothing to assess or evaluate them after they reentered the facility. Both said they had been locked out of facility before. R22 said, we are grown. Not kids. Stop treating us like babies. We should have a say. We were never notified by this place about changing the code.<br><br>According to Past Weather in [NAME] Minnesota, USA the temperature outside at midnight on 12/4/25 was -2 degrees Fahrenheit.<br><br>R66's quarterly MDS dated [DATE] identified R66 as cognitively intact, did not reject care, and was independent in self-care, and utilized a wheelchair for mobility. Diagnoses include anemia, hypertension, peripheral vascular disease, amputation of left lower leg, arthritis, anxiety, bipolar, PTSD, tobacco use, and chronic lung disease.<br><br>During interview with R66 on 12/4/25 at 11:35 a.m., R66 stated she was a smoker and was locked out of facility during a cold night about a week ago and 3 or 4 other times. R66 stated she was never informed about the code being changed and was surprised to find out her code did not work. Eventually someone [staff] let her in. R66 stated the phone in the unheated breezeway was not there a month ago and now they have a phone, but it does not work. R66 said residents talked to [administrator] but nothing is done. He said, No one could get the code. R66 said the situation is very frustrating and [facility] takes my social security check to live here, and I can't get in.<br><br>R36's quarterly MDS dated [DATE], identified R36 with having independent decision-making skills, did not reject cares, independent with hygiene and dressing, and utilized a wheelchair for mobility. Diagnoses include diabetes, depression, PTSD, and chronic pain.<br><br>During interview with R36 on 12/4/25 at 11:43 a.m., R36 stated she was a smoker and I have been stuck outside before. R36 stated facility had changed the after-hours door code and did not let any of the residents know what the new code was. The phone down there was not there at first and now the one [that is there] does not work. No one at the reception desk at night. I got in because I had to wait for someone to walk by before they would let me in. It was very cold. Had to wait 20 minutes. R36 could not recall what date it was that she said she was left outside. It was a total surprise.<br><br>During interview with facility's infection control preventionist (IP) on 12/4/25 at 11:54 a.m., IP stated the after-hours door code was changed. We put a phone out there in the breezeway to have the residents call if they need to get in, and I don't know if the phone is working.<br><br>During interview with receptionist (REP) on 12/4/25 at 12:06 p.m., REP stated her understanding was during the daytime between 7:00 a.m., and 10:00 p.m., no code is needed [to reenter], otherwise they [everyone] need a code to get in. REP also stated, I have heard of residents saying they could not get in which is why there is a phone out there to use if they get stuck out there. REP said, for safety I believe it is important for everyone to be able to get in during this cold weather.<br><br>On 12/4/25 at 1:18 p.m., all four numbers were called from the phone provided in the breezeway. All four numbers rang once and then went to a busy tone; no staff were able to be reached using the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | telephone.<br><br>During interview with maintenance director (DOM) on 12/4/25 at 1:30 p.m., stated he was directed by the Administrator to change the door code on 10/17/25 and again on 11/5/25. DOM said, at first we did not have a phone [in the breezeway]. DOM said, I had a suspicion it was going to be an issue [not giving out the after-hours door code] and wasn't sure if any or all the residents were told about the changing of the code. DOM stated, this is a safety concern if people cannot get back into the facility. It is too cold [sic] be left outside in this weather.<br><br>During interview with registered nurse (RN)-A on 12/4/25 at 1:54 p.m., RN-A stated she was aware of the after-hours door code being changed and did not know if the residents were ever told about it or were informed of a new door code. They should have access to get into their home.<br><br>During a joint interview with the administrator and the maintenance director on 12/4/25 at 2:27 p.m., the administrator stated he had changed the code to the door a few months ago due to safety concerns of unknown persons entering the building. However, the administrator stated he only shared that information with resident council president at that time. The administrator confirmed residents had recently brought concerns to him about wanting the new door code and being worried they would be stuck outside in the cold at night. The administrator stated he was unaware the phone was not working and did confirm that at times the phone system went down but that maintenance lived nearby and could fix it when needed. During the same interview, the maintenance director confirmed the phone system went down at times and that the only way staff would be aware the phones were not working was if they were trying to use the phone or noticed calls were not coming in.<br><br>During observation on 12/4/25 at 2:35 p.m., the administrator attempted to use the phone in the breezeway. Three of four phone numbers provided would ring once and then go to a busy tone. One phone number did go through to a staff member on the floor.<br><br>During interview with R40 on 12/5/25 at 11:55 a.m., R40 stated he was previous resident council president. R40 stated, I told [administrator] that people need to get back into this place, and the phone down there don't work when he changed the code. And he said he was not going to tell any of the residents the code. That is wrong of him. And he stated that the administrator was told that staff won't answer the phone if it does work. That phone hasn't worked regularly and everyone especially the staff know it but don't care. R40 stated, We feel beaten down and frustrated.<br><br>The IJ was removed on 12/5/25 after a removal plan was implemented; however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level E). The facility implemented the following actions:<br><br>The front door code was updated and provided to all residents, who were instructed not to share the code, and a resident acknowledgement form was completed.<br><br>A wireless doorbell was installed at the front entrance with receivers located on each floor nursing stations.<br><br>Residents were assessed for their ability to use the door code, wireless doorbell, and breezeway, new residents will be assessed on admission, and all will be re-assessed at readmission, quarterly, and with any significant change in condition.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Residents were educated on the use of the front door code, wireless doorbell, breezeway phone, cold weather safety, and appropriate entry procedures<br><br>Staff were educated to respond promptly to after-hours entry requests, assess residents for cold exposure or hypothermia, provide warming measures as needed, and document all incidents.<br><br>An After-Hours Entry policy was developed and implemented, outlining procedures for code assignment, use of the wireless doorbell and breezeway phone, resident and staff responsibilities, assessment schedules, documentation expectations, and response to malfunctioning equipment.<br><br>The maintenance director or designee will perform daily checks of the front door and wireless doorbell, log results, and immediately correct any identified issues<br><br>Resident acknowledgement forms, assessment documentation, and maintenance logs will be maintained for tracking and accountability.<br><br>Facility policy titled Dignity, revised February 2021 identify, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. A policy regarding facility hours and access was requested but not received. |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure contact precautions were followed 1 of 1 resident (R1, R12 ) reviewed for contact precautions. In addition, the facility failed to ensure infection prevention practices were followed for medications and food storage. This had the potential to affect all 31 residents on the 3rd floor.<br><br>Findings include:<br><br>Contact Precautions<br><br>R1's quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, identified R1 had intact cognition, and demonstrated no delusional thinking. Further, the MDS identified R50 as having a primary medical condition of, Medically Complex Conditions, along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and respiratory failure.<br><br>During observation on 12/1/25 at 3:15 p.m., R1 was observed to have a single page document hung on the door that indicated: Contact Precautions. The sign included two stop signs on the signs indicating Everyone Must: clean their hands, including before entering and when leaving the room, with a picture of a hand and soap dispenser. Below that indicated providers and staff must also put on gloves before room entry, discard gloves before room exit, with a picture a gloves on the sign. Followed by: Put on gown before room entry, discard gown before room exits. Do not wear the same gown and glove for the care of more than one person with a picture of a gown. Followed by: Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person with a picture of a stethoscope. To the left of the door was a three-drawer plastic bin to the left of the door which contained disposable gowns, and gloves. On top of the plastic bin was hand sanitizer. R1 was observed sitting in her wheelchair in the hallway.<br><br>During an observation and interview on 12/1/25 at 3:21 p.m., R1 was observed sitting in her wheelchair in her room. Surveyor introduced self and started interview at which time LPN-A was observed to enter R1's room without any PPE on. LPN-A prepared and started R1's nebulizer's machine. LPN-A stayed in R1's room while nebulizer machine was running. Surveyor excused self from room and asked to continue interview later which R1 agreed. At 3:26 p.m., LPN-A was observed to exit R1's room and perform hand hygiene with hand sanitizer.<br><br>During a follow up interview on 12/1/25 at 4:05 p.m., R1 stated that staff do not wear gowns when they are assisting her. R1 stated they do wear gloves when helping her but no other PPE. R1 stated she was unaware of why there would be a contact precautions sign on her door.<br><br>During an observation on 12/3/25 at 9:40 a.m., LPN-A was observed carrying a small cup of medications to R1's room. LPN-A was observed performing hand hygiene prior to entering R1's room. During continual observation, LPN-A was observed to come out of R1's room with an oxygen tank, walk down the hallway and fill it and go back into R1's room. R1 was observed to perform hand hygiene upon exiting R1's for the last time but was not observed with any other PPE on.<br><br>During an interview on 12/3/25 at 9:57 a.m., LPN-A stated they had given R1 oral medications, filled R1's oxygen tank and assisted R1 in the bathroom. LPN-A stated they had not worn a PPE gown in R1's room. LPN-A stated they should have a worn a gown and PPE. LPN-A verified R1's door had a<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | contact precaution sign on it. LPN-A stated they believed R1 was on contact precautions for a wound.<br><br>R12<br><br>R12's admissions Minimum Data Set (MDS) dated [DATE] identified R12 with methicillin-resistant Staphylococcus aureus (MRSA), a multi drug resistant organism. In addition, R12 with intact cognition, and was taking antibiotics.<br><br>R12's care plan dated 10/28/25 identified, The resident has MRSA and is on contact isolation r/t MRSA infection.<br><br>Review of 2nd floor nurse care sheet identified R12 with Contact Precautions.<br><br>During observation on 12/1/25 at 1:59 p.m., R12 door with posted Contact Precautions sign and personal protective equipment cart located outside his door. The sign directed staff and visitors to wear gloves and gown before entering the room.<br><br>During observation and interview on 12/3/25 at 9:21 a.m., rehabilitation aide (RA) had R12 in wheelchair out in common area of 2nd floor in front of the nursing station and the main elevator. R12 was wearing a hospital gown and RA did not have personal protective equipment (PPE) gown and gloves on during transport. RA wheeled R12 to his room past the PPE cart posted outside his door and the Contact Precautions sign posted on his door. RA left room and sanitized her hands from sanitizer container resting on top of the PPE cart. R12 stated RA had not worn any PPE when she got me to be weighed down the hall.<br><br>During interview with licensed practical nurse (LPN)-D on 12/3/25 at 9:30 a.m., LPN-D stated, Everyone who touches [R12] in his room, including wheeling him from the room to and from rehab should wear the gown and gloves. LPN-D stated R12 has MRSA in nares[nose] and wound. LPN-D stated staff care sheets identify residents on precautions pointing to the 2nd floor nurse care sheet.<br><br>During interview with RA on 12/3/25 at 9:31 a.m., RA stated she I did not wear gown and gloves when I went into [R12] room to take him to the scale. I did not even see the cart there (pointing to the PPE cart and sign outside R12's room). RA stated, I should have worn the gown and gloves like the sign says.<br><br>During interview with infection control preventionist (IP) on 12/4/25 at 11:54 a.m., IP stated expectation of staff to follow the signs that are posted on doors of residents on precautions. IP stated R12 was on contact precautions due to MRSA in nose and wound and not following precautions is risking everyone's health, including [R12].<br><br>A facility policy on contact precautions was requested but not received.<br><br>Medication Storage<br><br>During observation on 12/4/25 at 8:06 a.m., the third-floor medication room was inspected with licensed practical nurse (LPN)-A. The medication room had two refrigerators, one assigned to store medications and the other used to stored food items (e.g., boost supplement, apple sauce, etc.). The medication refrigerator contained several insulin pens, Mantoux vials and had 5- 8 oz cartoons of boost (nutritional supplement). The food refrigerator had a rectangular stainless-steel container with (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | vanilla pudding, undated, and loosely covered with clear plastic wrap. The container had several spots of dry pudding touching an open plastic bag with 3 elastomeric intravenous pumps containing vancomycin (an antibiotic). One of the pump's tubing was sticking out of the plastic bag. The food refrigerator also contained 3 cartoons of boost. LPN-A stated medications should never been store in the food refrigerator, and we should never store food items in the refrigerator designated for medications. LPN-A added it posed a risk for contamination, and it was an infection control issue.<br><br>During interview on 12/4/25 at 9:54 a.m., nurse manager/LPN-B stated the vancomycin was supposed to be stored in the medication refrigerator, and the staff should never store food in the refrigerator used for medications. LPN-3 indicated these findings represented infection control concerns. LPN-3 added, per nursing practice the food and medications should be kept separated.<br><br>During interview on 12/5/25 at 9:09 a.m., the administrator stated there were two refrigerators in each med room, one was used for medications, and the other was used to store supplements, apple sauce, pudding and other food items used by the residents. Administrator stated it was unacceptable to store meds and food together. Administrator stated the concern was obviously an infection control issue due to risk for contamination.<br><br>Facility policy titled Infection Prevention and Control Program dated 10/2018 indicated, an infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and document review, the facility failed to ensure written Physician's Orders for Life Sustaining Treatment (i.e., POLST) were accurately entered, transcribed and reflected in the medical record to ensure current resuscitation measures (i.e., DNR - Do Not Resuscitate or CPR - Cardiopulmonary Resuscitation) would be performed in accordance with resident wishes for 1 of 2 residents (R1) reviewed for advanced directives. These findings constituted an immediate jeopardy (IJ) situation for R1 who would have received CPR against her declared wishes documented on a POLST dated [DATE].The IJ began on [DATE], when R1's POLST, indicating R1's wishes for DNR comfort focused treatment (allow natural death) was signed and it wasn't changed within the facility' electronic Medical Record (EMR) system (i.e., banner) to reflect R1's wishes. This error was not identified despite multiple opportunities; and a series of interviews with direct care nurses outlined they would implement the incorrect directions and begin CPR on R1 against her wishes due to this error. The administrator was notified of the IJ for R1 on [DATE] at 1:38 p.m. The IJ was removed on [DATE] after a removal plan was implemented; however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level D).Findings include:R1's quarterly Minimum Data Set (MDS) assessment, dated [DATE], identified R1 had intact cognition, and demonstrated no delusional thinking. Further, the MDS identified R1 as having a primary medical condition of, Medically Complex Conditions, along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and respiratory failure with admission to the facility on [DATE].R1's health care directive, signed by R1 on [DATE], indicated R1's wishes included the following: allowed to die naturally and not be kept alive by artificial means or heroic measure; do not want any medical treatment that will not substantially improve my condition or help me recover, but will only postpone the moment of my death; however, I want whatever care is appropriate to keep me as comfortable and as free of pain as reasonable possible, including the administration of pain relieving drugs and surgical or medical procedures calculated to relieve my pain, even though some drugs or procedures may hasten my death; I specifically do not want any of the following: feeding tubes, artificial nutrition and hydration to prolong my life; tests, procedures or other treatments that will not add to my comfort or quality of life; resuscitation or intubation expect for the short-term purposes of organ donation.R1's hospital Discharge summary, dated [DATE], indicated R1's code status as DNAR/DNI (Do Not Attempt Resuscitation/Do Not Intubate) and was determined by patient.R1's hospital Discharge summary, dated [DATE], indicated R1's code status DNAR/DNI and was determined by patient, advance directive/POLST and family.R1's POLST, signed and dated by R1 on [DATE], indicated R1's wishes were DNR (Do Not Resuscitate) with comfort focused treatment.R1's care plan indicated R1 had signed Do Not Resuscitate (DNR) Orders with a creation date of [DATE].R1's order summary included the following:DNI with comfort measures starting [DATE] with end date of [DATE]admitted to hospice with a start date of [DATE]Full code with a start date of [DATE] and an end date of [DATE]DNR- do not attempt resuscitation - allow natural death with a start date of [DATE]R1's progress notes, dated [DATE] to [DATE], were reviewed and identified the following:[DATE] at 5 p.m.: resident returned to facility. Code status updated to DNIXXX[DATE] at 5:48 p.m. provider note indicated She had a health care directive dated [DATE] specifying no intubation, CPR, artificial nutrition, or treatments unlikely to provide meaningful recovery. In the ED, her DNR/DNI status was confirmed. The intensivist reviewed the directive with her designated decision makers, who requested removal of BiPAP and transition to comfort care. Other family members were informed and supportive, though unable to be present. Comfort measures were initiated, hospice consulted, and plans were made to return her to her nursing home with palliative support. Furthermore, the note indicated code status as full code.[DATE] at 11:21 p.m.<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | provider note indicated She had a health care directive dated [DATE] specifying no intubation, CPR, artificial nutrition, or treatments unlikely to provide meaningful recovery. In the ED, her DNR/DNI status was confirmed. The intensivist reviewed the directive with her designated decision makers, who requested removal of BiPAP and transition to comfort care. Other family members were informed and supportive, though unable to be present. Comfort measures were initiated, hospice consulted, and plans were made to return her to her nursing home with palliative support. Furthermore, the note indicated code status as full code.[DATE] at 9:36 p.m.: staff called POA to update R1 signed a new POLST to be FULL code. POA stated per her record, R1's supposed to be DNR. Hospice called and waiting for a call back.R1's progress notes lacked indication that a conversation was had with R1 or R1's POA regarding wishes for code status upon return from the hospital on [DATE] or upon admission to hospice on [DATE].R1's hospice binder included the following information:[DATE] Interdisciplinary Group Meeting (IGM) note identified R1's code status was confirmed as DNR/DNI at recent emergency department (ED) visit along with having an advance directive stating R1 did not want any medical treatment that would not substantially help recovery, specifically not wanting feeding tubes, artificial nutrition, intubation or CPR. Code status listed as DNRXXX[DATE] IGM note indicated R1 code status as DNRXXX[DATE] IGM note indicated R1 code status as DNRXXX[DATE] IGM note included R1's hospice care plan indicated R1 code status as DNR.On [DATE] at 6:52 p.m., R1's Electronic Medical Record (EMR) banner indicated R1's code status as DNI with Comfort Measures.On [DATE] at 7:03 p.m., R1 stated if she were to be found unconscious without a pulse or breathing, she would want chest compressions to be done. Furthermore, R1 stated if I end up on the machine, pull the plug if I am nonfunctional. During a follow up interview at 7:51 p.m., R1 stated she would want to be intubated meaning she would want a tube put down her throat, if needed, if she was not breathing. R1 stated if it was found that she had brain damage, then pull the plug as I want a life that is functional. R1 was unsure if hospice or the facility discussed if she wanted CPR or to be intubated when she signed onto hospice. During an interview on [DATE] at 7:08 p.m., trained medication aid (TMA)-A stated if they found a resident unconscious they would get a nurse right away. TMA-A stated they wouldn't do anything without a nurse present.During an interview on [DATE] at 7:11 p.m., TMA-D stated if they found a resident unconscious, they would yell for more help. TMA-D stated they would check the EMR banner to see if the resident was full code or DNR and get the nurse. TMA-D stated they would ask the nurse what DNI means as they were not sure. TMA-D stated they would never start CPR without direction from a nurse. During an interview on [DATE] at 7:36 p.m. licensed practical nurse manager (LPN)-B stated the expectation would be if a resident was found on the floor, the staff would call for help. LPN-B stated a nurse would check the resident code status located in the EMR on the banner. LPN-B reviewed R1 medical record and verified R1 record indicated DNI with Comfort Measures. LPN-B stated R1's banner was not clear and should be clarified, DNI conflicts with comfort measures, and it should also indicate whether R1 was Full code or DNR. LPN-B verified the POLST in R1's records indicated R1 wishes were Full Code with selective treatment signed on [DATE]. LPN-B verified R1 signed onto hospice on [DATE] and a new POLST would typically be completed upon admission to hospice. LPN-B stated he could not find that a POLST had been completed since admission to hospice and it should be followed up on.During an interview on [DATE] at 7:36 p.m., registered nurse (RN)-B stated if a resident was found without a pulse, they would check for the code status on the EMR banner. RN-B stated if there wasn't a code status on the banner, then they would look in the hard chart at the nursing station. RN-B reviewed R1's banner which indicated DNI and stated that means do not intubate. RN-B reviewed R1's POLST in the EMR miscellaneous tab, dated [DATE]. After review, R1 stated they would initiate CPR according to the POLST on file. RN-B then reviewed the care plan and verified it indicated no CPR.During an interview on [DATE] at 7:54 p.m., director of nursing (DON) stated if a resident was unconscious, the expectation would be to check the resident pulse and implement their POLST. DON reviewed R1's EMR and stated the POLST in R1's chart dated [DATE] indicated to attempt resuscitation. DON<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | stated R1 should have CPR initiated. DON reviewed care plan for R1 and stated the care plan indicated resident has signed do Not Resuscitate (DNR) Orders. DNR which was initiated on [DATE].During an interview on [DATE] at 11:59 a.m. hospice nursing assistant (NA)-L stated they didn't typically work with R1 and were covering for her regular hospice nursing assistant. NA-L stated they came to see her quick, was unsure if the nurse case manager would be out to see R1 today, and quickly ended the interview, stating she had to leave. During an interview on [DATE] at 12:27 p.m., RN-C verified they were R1's case manager. RN-C stated R1 signed a POLST upon admission with hospice which indicated R1's wishes to be DNR comfort focused treatment. RN-C stated another nurse had completed R1's admission but the process was to provide a signed copy of the POLST to the facility, and she was not aware the facility had R1 listed as a full code in their medical records. RN-C stated R1 had been listed as DNR in their system since admission to hospice. RN-C stated she received a request last night [DATE] to follow up as triage received a call from the facility indicating R1 expressed wishes to be full code. RN-C stated she had talked to R1's sister who was surprised by this and expressed R1's wishes had been to be DNR. During a follow up interview on [DATE] at 2:52 p.m., RN-C stated she met with R1 to clarify and R1's wishes were to be DNR with comfort focus treatment. RN-C stated a new POLST was completed and provided to the facility.During a follow up interview on [DATE] at 3:20 p.m. LPN-B stated a POLST indicating R1 wished to be DNR with comfort focused treatment was signed upon admission to hospice, but he was not able to locate a copy. LPN-B stated a nurse did follow up with R1 last night and R1 expressed wishes to be full code, and then today R1 met with her hospice RN case manager (RN-C) and expressed wishes to be DNR and a new POLST indicating these wishes (DNR) were signed. During a follow up interview on [DATE] at 11:57 a.m., LPN-B reviewed R1's hospice binder and documents within. LPN-B verified IGM's notes listed above were in R1's hospice binder. LPN-B stated it was a team approach, shared between nursing and social work, to ensure that coordination was done between hospice and the facility, and nursing and social work review documents within the hospice binder.During an interview on [DATE] at 1:45 p.m., director of admissions with hospice (AD)-A stated when a resident was admitted to hospice, their POLST status was reviewed. A POLST would be completed if a resident did not have one or updated if their current POLST did not match their current wishes. AD-A stated POLSTs were signed using docu-sign (a platform used to obtain electronic signatures) by residents/POA/guardians then transferred to the provider to sign within 24 hours. AD-A stated after the provider signs the POLSTs they were faxed from their EMR system to the facility for their records. AD-A stated R1 signed a new POLST upon admission with hospice on [DATE], and verified it was signed by their provider. AD-A stated it should have been sent to the facility after the physician signed the POLST.During an interview on [DATE] at 10:04 a.m., RN-A stated it was a shared responsibility between the floor nurses, the nurse manager, and social worker to ensure the documentation in the hospice chart matched the facility chart.During an interview on [DATE] at 10:32 a.m., R1's family member (FM)-B stated they were also the healthcare and financial power of attorney. FM-B stated they received a confusing call Monday [DATE] from the facility stating R1 had stated she wanted to be Full Code. FM-B stated R1 had been DNR since [DATE] per her wishes on her advance directive that had been provided to the facility. FM-B stated it had also been discussed when R1 was in the hospital and starting on hospice.During an interview on [DATE] at 11:00 a.m., director of social services (DSS) stated it was a collaboration between social services and nursing to ensure hospice care plans and facility information match. DSS stated information that was sent from hospice was reviewed by nursing and social services. During an interview on [DATE] at 1:40 p.m. LPN-A stated coordination with medical providers was done via phone, in-person, and through messaging on the portal system (online communication system). LPN-A reviewed the provider portal system and verified a POLST indicating DNR for R1 was uploaded in the provider system on [DATE] and signed as sister gave verbal consent over the phone. A message was left for the facility medical director on [DATE] at 12:19 p.m. with no return call.The IJ was removed on [DATE] after a removal<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | plan was implemented; however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level D). The facility implemented the following actions:R1's code status was verified, a new POLST was signed, and any inconsistencies within the EMR, including the POLST, physician orders, EMR banner, and care plan were corrected. R1's status was communicated to staff. A full house audit of resident code statuses was conducted which identified three residents whose POLST was not signed by a provider, and one resident's POA was contacted to update their status. These records were uploaded and/or corrected as needed to be consistent with resident wishes throughout the medical record. The facility CPR/Code Status and Advance Directives policies were updated to expand verification requirements for code status at admission, readmission, significant change in condition, hospice involvement and any resident directed updates. In addition, a policy was created specifically for POLST documentation and procedures. A hospice Communication Protocol was created to ensure code status communication between agency and facility. Education was provided to all licensed staff and hospice partners regarding the POLST process, and any who were unavailable will be educated prior to their next shift. This training has also been added to orientation for new staff. The facility will continue to conduct audits to ensure all code status/POLST documentation accurately reflects residents' current wishes. A facility policy titled POLST Policy and Procedures, dated [DATE], indicated POLST orders must be verified and reviewed under the following conditions: admission and readmission, signification change in condition, initiation or changes in hospice care, whenever resident updates treatment preferences and during quarterly interdisciplinary care conferences. Furthermore, nursing leadership is responsible for reconciling POLST documentation across all systems and upon receipt of updated POLST information, nursing leadership must promptly update the EMR< physician orders and care plan to ensure full alignment. In additions, documentation of all updates, communications and reconciliations must be maintained in the EMR. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a dignified dining experience for all 68 of 68 residents who were served meals using plastic silverware, Styrofoam cups and Styrofoam to-go containers. The facility further failed to ensure cares were provided in a dignified and respectful manner. Findings include:<br><br>During observation of meal service on third floor on 12/2/25 at 12:12 p.m., dietary aide (D)-A filled four room trays (R8, R17, R34, R48) and set the trays in a rolling meal cart. All meal trays had plastic eating utensils and Styrofoam cups. A nursing assistant wheeled the meal cart down the hall to dispense the trays. At 12:31 p.m., R65 wheeled self-up to serving station with a plastic spoon and knife in his hand and requested a fork. Staff informed him that no forks up here.<br><br>During interview with dietary manager (DM) on 12/2/25 at 12:31 p.m., DM stated, Silverware is totally missing every single day. I ordered them and I am trying to get them. Everything is gone. Every day it is missing. DM stated, it is understandable to be frustrated in not having metal silverware instead of plastic.<br><br>During interview with district manager of food services (MGR) on 12/2/25 at 12:42 p.m., MGR stated lack of silverware is not a homelike environment. The staff view it as childlike. MGR also stated plastic silverware and Styrofoam cups is a common thing here. We go from enough to not enough.<br><br>During observation of meals service on second floor on 12/3/25 at 10:00 a.m., R37 stated facility used plastic silverware and they say they can't afford it [metal silverware]. I don't like plastic. I want real silverware and not plastic.<br><br>During interview with R25 on 12/3/25 at 10:34 a.m., R25 stated, I went down for dinner yesterday it was plastic and I like silverware over plastic.<br><br>During interview with trained medication aide (TMA)-A on 12/3/25 at 11:58 a.m., TMA-A stated rationale for using plastic utensils in long term care facilities is for residents on precautions. I would not like to use plastic silverware.<br><br>During interview with licensed practical nurse (LPN)-D on 12/3/25 at 12:24 p.m., LPN-D stated facility used plastic and Styrofoam daily, the real stuff goes missing. They [residents] shouldn't have to have plastic. It is a long-standing problem [here]. Plastic silverware is not dignified. Also, residents hate it and it looks bad [to serve food with plastic].<br><br>During observation and interview on 12/4/25 at 8:40 a.m., multiple residents in the first-floor dining room were eating breakfast with plasticware and using square, Styrofoam to go boxes, ripped in half and flipped upside down for bowls. R30 stated, this is not okay. They [the facility] are always running out of stuff [real dishes, cups and silverware]. An unnamed resident who was using a Styrofoam container as a bowl stated, F*** no, I don't like this and stated they would never eat like this at home, preferring a real bowl and silverware.<br><br>During an interview on 12/4/25 at 8:45 a.m., the dietary manager (DM) stated she started working at the care facility about four months ago and at that time had to order bowls, plates, cups silverware<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | because the facility did not have enough to serve all the residents. The DM stated she just put in her third order for dining supplies, stating, stuff just keeps going missing.<br><br>During observation of meal service on second floor on 12/4/25 at 8:58 a.m., R54 was sitting at dining room table with plastic fork and Styrofoam cup in front of him. R54 was unable to respond to questions. DA-B was serving food and stated, we don't have time to get cups from downstairs [kitchen] sometimes there is not enough silverware to use so we have to use plastic. NA-F stated lack of silverware and cups is also a long-standing problem for residents. when we are low on the supplies, we have to use plastic.<br><br>During interview with NA-G on 12/4/25 at 9:12 a.m., NA-G stated, we have hoarders. We used to have so many [regular silverware and cups] and they disappear. NA-G stated some residents complain and want real silverware and the issue [has] been going on a long time. I would not like plastic stuff to eat.<br><br>During observation on 12/4/25 at 9:15 a.m., R52 sitting in her room with meal tray in front of her which contained all plastic silverware and two Styrofoam cups. R52 unable to verbalize when asked about it.<br><br>During observation on third floor dining room following the meal service on 12/4/25 at 9:20 a.m., there was a stack of 15 Styrofoam cups on the counter in front of the steam table. A rolling meal cart had room trays from residents who already ate, all of which had Styrofoam cups and plastic silverware on them. Only the housekeeper (HK)-A was in the room. HK-A looked at the Styrofoam cups and stated, the residents [here] deserve a homelike place and they shouldn't be served anything in a Styrofoam cup or plastic stuff. You don't eat off plastic stuff at home.<br><br>During an interview on 12/4/25 at 9:50 a.m., the district manager of food services (MGR) stated he was aware the kitchen staff were using Styrofoam to-go containers as bowls and plasticware to residents in the first-floor dining area. The MGR stated, we know it's [lack of real bowls, cups and silverware] is a problem. The MGR stated they order more supplies when they noticed things are running low and are usually out of supplies before a new shipment arrives.<br><br>During interview with R79 on 12/4/25 at 10:56 a.m., R79 pointed to Styrofoam cup for juice on bedside table. I prefer a regular cup instead of this (squeezing it and spilling). They have been using Styrofoam since I got here. I hate it. It is cheap and not good. No one has told me why they always use the Styrofoam or plastic crap instead of the real stuff.<br><br>During interview with registered nurse (RN)-A on 12/4/25 at 2:14 p.m., RN-A stated expectation for facility to use plastic silverware and Styrofoam cups for food service is for residents who are on precautions. we should use regular silverware. It is a standard. It is home. They should be homelike.<br><br>During observation on third floor dining room following meal service at 12/5/25 at 9:45 a.m., Styrofoam cups were stacked on the counter next to steam table. Nine room trays were on rolling cart, all had Styrofoam cups and plastic silverware on the meal trays.<br><br>During interview with R40 on 12/5/25 at 12:09 p.m., R40, who was former Resident Council President stated Styrofoam and plastic is used all the time here. They are not right to serve in, [facility] act like [they] don't want to buy cups and silverware. This place tells us, 'we are out of silverware'. I don't know why they can't order before running out.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During interview with NA-F on 12/5/25 at 12:20 p.m., NA-F stated plastic silverware and Styrofoam cups is used all the time here. They are not right to serve in. [Facility] acts like [they] don't want to buy cups and silverware. Also, I don't know why [facility] can't order before running out.<br><br>During interview with DM on 12/8/25 at 12:33 p.m., DM stated she was responsible for ordering silverware and stated she was aware of residents complaining of plastic silverware and, we have been reactive to it instead of proactive with getting silverware. We should be providing real silverware for dignity.<br><br>Facility policy titled Meal Distribution: Infection Control Considerations, revised 9/2017 identified:<br><br>2. Durable dishware, utensils, and service ware will be provided unless indicated by the CDC guidelines.<br><br>DIGNITY WITH CARES<br><br>R30's quarterly minimal data set (MDS), dated [DATE], indicated R30 was admitted to the care facility on 7/12/24 and was cognitively intact. The MDS further indicated R30 was dependent on staff for most activities of daily living (ADLs).<br><br>During an interview on 12/1/25 at 6:15 p.m., R30 stated there was one particular staff member, trained medication aide (TMA)-C, who gave him is medications that was very rude to him, stating, I get tired of the way she [TMA-C] talks to me and he did not feel like is interactions with TMA-C were dignified and left him feeling angry and upset.<br><br>During observation on 12/1/25 at approximately 6:20 p.m., R30 approached the nurse station and asked TMA-C for his pain pill. TMA-C continued to sit for several seconds, not responding to R30 before standing up and walking over to the medication cart. TMA-C pulled out a cup of medications from the cart and without acknowledging R30, walked over to him and attempted to pour the medications into R30's mouth. R30 pulled away and asked TMA-C what medications he was giving. TMA-C responded with what medications were in the cup but did not have R30's pain pill. R30 repeated he would like a pain pill. TMA-C went back to the cart, asked R30 his pain level, and proceeded to administer his medications. TMA-C did not acknowledge R30 throughout the interaction until he voiced a direct question to her and stopped her from putting his medications directly to his mouth. R30 stated the interaction with TMA-C was typical and did not make him feel good.<br><br>A facility policy titled Dignity, dated 2/2021, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem further indicating residents would be treated with dignity and respect at all times. |

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| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident mail was delivered on Saturdays for 2 of 2 residents (R8, R17) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 68 residents residing in the facility. Findings include:R8's quarterly Minimum Data Set (MDS) dated [DATE], indicated R8 had no cognitive impairment. R17's comprehensive MDS dated [DATE], indicated R17 had no cognitive impairment. During an observation and interview on 12/1/25 at 3:21 p.m., activities assistant (AA)-A was observed to enter R8's room with a large stack of mail (greater than 50 items) and gave five to ten letters to R8. R8 stated she was lucky if she got her mail every month. R8 stated that sometimes the mail she received was time sensitive, so she would like to get the mail the day it arrived at the facility. R8 confirmed she did not get her mail on the weekends.During an interview on 12/3/25 at 11:56 a.m., R17 stated he received his mail most weekdays but not on the weekends. During an interview on 12/4/25 at 8:25 a.m., AA-A stated she worked all weekdays except Tuesdays and worked on Sunday. AA-A stated she oversaw delivering resident mail, which she completed every day she worked except Sunday. AA-A stated she did not believe mail was delivered on the weekends. AA-A stated on 12/1/25 that she had a stack of mail to deliver because the business office manager (BOM) was on vacation the week prior. AA-A stated that the business office manager oversaw sorting the mail, so when she was on vacation or on the weekends, the mail was not delivered. During an interview on 12/4/25 at 8:29 a.m., the BOM stated she oversaw sorting mail. The BOM stated she then gave the mail to the activities department to deliver to residents. The BOM stated she worked Monday-Friday and did not believe the mail was delivered on the weekends. During an interview on 12/8/25 at 10:36 a.m., the administrator confirmed that the facility did not have a process in place to deliver mail on the weekends. The facility's Mail and Electronic Communication policy dated 5/17, indicated mail and packages would be delivered to residents within 24 hours of delivery including on Saturdays. |

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| | 245289 | A. Building<br>B. Wing | 12/08/2025 |

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|---|---|
| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>Crystal, MN 55422 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide sufficient staffing and or oversight of non-licensed nursing staff to ensure the residents received care and assistance as needed and in a timely manner. This deficient practice had the potential to affect all 68 residents who reside in the facility. Findings include:Refer to F677: The facility failed to ensure routine personal hygiene (i.e., showers) were completed for 6 of 8 residents (R12, R30, R31, R37, R52, and R54) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.Refer to F919: The facility failed to ensure the resident call light system was functioning throughout the building. The Terrace at [NAME] Facility assessment dated [DATE], indicated their average daily census was 58. Residents' interviews R15's admission Minimum Data Set (MDS) dated [DATE] indicated R15 had moderate cognitive impairment, needed substantial assistance with toileting, dressing, footwear, personal hygiene, bed mobility, transfers, was unable to ambulate, and was dependent with bathing. R15's medical diagnoses included cutaneous abscess, muscle weakness, repeated falls and adult failure to thrive.During interview on 12/1/25 at 1:39 p.m., R15 stated staff treats me with respect, but the service is screwed, they take forever to answer a call light.R17's comprehensive/annual Minimum Data Set (MDS) dated [DATE] identified R17 with intact cognition, needed substantial assistance with showers, toileting, dressing, personal hygiene, dependent with bed mobility, transfers, and did not reject care. In addition, R17 was identified as having limited lower extremities range of motion (ROM), risk of developing pressure ulcers/pressure injury. R17's medical diagnoses included diabetes, chronic pain syndrome, lymphedema and depression.During interview on 12/1/25 at 1:25 p.m. R17 stated, when the call light is working it takes anywhere between 30-40 minutes to get answered, all the time. Theoretically they have another way when the lights are not working. Usually nobody responds. Most people/residents will text and chase down aids and staff. I have never had anyone respond when I ring the bell.R1's quarterly Minimum Data Set (MDS) dated [DATE] identified R1with intact cognition, needed set-up or clean-up assistance with grooming, bathing, dressing and was independent with transfers. R1's medical diagnoses included stage 3 pressure area, anemia, heart failure, renal disease, respiratory failure, depression and anxiety.During interview on 12/1/25 at 3:54 p.m. R1 stated I don't usually hit the light. It takes forever to wait for staff, at least 15-20 minutes, sometimes a staff member comes and turns it off and leave.R43's quarterly Minimum Data Set (MDS) dated [DATE] identified R43 with intact cognition, was dependent with toileting hygiene, bathing, dressing, wheelchair mobility, and substantial assistance with personal hygiene, and did not rejected cares. R43's diagnoses included diabetes mellitus, atrial fibrillation, hypertension, urinary retention, and gastro esophageal disease.During interview on 12/1/25 at 12:42 p.m., R43 stated I just got my diaper changed. R43 stated last night, a nursing assistant (NA) changed her brief at 4 a.m. and 6 a.m. R43 stated this morning a NA brought breakfast and said she would come back and added I was changed a few minutes ago. R48's comprehensive Minimum Data Set (MDS) dated [DATE] identified R48 with intact cognition, no behaviors, needed set up to eat, moderate assistance with oral hygiene, personal hygiene, maximal assistance with bed mobility, transfers, and dependent with wheelchair mobility.During interview on 12/1/25 at 4:09 pm R48 stated he had to wait 1/2 to 2 hours. Resident stated, anytime of the day is the same, but it was worse at night. Resident indicated he used the call light and the bell. R48 added, apparently the call light is fixed now. Or if none of that works then he called the facility's desk.R78's was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease, diabetes, quadriplegia (paralysis affecting all limbs), and a history of pneumonia. MDS was in progress.During interview on 12/1/25 at 1:13 p.m., R78 stated he had been at facility for about a week. R78 stated the call light didn't work. The light worked on the alarm on the wall but didn't turn on outside. R78 stated he had<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | reported this to the staff, R78 added he hoped they'd fix it today. R78 stated he didn't feel the facility had enough staff; people have told him I'll be right back but never came back. R78 stated he had to call his mother and had her called the desk. R78 stated his call light gets unplugged from the wall, and he yells for help, and the call lights have not worked the whole time he has been here, adding it's scary.R57's Minimum Data Set (MDS) dated [DATE] identified R57 with intact cognition, no behaviors/no rejection of cares, lower extremities limited ROM, unable to ambulate, needed set up to eat, needed substantial assistance with dressing, toileting hygiene, bathing, and transfers. R57's diagnoses included chronic pulmonary edema, anemia, renal disease, cardiomegaly and acute respiratory failure.During interview 12/1/25 at 2:02 p.m., R57 stated the facility needed more nursing assistants, especially on the weekends, stating, it's bad. R57 added sometimes they didn't see the aids the whole day. R57 stated the call lights didn't work, because the staff didn't answer them. R57 stated sometimes the staff mentioned they were low staff, or they have only two aids on duty. R57 stated the morning staff usually check with her at 2 pm, and then you don't see the aides until 9 p.m. R57 stated she had complained to the nurses on duty, she added I think they are getting rid of the bad ones [NAs].R10's Minimum Data Set (MDS) dated [DATE] identified R10 with moderate cognitive impairment, had impaired movement of one upper extremity, and impaired movement in both lower extremities. MDS also indicated R10 needed set up to eat, moderate assistance for oral hygiene, and was dependent for dressing, toileting hygiene, showers/bathing, bed mobility, transfers, and had no behaviors or refused cares.During interview on 12/1/25 at 1:51 p.m., R10 stated the call light was kind of useless, especially during the weekend, and the staff takes a long time to answer the call light or don't answer it altogether. Call-light response reviewroom [ROOM NUMBER]-1Call light record reviews between 11/18/25 and 12/1/25. The call was activated 10 times with call light response of:>20 minutes=2 times>30 minutes= 2 times>60 minutes=1 time>90 minutes=1 time>160 minutes=1 timeroom [ROOM NUMBER]-1Call light record reviews between 11/17/25 and 12/1/25. The call was activated 20 times with call light response of:>20 minutes= 3 times>40 minutes= 3 times>60 minutes= 2 times>70 minutes= 1 time>420 minutes= 1 timeroom [ROOM NUMBER]-1Call light record reviews between 11/17/25 and 12/1/25. The call was activated 16 times with call light response of:>20 minutes= 5 times>30 minutes= 2 times>50 minutes= 1 time>60 minutes= 1 time>90 minutes= 2 times>150 minutes= 2 timesroom [ROOM NUMBER]-1 Call light record reviews between 11/17/25 and 11/27/25. The call was activated 3 times with call light response of:>20 minutes+ 1 timeroom [ROOM NUMBER]-2Call light record reviews between 11/17/25 and 11/28/25. The call was activated 43 times with call light response of:>20 minutes= 9 times>30 minutes= 1 time> 50 minutes= 1 time>60 minutes= 1 time>80 minutes= 1 time>90 minutes= 1 time>100 minutes= 1 timeroom [ROOM NUMBER]-2Call light record reviews between 11/17/25 and 11/28/25. The call was activated 31 times with call light response of:>20 minutes= 5 times>190 minutes= 1 timeroom [ROOM NUMBER]-1Call light record reviews between 11/17/25 and 11/28/25. The call was activated 12 times with call light response of:>40 minutes= 1 time>130 minutes= 1time>230 minutes= 1 timeResident Council Meeting Minutes Review8/13/25 Meeting Minutes indicated the following:- Call lights not being answered, Call light is still an issue, haven't been resolved.- Resident' family members tried to call multiple times, no answer. - Resident's not getting their medications on time.9/10/26 Meeting Minutes indicated the following:- Call lights still not being answered.- Staff is not coming to work, short staff.- Medicine still not getting received on time due to insufficient staff.10/8/25 Meeting Minutes indicated the following:- Facility should have fully staffed workers.- The facility should hire certified staff that can pass meds. Staff interviews During interview on 12/2/25 at 12:35 p.m., trained medication assistant (TMA)-C stated she mainly worked on the 2nd floor which was supposed to have 4 NAs on the morning and afternoon shifts but was not always like that. TMA-C stated sometimes they only have 2 NAs. TMA-C stated 4 NAs was adequate, 3 NAs was challenging, and the TMAs had to help. They stated when the floor had 2 NAs some things were left undone for the residents. TMA-C stated she heard complaints form residents about how long they<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | wait for their call lights to be answered, the waiting time depends on the staff-resident's ratio. TMA-C stated when they had 4 NAs, the residents should wait no more than 2 minutes. TMA-C stated when a call light was on over 5 minutes, she answered the call lights if she was able to meet the resident's needs. If the resident's needs required assist of 2 NAs, she turned the call light off and informed the NAs. TMA-C stated she had never tracked when the NA-s went to the resident's room to take care of the resident's needs after she turned off the call light.During interview on 12/2/25 at 12:27 p.m., NA-Q stated the call light system did not always work, but they also had pagers and added today she didn't have a pager because they were unavailable. NA-Q stated the residents have complained about waiting for long times. NA-Q stated, the second floor often worked with 3 NAs and if it was a bad crew, it was also a bad day, and the residents didn't receive the necessary cares.During interview on 12/3/25 at 11:24 a.m., NA-E stated they had problems with the call light system and the pagers. NA-E stated sometimes the pager received a message, but the resident didn't call for help. Other times, a resident calls for help, the call light didn't work, or the pager didn't work. NA-E stated every week she received complaints from residents about waiting a long time to get their call lights answered, and they often worked with 3 NAs and it was hard to answer the call lights as the residents would like.During interview on 12/5/25 at 2:01 p.m., the staffing coordinator (SC) stated she started to work at the facility about 5 weeks ago. SC stated she believed they had enough staff members, but some employees called in too often with too many excuses. SC stated the facility was not using pool agencies. SC stated when a staff member called in, they tried their best to replace the employee. SC stated the nursing department was staffed 7 days a week as follows:2 nurses or 1 nurse and 2 trained medical assistants (TMAs) and 4 nursing assistants (NAs) on both the 2nd and the 3rd floors during the morning shift and the afternoon shift.1 nurse and 2 NAs on both the 2nd and 3rd floors during the overnight shift.The SC stated she worked full time and was on call on the weekends. SC explained the staff called her when they have a call in, and she reported to the director of nursing (DON). SC stated she contacted employees and tried to cover the open shifts, and sometimes the DON would call herself. SC stated when they could not replace a NA, they had to pull one of the TMAs to work as a NA.Schedule review:Review of the staff schedules revealed the facility was short the following staff/roles on the following days and shifts as outlined by the staffing coordinator:11/3/25- 2 nurses or TMAs on the morning shift11/4/25- 1 nurse and 1 NA on the morning shift.11/5/25- 1 nurse or TMA and 1 NA on the morning shift.11/6/25- 1 nurse or TMA on the morning shift.11/7/25- 2 nurses or TMAs on the morning shift.11/8/25- 2 nurses or TMAs on the morning shift and 1 NA on the afternoon shift. 11/9/25- 1 NA on the morning shift. 1 nurse or TMA and 1 NA on the afternoon shift.11/10/25- 2 nurses or TMAs and 2 NAs on the morning shift.11/12/25- 1 NA on the morning shift.11/13/25- 1 NA on the morning shift.11/14/25- 1 nurse or TMA on the morning shift and 1 nurse or TMA on the evening shift.11/15/25- 2 nurses or TMAs and 3 NAs on the morning shift.11/16/25- 1 nurse or TMA and 1 NA on the morning shift.11/17/25 -1 nurse or TMA and 1 NA on the morning shift and 1 nurse or TMA on the afternoon shift. 11/18/25- 1 NA on the morning shift and 1 nurse or TMA on the afternoon shift. 11/21/25- 2 nurse or TMAs on the morning shift. and 1 nurse or TMA on the afternoon shift.11/22/25- 1 nurse or TMA, on the morning shift.11/23/25- 1 nurse or TMA and 1 NA on the afternoon shift.11/26/25- 1 nurse or TMA and 2 NAs on the morning shift.11/27/25- 1 nurse or TMA on the afternoon shift and 1 nurse or TMA and 1 NA on the afternoon shift.11/28/25- 2 nurse or TMAs and 2 NAs on the morning shift.11/29/25- 1 nurse or TMA on the morning shift.12/1/25 - 1 nurse or TMA on the morning shift12/2/25 - 1 or TMA on the morning shift12/3/25 - 1 nurse or TMA on the morning shift12/5/25 - 1 nurse or TMA on the morning shift and 1 nurse or TMA on the afternoon shifts.12/6/25 - 1 nurse or TMA on the morning shift and 1 nurse or TMA on the afternoon shifts.During interview on 12/5/25 at 2:27 p.m., LPN-A stated the floor was staffed with 4 NAs and 2 nurses or 1 nurse and 2 TMAs, which she believed was adequate. LPN-A added when they can't cover a NA's call in, and she is working with 2 TMAs, one of the TMAs worked as a NA. LPN-A explained when she worked with one TMA, besides taking one of the medication carts to pass meds, she has to<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | check blood sugars, administer insulin, do all the wound treatments, and call providers and family members as needed, as well as help the nursing assistants when necessary. LPN-A stated often she worked 3-4 hours overtime. LPN-A stated she worked the hardest and fastest she could attend to her residents' needs, but often medications and treatments were not done in a timely manner.During interview on 12/8/25 at 9:59 a.m., LPN-D stated when they pulled one of the TMAs to work as a NA, she could administer medications on time, but she was unable to do wound treatments, scheduled assessments, or any follow ups (i.e. laboratory results, phone calls). LPN-D stated she tried to do as much as she could, but the PM shift would need to pick up the wound treatments and assessments. LPN-D stated it seemed every day they had some kind of staff shortage which affected residents' care. LPN-D stated the residents complained about having to wait a long time to get their call lights answered, and she believed it was a real problem. LPN-D stated they didn't have a reliable call light system. The other problem was the need to babysit some of the NAs to answer the call lights, and to make sure they didn't turn the call lights off until they meet the resident's needs. LPN-D stated some NAs turned the call lights off, told the residents they would be back, and either they wouldn't go back or forgot about it.During interview on 12/8/25 at 10:09 a.m., TMA-E stated she answered easy call lights, but if the resident needed more help or needed 2 NAs, she turned the call light off and found the NA assigned to the resident and informed her/him about the call light. TMA-E added, if we had 2 TMAs and a nurse, she would have more time to help the residents. TMA-E stated if the resident put the call light a second time, she looked again for the NA and informed the nurse. If the resident put the call light a third time, she informed the NA and the nurse. Usually, at this point the nurse approached the NA.During interview on 12/8/25 at 11:12 a.m., the administrator stated the facility had sufficient staff and would continue to hire. Administrator stated on daily basis the facility strived to be fully scheduled, but when the staff called in it put pressure on the rest of the team. He added, they offered bonuses to employees to cover call-ins. The facility's goal was to be fully staffed. The administrator stated the expectation was for staff to answer the call light and take care of the resident in a timely manner. The staff is not supposed to turn the call light off until the cares or needs of the residents have been met. The undated facility policy titled Answering the Call Light indicated to answer the call light as soon as possible.A Nursing Staffing policy was requested but not received. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observe each nurse aide's job performance and give regular training.<br><br>Based on interview and document review, the facility failed to complete annual performance evaluations for 3 of 3 nursing assistants (NA-M, NA-N, NA-O) who had been employed by the facility for over one year.Findings include:NA-M personnel record identified a hire date of 7/31/24, with no job performance review.NA-N personnel record identified a hire date of 10/31/22, with no job performance evaluation reviews.NA-O- personnel record identified a hire date of 3/4/19, with no job performance evaluation reviews.A voice mail was left for NA-N and NA-O, no call back was received.During interview on 12/4/25 at 4:04 p.m., the administrator stated he was not aware if annual performance reviews were done. The administrator stated currently the facility didn't have a human resources employee, but he would provide the requested information.During interview on 12/8/25 at 11:12 a.m., the administrator stated the annual reviews had not been conducted and it was something the facility would need to correct.Facility's policy titled Performance Evaluations dated 9/2020 indicated the job performance of each employee shall be reviewed and evaluated at least annually. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to have evidence of a goal, an action plan, and analysis of data to identify Performance Improvement Projects (PIP). This had the potential to affect all 68 residents of the facility.Findings include:Facility assessment dated [DATE], identified, QAPI Program activities. (3). The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources.Review of the facility's QAPI committee meeting minutes from September to December 2025 lacked information on a Performance Improvement Project (PIP).Review of facility's QAPI Plan, revised 1/20/25, identified the Design and Scope to Develop corrective action or performance improvement activities. In addition, The development of a PIP charter should begin once a specific area for improvement has been identified through data analysis, stakeholder feedback, or because of identified deficiencies needing attention. Also, Results of PIP will be communicated via: QAPI interdisciplinary meetings.During interview with facility's administrator on 12/8/25 at 1:47 p.m., the administrator identified that he was the leader of the facility's QAPI committee. He reviewed the facility's QAPI binder that he provided to the surveyor and stated, at this time, we do not have a PIP and PIP has not been started this year.Review of policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership, reviewed October 2022, identified the responsibility of the QAPI committee are to g. coordinates the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals. Review of policy titled Quality Assurance and Performance Improvement (QAPI) Program, revised February 2020, identified an objective of the QAPI program as, provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.Review of policy titled Quality Assurance and Performance Improvement (QAPI) Program-Feedback, Data and Monitoring, reviewed October 2022, identified The QAPI program is committed to no less that [sic] one project annually that focuses on a high-risk or problem-prone area identified through data collection and analysis. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents' call light system was functioning throughout the building. This had the potential to affect all 70 residents in the facility.Findings include:<br><br>R78's census list dated 11/26/25, indicated R78 was admitted to the facility on [DATE].<br><br>R78's screening tool dated 11/26/25, indicated R78 was oriented to self, place, and time. The tool indicated R78 was able to make his needs known and had the ability to understand others. The tool indicated R78 required maximum assistance from staff for bed mobility and dressing.<br><br>During an observation and interview on 12/1/25 at 1:13 p.m., R78 was observed lying in bed on his right side with his back facing the wall and looking at the television on the far wall. A soft touch call light was noted hanging over the head of the bed, about three feet from the top of the mattress, out of the reach of the resident. The call light was not plugged into the wall. A manual (non-electronic) call bell was not observed in R78's room. R78 stated his call light had not worked since he was admitted to the facility about a week ago. R78 stated he had no feeling or movement from his chest down and depended on staff for his care, but he had no way to ask for staff assistance as the call light did not function even when it was plugged into the wall. R78 stated he used a cough assist device as needed, and he had no easy way to ask for staff assistance when he felt like he needed to use. R78 stated he had to either call the nursing station with his phone or have his mom do it and hope someone answered.<br><br>During an observation and interview on 12/1/25 at 1:34 p.m., R78 was observed lying in bed on his right side with his back facing the wall and looking at the television on the far wall. A soft touch call light was noted hanging over the head of the bed, about three feet from the top of the mattress, out of the reach of the resident. The call light was not plugged into the wall. A manual (non-electronic) call bell was not observed in R78's room. Nursing assistant (NA)-C was observed to plug the call light back in to the wall, press the call light button, and then go into the hallway and look at the electronic screen at the end of his hall. NA-C stated the call light did not appear to be working, as the electronic screen at the end of R78's hall was how she knew if R78 needed help.<br><br>During an interview and observation on 12/2/25 at 12:48 p.m., NA-A confirmed that R78 was dependent on staff for care but had intact cognition and would be able to use a call light. NA-A stated that R78's call light had not been working since the resident was admitted last week, so staff would check on the resident every two hours when they helped him turn. NA-A stated that R78 did not have a further method to ask for staff assistance. NA-A was observed to press R78's call light, step into the hallway, and demonstrate that the call light did not show up on the electronic screen at the end of R78's hallway. NA-A stated she used the electronic screen at the end of R78's hallway to see if R78's call light was working, and it did not appear to be. NA-A stated that some staff members had pagers to know when call lights were on, but some of the pagers went missing so there were not enough for her to have one.<br><br>During observation on 12/1/25 at 6:00 p.m., on the third floor there were six light-emitting Diode (LED) panels in different locations of the third floor. The LED panels were used to display the room number and bed number when a resident pressed their call light to ask for help. Four of the six panels were not working.<br>(continued on next page) |

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|---|---|---|---|
| | 245289 | A. Building<br>B. Wing | 12/08/2025 |

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

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During observation on 12/2/25 at 8:40 a.m., on the second floor there were six light-emitting Diode (LED) panels in different locations of the third floor. The LED panels were used to display the room number and bed number when a resident pressed their call light to ask for help. Three of the six panels were not working.<br><br>During interview on 12/2/25 at 12:57 p.m., licensed practical nurse (LPN)-D working on the second floor verified 3 out of 6 LED panels were not working. LPN-D stated the nursing staff was also supposed to carry a pager just in case the LED panels didn't work. LPN-D added there was a problem with the pagers, because there were not enough pagers, or they didn't work. LPN-D stated, I think there are only 5 pagers between the 2nd and 3rd floor.<br><br>During interview on 12/3/25 at 7:45 p.m., LPN-A stated she worked full-time mainly on the third floor. LPN-A stated the LED panels were always broken, and the pagers didn't really work. LPN-A stated the maintenance person would reset the system every so often, and the panels worked for 2 or 3 days. LPN said management thought the pagers would help but they didn't really work. The pagers would work if there were not broken or they had enough pagers, and if the staff used them. LPN-A stated today two out of 4 nursing assistants have a pager and the nurses had none. LPN-A said today the LED panels were working and added we have to see how long they will work.<br><br>During interview on 12/3/25 at 8:33 a.m., nursing assistant (NA)-R stated this morning there were not enough pagers, so she didn't get one.<br><br>During observation and interview on 12/3/25 at 11:45 a.m., surveyor pressed the call light in room [ROOM NUMBER] and it only activated 1 of 2 LED panels in the hallways. NA- Q verified only one LED panel was working. NA-Q stated she knew the call light in room [ROOM NUMBER] was on because the pager sent a message.<br><br>During observation and interview on 12/4/25 at 8:40 a.m., NA-B did not have a pager. She said she got busy right away and forgot to pick one up, but she could look at the LED panel. NA-B answered the alarm in room [ROOM NUMBER]-2, but the room was empty. NA-B turned off the call light, but the LED panel continued to display 204 room bed 2. NA-B stated sometimes the LED panels display a room number, and the residents did not press the call lights, and other times the residents said they pressed the call light, but it's not displayed on the LED panel.<br><br>During interview on 12/4/25 at 9:08 a.m., nurse manager/licensed practical nurse (LPN)-B said he has worked at the facility for several months. LPN-B stated, when residents expressed concerns about waiting for long periods for staff to answer their call light, maybe their call lights are not working so we give them a call bell and/or put them on frequent checks. LPN-B stated they knew the LED panels didn't work as they should, and it had been an ongoing problem. The nurses and nursing assistants need to have a pager and should report concerns to the administrator or the maintenance staff.<br><br>During interview on 12/4/25 at 3:40 p.m., the administrator stated sometimes for some reason their call light system didn't work. Sometimes the system didn't alert the staff and other times the system alerted the staff when the residents didn't press their call light. The administrator stated they have contacted the company several times, but they were unable to find a problem, and due to this the facility started to use pagers. The administrator said each floor received 10 pagers. In addition, the nurse managers, the director of nursing and the administrator had their own. The administrator stated he was not aware there were problems with the pagers and added the nurse managers on each floor<br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | were responsible to check the pagers log and inform him if they were any concerns. The administrator stated the resident were also provided manual bells as a backup, it they had waited for too long and their call lights were not answered. The administrator acknowledged receiving complaints from the residents about the call light system. The administrator stated their goal was to answer call lights in a timely manner and meet residents' needs.<br><br>Facility's policy titled Maintenance Service dated 3/5/25, indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy also indicated maintenance personnel were responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner, at all times. |

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| F 0941<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory communication training for 3 of 10 staff (the director of nursing (DON), registered nurse (RN)-B, nursing assistant (NA)-I) reviewed for training requirements. This had the potential to affect all 68 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated the facility cared for a multi-cultural diverse population. The assessment indicated that clinical staff were to receive training on effective communication annually.Review of personnel records indicated the DON, RN-B, and NA-I had not completed education that included effective communication in the last year. During an interview on 12/8/25 at 10:28 a.m., the administrator was informed that education on effective communication was not found in the personnel records he had provided for the DON, RN-B, and NA-I. The administrator stated he was not previously aware of this and would continue to look for further education for these staff members. The administrator stated the facility's human resources staff member, who oversaw staff training completion, had recently left, and if the required annual training was not completed, the human resources staff member was to notify the DON, so they were not to be assigned to work until the training was completed. The administrator stated since he had not previously been aware that staff had not been completing their training, this had not happened, and it was important for staff to complete their training annually to ensure they were up to date on current practices and expectations for resident care. Further training was not received from the facility.The facility's Competency of Nursing Staff policy dated 5/19, indicated that competency in skills and techniques necessary to care for residents included communication and resident's rights. The policy indicated specialized skills and training needed based on their resident population, was considered when creating their training program. The policy indicated facility and resident-specific competency evaluations will be conducted upon hire, annually, and as deemed necessary based on the facility assessment. |

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| F 0942<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory resident rights training for 2 of 10 staff members (the director of nursing (DON), nursing assistant (NA)-J) reviewed for training requirements. This had the potential to affect all 68 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on resident rights annually.Review of personnel records indicated the DON and NA-J had not completed education that included resident rights in the last year. During an interview on 12/8/25 at 10:28 a.m., the administrator was informed that education on resident rights was not found in the personnel records he had provided for the DON and NA-J. The administrator stated he was not previously aware of this and would continue to look for further education for these staff members. The administrator stated the facility's human resources staff member, who oversaw staff training completion, had recently left, and if the required annual training was not completed, the human resources staff member was to notify the DON, so they were not to be assigned to work until the training was completed. The administrator stated since he had not previously been aware that staff had not been completing their training, this had not happened, and it was important staff completing their training annually to ensure they were up to date on current practices and expectations for resident care. Further training was not received from the facility.The facility's Competency of Nursing Staff policy dated 5/19, indicated that competency in skills and techniques necessary to care for residents included communication and resident's rights. The policy indicated specialized skills and training needed based on their resident population, was considered when creating their training program. The policy indicated facility and resident-specific competency evaluations will be conducted upon hire, annually, and as deemed necessary based on the facility assessment. |

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| F 0944<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory quality assurance and performance improvement training for 1 of 10 staff members (the director of nursing (DON)), reviewed for training requirements. This had the potential to affect all 68 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on quality assurance and performance improvement (QAPI) annually.Review of personnel records indicated the DON had not completed education that included QAPI in the last year. During an interview on 12/8/25 at 10:28 a.m., the administrator was informed that education on QAPI was not found in the personnel records he had provided for the DON. The administrator stated he was not previously aware of this and would continue to look for further education for this staff member. The administrator stated the facility's human resources staff member, who oversaw staff training completion, had recently left, and if the required annual training was not completed, the human resources staff member was to notify the DON, so they would have been aware their training was not complete. Administrator stated staff were not to be assigned to work until the training was completed. The administrator stated since he had not previously been aware that staff had not been completing their training, this had not happened, and it was important staff completing their training annually to ensure they were up to date on current practices and expectations for resident care. Further training was not received from the facility.A policy regarding QAPI training was requested but not received. |

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| F 0946<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide training in compliance and ethics.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory compliance and ethics training for 1 of 10 staff members (the director of nursing (DON), reviewed for training requirements. This had the potential to affect all 68 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on compliance and ethics annually.Review of personnel records indicated the DON had not completed education that included compliance and ethics in the last year. During an interview on 12/8/25 at 10:28 a.m., the administrator was informed that education on compliance and ethics was not found in the personnel records he had provided for the DON. The administrator stated he was not previously aware of this and would continue to look for further education. The administrator stated the facility's human resources staff member, who oversaw staff training completion, had recently left, and if the required annual training was not completed, the human resources staff member was to notify the DON the training was not completed. The staff were not to be assigned to work until the training was completed. The administrator stated since he had not previously been aware that staff had not been completing their training, this had not happened, and it was important staff completing their training annually to ensure they were up to date on current practices and expectations for resident care. Further training was not received from the facility.A policy regarding compliance and ethics training was requested but not received. |

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| F 0949<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide behavior health training consistent with the requirements and as determined by a facility assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory behavioral health training for 5 of 10 staff members (the director of nursing (DON), registered nurse (RN)-B, nursing assistant (NA)-I, NA-J, NA-K) reviewed for training requirements. This had the potential to affect all 68 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on caring for residents with mental and psychosocial disorders annually. The assessment indicated the facility cared for residents with various psychiatric/mood disorders, including depression, bipolar disorder, and schizophrenia. Review of personnel records indicated that the DON, RN-B, NA-I, NA-J, and NA-K had not completed education that included behavioral health training in the last year. During an interview on 12/8/25 at 10:28 a.m., the administrator was informed that education on behavioral health training was not found in the personnel records he had provided for the DON, RN-B, NA-I, NA-J, and NA-K. The administrator stated he was not previously aware of this and would continue to look for further education for these staff members. The administrator stated the facility's human resources staff member, who oversaw staff training completion, had recently left, and if the required annual training was not completed, the human resources staff member was to notify the DON, so they were not to be assigned to work until the training was completed. The administrator stated since he had not previously been aware that staff had not been completing their training, this had not happened, and it was important that staff completed their training annually to ensure they were up to date on current practices and expectations for resident care. Further training was not received from the facility.The facility's Competency of Nursing Staff policy dated 5/19, indicated that competency in skills and techniques necessary to care for residents included communication and resident's rights. The policy indicated specialized skills and training needed based on their resident population, was considered when creating their training program. The policy indicated facility and resident-specific competency evaluations will be conducted upon hire, annually, and as deemed necessary based on the facility assessment. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure routine personal hygiene (i.e., showers and toileting) were completed for 6 of 8 residents (R12, R30, R31, R37, R52, and R54) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.Findings include:<br><br>R12<br><br>R12's admission Minimum Data Set (MDS) dated [DATE], identified R12 with intact cognition, and was dependent on staff for toileting, showers and baths, upper body dressing, putting on and taking off footwear and personal hygiene. In addition, R12 had diagnoses of anemia, heart failure, kidney disease, diabetes, and respiratory failure and was dependent on Oxygen.<br><br>R12's care plan dated 10/27/25 identified R12 required assist of two staff with bathing/showering weekly and as necessary.<br><br>The facility 2nd floor nursing assistant care guide identified R12 with Bath: Tue PM and Bathing: Dependent 1-2 PA. In addition, R12's 2nd Floor Nurse care sheet identified R12's bath schedule as Tue PM. Also, the 2nd floor weekly shower schedule posted on both of the nursing stations identified R12's room number as Tuesday PM for a shower.<br><br>During observation and interview with R12 on 12/1/25 at 5:29 p.m., R12 was sitting in recliner in his room wearing a hospital gown with large dark stain on front of abdomen. R12 stated he had admitted to facility for rehabilitation on 11/2/25, and had not been offered or given a shower or bath during his stay at the facility. R12 stated he had worn the same hospital gown probably a week and the stain looks like blood.<br><br>R37<br><br>R37's quarterly MDS dated [DATE], identified impaired cognition, no rejections of care, and impairment to one side of both upper and lower extremity. In addition, R37 required substantial or maximal assist with upper and lower body dressing and was dependent on personal and toileting hygiene. Also, R37 had diagnoses of stroke, diabetes, anxiety, depression, paralysis on one side of body and dementia.<br><br>During observation and interview on 12/3/25 at 10:00 a.m., R37 was seated in wheelchair with facial hair that was quarter of an inch long. R37 stated he had not received weekly showers, I would really like to get a shower. I feel better when I get a shower. My whiskers need to be trimmed. I don't like the look or feel of these whiskers.<br><br>R52<br><br>R52's quarterly MDS dated [DATE] identified R52 with significantly impaired cognition, unclear speech or mumbled, was rarely understood, dependent on staff for toileting, personal hygiene and showers or baths. In addition, R52 had diagnoses of Alzheimer's disease, diabetes, dementia, and schizophrenia.<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During observation on 12/4/25 at 9:15 a.m., R52 was sitting in room with door open to the hallway. R52 had facial hair half an inch long and was wearing a hospital gown. R52 was not interviewable, and was rubbing her chin hairs and rocking back and forth in her chair.<br><br>The facility 2nd floor NAR care guide identified R52 with Bath: Thurs AM, Fri PM and Dressing: Bathing: EA 2. In addition, R52's 2nd Floor Nurse care sheet identified R52's bath schedule as Shower: Thu AM with nothing for Friday. Also, the 2nd floor weekly shower schedule posted on both nursing stations identified R52's room number as Thursday AM with nothing for Friday.<br><br>R54<br><br>R54's admissions MDS dated [DATE] identified severely impaired cognition, required substantial to maximal assistance with personal hygiene and dressing, and was dependent on staff for showering and bathing. In addition, R54 had diagnoses of dementia, seizures, and failure to thrive.<br><br>R54's care plan dated 11/15/25 identified: The resident requires (SPECIFY what assistance) by (X) staff with (SPECIFY bathing/showering) (SPECIFY FREQ) and as necessary. Assist of one.<br><br>The facility 2nd floor NAR care guide identified R54 with Bath: Thu PM and Bathing: Dependent 1-2 PA. In addition, R54's 2nd Floor Nurse care sheet identified R54's bath schedule as Wed AM. Also, the 2nd floor weekly shower schedule posted on both of the nursing stations identified R54's room number as Thursday PM and Friday PM for a shower.<br><br>During observation on 12/1/25 at 2:08 p.m., R54 was pacing in his room and hallway with shiny uncombed hair and whiskers about quarter of an inch long.<br><br>During observation on 12/2/25 at 8:13 a.m., R54 was sitting on edge of his bed facing the hallway with no pants on. R54 with shiny uncombed hair and whiskers about quarter of an inch long. R54 scratched his whiskers and said, I would like to be shaved.<br><br>During interview with R12 on 12/3/25 at 9:21 a.m., R12 stated his hospital gown was changed yesterday, socks too. Toenails [were] clipped. First time since I got here. Now I feel like a human being. Instead of feeling like a bump on the log.<br><br>During observation on 12/3/25 at 9:40 a.m., R54 was sitting in chair facing television set in dining room. R52 had shiny uncombed hair and facial hair.<br><br>During interview with NA-D on 12/3/25 at 9:48 a.m., NA-D pointed to the electronic medical record (EMR) and stated expectation of nursing assistants to document all showers, baths and refusals. NA-D stated expectation of nursing assistants to use their care sheets and follow the posted shower schedules to plan for and provide weekly showers to the residents. NA-D stated she did not have her care sheet with her and pointed to the posted weekly shower sheet at the nursing station. NA-D was unable to determine when R12, R37, R52, and R54 received a shower or bath.<br><br>During interview with trained medication aide (TMA)-A on 12/3/25 at 11:58 a.m., TMA-A stated the nursing assistants were responsible for all of the showers and baths and to follow their care sheets and the posted shower schedules. TMA-A looked at R12, R37, R52, and R54's EMR and stated they lacked documentation of showers or baths.<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview with nursing assistant (NA)-E on 12/3/25 at 12:07 p.m., NA-D stated expectation of all nursing assistants to follow their care sheets and the posted shower schedules for planning and providing showers and baths to the residents. NA-D stated the expectation of nursing assistants to document in the EMR and to notify the nurse if there were refusals. NA-E looked at R12, R37, R52, and R54's EMR and stated they lacked documentation of showers or baths. NA-E stated, they should be getting it. And the reason is, [it is]important basic hygiene, respect of[sic] dignity.<br><br>During observation and interview with licensed practical nurse (LPN)-D on 12/3/25 at 12:15 p.m., LPN-D stated, I doubt [R54] has had one [shower] and likely [R54] has not had his hair washed since he was admitted . Should be washed. LPN-D reviewed R54's EMR and stated, I don't see when he last had a shower. LPN-D stated refusals should also be documented too.<br><br>During interview with registered nurse (RN)-A on 12/4/25 at 2:05 p.m., RN-A stated expectation of nursing assistants to document all showers, baths and refusals in the TASK tab section of the electronic medical record. RN-A looked at R12's and R54's EMR and noted, Nothing is documented. RN-A stated, I would agree that documentation does not support [they] were offered or given a weekly shower.<br><br>R30<br><br>R30's quarterly minimum data set (MDS), dated [DATE], indicated R30 was admitted to the care facility on 7/12/24 and was cognitively intact. The MDS further indicated R30 was dependent on staff for most ADLs, including toileting.<br><br>R30's Bowel and Bladder Program Screener, dated 11/11/25, indicated R30 was able to void properly not always, but at least daily, was never incontinent of stool, required assist of one staff member for toileting, was alert and oriented and was always aware of need to toilet.<br><br>R30's care plan, dated 3/28/25, indicated R30 used a urinal and directed staff to empty and rinse after use. The care plan, dated 10/6/24, indicated R30 was able to use a hand-held urinal for bladder elimination and bedpan/toilet assist of 1-2 staff. The care plan, further directed staff to offer bedpan/urinal frequently and upon rising, before and after each meal, at bedtime, and NOC [night] rounds.<br><br>During an interview on 12/1/25 at 6:15 p.m., R30 stated when he asked staff to go to the bathroom they respond with you have a diaper on? and would tell him to urinate or have a bowel movement in his brief. R30 stated in the evening, staff changed his brief before bed and if he had to urinate during the night so be it. R30 stated he had a hard time managing a hand-held urinal by himself.<br><br>During observation on 12/4/25 at 7:44 a.m., nursing assistant (NA)-E assisted R30 with morning cares. NA-E provided peri-care and put a clean brief on R30. NA-E asked R30, remind me why you stopped using the [hand-held] urinal to which R30 replied he had difficulty placing the urinal because of his stomach. NA-E did not offer to help R30 with a hand-held urinal nor toilet him before transferring R30 with an easy stand into his electric wheelchair and leaving R30's room. R30 was able to sit on the side of the bed and in his wheelchair unassisted. R30 proceeded to go downstairs for breakfast.<br><br>During an interview on 12/4/25 at 10:45 a.m., NA-E stated previously R30 was able to use the hand-held urinal but had not used it in a few months. NA-E stated R30 was able to tell staff when he (continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | needed to use the toilet which was why toileting was not offered and R30 was a little wet this morning.<br><br>During an interview on 12/5/25 at 8:38 a.m., registered nurse and nurse manager (RN)-A stated R30 was able to use the toilet after being transferred via an easy stand, but at times he was incontinent. RN-A stated it was expected that any resident who was incontinent be toileted upon rising, including R30. RN-A stated she was aware R30 was no longer using the urinal but had not assessed why or if a new toileting plan was needed.<br><br>R31<br><br>R31's quarterly MDS, dated [DATE], indicated R31 was admitted to the care center on 1/15/25 and was cognitively intact. The MDS further indicated R31 required partial to moderate assistance with most ADLs however bathing was marked as not occurring during 7-day lookback period.<br><br>R31's care plan, dated 5/6/25, indicated R31 was limited assist by 1 staff to provide shower/bed bath per her [R31] preference weekly and as necessary. If resident [R31] refuses, reapproach later.<br><br>R31's progress notes, dated 10/1/25 through 12/5/25 lacked any documentation of refusals of care for assessment by the interdisciplinary team despite staff confirming R31 had daily refusals of care.<br><br>R31's most recent care conference note, dated 7/11/25, indicated R31 was at times non-complaint refuses care however did not address why or potential ways to support R31's compliance with cares.<br><br>R31's Weekly Bath Audits, from the past four months, dated 8/5, 8/12, 8/19, 9/9, 9/23, 9/30, 10/7, 10/21, 10/29, 11/4, and 11/25 all indicated R31 had refused a shower and body audit, with the exception of 10/29 in which none was selected for bathing type.<br><br>During observation on 12/1/25 at 3:30 p.m., R31 was lying in bed in a hospital gown with a notable foul odor in her room.<br><br>During observation on 12/4/25 at 11:40 a.m., R31 was again seen in her room, in a hospital gown.<br><br>During an interview on 12/4/25 at 11:35 a.m., licensed practical nurse (LPN)-D stated R31 would not let us [staff] do anything and would refuse her showers and her body audits.<br><br>During an interview on 12/5/25 at 8:03 a.m., trained medication aide (TMA)-C also stated R31 refused everything. TMA-C stated R31 took a shower about two months ago, but she believes that was the last shower R31 received. TMA-C further stated she at times would bribe R31 to shower by offering her nicotine gum and stated, I think she [R31] is just lazy.<br><br>During an interview on 12/5/25 at 8:38 a.m., registered nurse and nurse manager (RN)-A stated R31's refusals of care were all related to her schizophrenia diagnosis stating they had tried all they could to encourage her. RN-A stated staff were expected to write a progress note with any behaviors including refusals of care, stating the interdisciplinary team would then review. RN-A confirmed there were no progress notes to review on R30 refusing care in the past 90 days despite confirming she was aware R31 refused cares. RN-A confirmed the last documented shower was 4/15/25 but she was aware staff had showered R31 about 2 months ago. RN-A stated R31's refusal of care should have been discussed and documented during quarterly care conferences, confirming it was not documented what<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | ideas were discussed during R31's last care conference.<br><br>Facility policy titled Activities of Daily Living (ADLs), Supporting, revised March 2018 stated:<br><br>Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. And, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care). |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>During observation and interview, the facility failed to ensure food was served at a preferable temperature to residents. This had the potential to affect all 68 residents of the facility who received meals from the facility.<br><br>Findings include:<br><br>R1<br><br>R1's quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, identified R1 had intact cognition.<br><br>During interview on 12/1/25 at 4:03 p.m., R1 stated the food was terrible due to the taste and temperature. R1 stated the hot food was served cold and the taste was just not good. R1 stated due to the taste and temperature of the food, she only eats a bowl of cereal for breakfast and supper and a cold sandwich for lunch.<br><br>During an observation and interview on 12/2/25 at 8:45 a.m., R1 was observed eating a bowl of cold cereal with a glass of reddish colored liquid with ice in a cup to drink for breakfast. R1 stated this was her preference due to the food being terrible.<br><br>During interview with R21 on 12/1/25 at 1:42 p.m., R21 stated, food is meh. Everything is icky. Food that should be hot or warm is never warm.<br><br>During interview with dietary aide (D)-A on 12/2/25 at 1:00 p.m., D-A stated it was important to make sure food is served at a preferred temperature.<br><br>During interview with R12 on 12/3/25 at 9:21 a.m., R12 stated the breakfast he was served which included scrambled eggs and hashbrowns was cold that should have been warm.<br><br>During interview with R25 on 12/3/25 at 9:59 a.m., R25 stated she was unhappy with the serving temperature of the meals she eats. Food that is usually supposed to be hot is not.<br><br>During interview with R37 on 12/3/25 at 10:00 a.m., R37 stated he did not like the temperature of the food that he is served, and the hot food is not heated like I like.<br><br>During interview with R17 on 12/3/25 at 11:47 a.m., R17 stated he routinely ate his meals in his room and almost every tray [he received], the food is cold.<br><br>During observation and interview with licensed practical nurse (LPN)-D on 12/4/25 at 9:09 a.m., LPN-D tasted the fried egg bake from the second-floor dining room steam table and stated, the temperature is marginal. I would want to heat it up.<br><br>During interview with R40 on 12/5/25 at 12:14 p.m., R40 stated, when food is served to me, the temp of the food is on and off. Sometimes it is hot when it should be and sometimes it is not. Why can't they serve us food that is the right temp? It is so frustrating.<br><br>During interview with DM on 12/8/25 at 12:33 p.m., DM stated she agreed that food served to<br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents was not always at an appetizing and preferable temperature and that facility was aware of resident concerns. DM stated they planned to address this concern with staff and to perform audits to ensure preferable temperatures for food served to residents.<br><br>Facility policy titled Meal Distribution, revised 9/2017 identified: All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide a safe, sanitary, comfortable environment for residents. This had the potential to affect all 70 residents, staff, and visitors.<br><br>Findings include:<br><br>Leaking sink in bathroom<br><br>During observation on 12/1/25 at 1:29 p.m., R45's bathroom had leaking water from sink into plastic container under the sink with 4 inches of water in the container. Also, no toilet paper was observed anywhere in the bathroom or resident room. R45 was not present during observation.<br><br>Closet door<br><br>During observation and interview with R3 on 12/5/25 at 9:56 a.m., R3 bedroom closet door was missing. R3 pointed to wall behind bathroom door, on the floor where the closet door was placed out of the way. Closet contents were visible from room and from hallway of facility. Also, R3 pointed to her bathroom and the mirror was not attached to the wall. It was resting unattached on top of the sink behind the faucet and the wall. R3 stated facility's director of maintenance (DOM) and other staff were aware of it and facility had not communicated to her about reattaching the closet door or mirror.<br><br>Hole in wall<br><br>During observation and interview with R40 on 12/5/25 at 12:17 p.m., a hole in the wallboard measuring 5 inches by 5 inches was observed where the circular door handle of door to room aligned with wall when door is opened to hallway. The area was surrounded by white plaster repair, which was different color than wall color. R40 stated the hole in the wall has been there a year and a half. I have told [DOM]. The rest of the staff know too. I am tired of talking about it and I am tired of looking at it.<br><br>During interview with NA-F on 12/5/25 at 12:20 p.m., NA-F observed the hole in R40's wall and stated, It is bad and looks like the patch did not work. NA-F stated she was not aware of how long the hole had been present and did not notify anyone in the facility regarding the hole.<br><br>1st Floor<br><br>Leaking sink<br><br>During observation and interview with R79 on 12/3/25 at 11:45 a.m., their bathroom's sink was leaking. There were 3 plastic containers next to each other on the floor, and a wet blanket around the plastic containers. R79 stated it had been leaking since his admission to the facility on [DATE], and they had the plastic containers and rag on the floor to catch the water.<br><br>2nd Floor<br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dining room<br><br>During observation on 12/1/25 at 5:40 p.m., two out of six ceiling lights were not working.<br><br>During interview on 12/1/25 at 5:45 p.m. trained medication assistant (TMA)-C stated she didn't notice the broken lights before, because she usually didn't work in the afternoon shift. TMA-C stated, it's dark in here.<br><br>During interview on 12/1/25 at 5:50 p.m., registered nurse (RN)-A stated she didn't know how long the lights were not working. RN-A said they would move the residents to a different table with proper lighting so they could see what they were eating.<br><br>TV room by the nurses' station<br><br>During observation on 12/1/25 at 12:30 p.m., the right side of the ceiling by the wall facing the nurses' station had signs of water damage. The ceiling had light brown colored areas.<br><br>During interview on 12/1/25 at 2:00 p.m. licensed practical nurse (LPN)-A stated the brown spots on the ceiling had been there for a long while, probably for several months.<br><br>Shower room<br><br>During observation on 12/3/25 at 12:15 p.m., the light cord next to the shower didn't work, and the light cord close to the toilet was broken.<br><br>During interview on 12/3/25 at 12:22 p.m., NA-Q stated she had not notice it before.<br><br>room [ROOM NUMBER]-1<br><br>During observation on 12/4/25 at 11:10 a.m., the wall by the bathroom had a 7 inch by 2-inch area where the outer layer of the sheetrock was ripped off, and there were several dark gray areas measuring between 2 to 3 inches wide and 4 to 14 inches long.<br><br>Hallway<br><br>During observation on 12/3/25 at 12:28 p.m., a wall on the north side hallway next to the nurses' station was painted with three different tones of beige, and there was an unpainted area near the base board measuring about 3 feet long and 4 inches wide where a dark blue wallpaper could be seen.<br><br>3rd Floor<br><br>Atrium/TV room<br><br>During observation on 12/3/25 at 1:12 p.m., a light brown area was observed on the atrium's ceiling and measured about 2 feet by 1 foot. Several areas near the ceiling had black spider webs. In addition, there were several areas where the wallpaper was separating from the walls. On the wall next to the hallway there was a hole one inch in diameter and approximately one inch deep.<br><br>During interview on 12/3/25 at 2:45 p.m., LPN-A stated the light brown areas appeared to be water<br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | damage. LPN-A said housekeeping should take care of the spider webs as they have been there for a long time.<br><br>Hallways<br><br>During observation on 12/3/25 at 1:15 p.m., the walls between rooms [ROOM NUMBERS], rooms [ROOM NUMBERS], rooms [ROOM NUMBERS], rooms [ROOM NUMBERS], and rooms [ROOM NUMBERS] had various sized areas of repairs. Some of which had dry unsanded spackling and others had patches of white paint.<br><br>room [ROOM NUMBER]-2<br><br>During observation on 12/1/25 at 1:55 p.m., the overhead light was off, it was on the floor leaning against the heat vent. R10 stated the headlight had been like that since he had been at the facility.<br><br>room [ROOM NUMBER]<br><br>During observation on 12/3/25 at 1:20 p.m., one of cabinet's door lower edges was unglued and hanging about 5 inches from the bottom edge.<br><br>room [ROOM NUMBER]<br><br>During observation on 12/3/25 at 1:22 p.m., the left side of the ceiling 3.5 inches away from the wall, had a crack extending from wall to wall.<br><br>room [ROOM NUMBER]<br><br>During observation on 12/3/25 at 1:20 p.m., the transition area between the hallway floor and the room's floor was covered with gray duct tape. The tape was lifted in the area next to the door and in the center of the entry way. The tape was lifted from the floor in ¾ of the doorway.<br><br>Dining room<br><br>During observation on 12/1/25 at 2:15 p.m., the doorway between the hallway and the dining room's kitchenette was missing the base board and the sheetrock was exposed. The wall on the left side of the refrigerator had a black stain or discoloration of an irregular shape measuring approximately 23 by 40 inches. On the back wall, next to the refrigerator, there was an air intake vent and a blow vent which were dirty and covered with brown/rusty spots.<br><br>During interview on 12/8/25 at 9:44 a.m., the maintenance director (MD) stated the black stain on the wall occurred when the heat system was bled. MD stated the vents needed to be repaired and the walls should be cleaned or painted.<br><br>During observation and interview on 12/8/25 at 9:41 a.m., MD verified all the areas of concern identified on the first, second and third floor. MD stated he knew about some of the concerns but did not know about a lot of the areas he observed during the building's walkthrough. MD stated often their planned repairs or projects got pushed back due to emergency repairs. MD stated the facility's goal was to provide a home like environment to the residents.<br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview on 12/8/25 at 11:12 p.m. the administrator stated the building had many challenges. The administrator stated there were many repairs to be done but sometimes an emergent situation occurred and planned repairs needed to be postponed. The administrator stated repairs will need to be done to provide residents with a home like environment.<br><br>Facility's policy titled Maintenance Service dated 3/5/25, indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy also indicated the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide a written notice of bed hold for one of 1 resident (R70) reviewed for hospitalization.Findings include:R70's Medicare-5-day Minimum Data Set (MDS) dated [DATE] indicated R70 was cognitively intact.R70's diagnosis form dated 12/8/25 indicated diagnoses of thoracic region discitis (infection of the intervertebral disc space), encephalopathy, heart failure, hypertension, renal insufficiency, depression and diabetes. This form indicated R70 was admitted to the facility on [DATE].R70's discharge MDS dated [DATE], included R70 had an unplanned discharge with return anticipated and was discharged to a short-term acute hospital. R70 returned to the facility on 9/6/25.R70's discharge MDS dated [DATE], included R70 had an unplanned discharge with return anticipated and was discharged to a short-term acute hospital.R70's progress note dated 8/28/25 at 6:48 p.m., indicated R70 was transferred to a local hospital due to confusion and lethargy. However, R70's electronic medical record (EMR) lacked evidence a written notice of bed-hold was provided to the resident or representative for the 8/28/25 to 9/6/25 hospitalization.R70's progress note dated 9/13/25 at 10:33 a.m., indicated R70 was transferred to a local hospital due to altered mental status. However, R70's medical record lacked evidence a written notice of bed hold was provided to the resident or representative.During interview on 12/3/25 at 11:55 a.m., social worker (SW) stated when residents were sent to the hospital, the nurses ask the residents if they want to hold their bed. SW stated if the bed-hold was not addressed, the next day the administrator, director of nursing or SW would reach the resident at the hospital, the family or their representative to determine if they want to hold the bed. SW stated whether the resident holds the bed or not, it was documented on the resident's EMR. When a verbal authorization was received, the bed-hold form would indicate who they talk to and when the consent was obtained. The form would be signed by the staff member, and a progress note would be done on the resident's EMR. SW stated the bed hold policy would be scanned and placed on the EMR. SW verified R70's EMR lacked documentation about whether or not the resident wanted to hold the bed when he was sent to the hospital on 8/28 or 9/13.During interview on 12/3/25 at 12:45 p.m., SW produced two bed-hold forms. One form was dated 8/28/25 and the other was dated 9/9/25. The form dated 8/28/25 indicated a verbal consent was obtained from R70's brother but it was not signed by a staff member. The form dated 9/9/25 indicated admission [unreadable] received verbal consent. R70 did not go to the hospital on 9/9/25. A bed-hold form was not provided for resident's transfer to the hospital on 9/13/25.During interview on 12/8/25 at 11:08 a.m., R70's family member stated the bed was held, but he did not remember talking to the staff about holding the bed or signing a form to hold the bed.During an interview on 12/4/25 at 2:00 p.m., the administrator stated the bed-hold should be discussed with the residents and a copy should be provided to the resident or family and everything needed to be documented in the residents' EMR. Facility's policy titled Bed-Holds and Returns dated 11/2022, indicated residents and/or representatives are informed (in writing) of the facility and state bed-hold policies. The policy indicated, residents were provided written information about these policies at least twice:a. A. Well in advance of any transfer (e.g., in the admission packet); andb. B. at the of transfer (or, if the transfer was an emergency, within 24 hours). |

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| | 245289 | A. Building<br>B. Wing | 12/08/2025 |

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| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>Crystal, MN 55422 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the faciality failed to ensure a resident's comprehensive care plan was appropriately implemented for 1 of 2 resident (R30) who had interventions for specialized boots and cares is pairs that were not implemented. Findings include: R30's quarterly minimum data set (MDS), dated [DATE] indicated R30 was admitted to the care facility on 7/12/24 and was cognitively intact. The MDS further indicated R30 was dependent on staff for most ADLs, including toileting. R30's care plan, dated 7/17/24, indicated R31 had a behavior of making sexual comments towards staff with an intervention of cares in pairs initiated on 7/23/24. R30's care plan also indicated R30 had potential impairment to skin integrity with interventions initiated 8/24/25 for controlled ankle motion (CAM) boot while out of bed and offloading boots to right foot when in bed.During an interview on 12/1/25 at 6:15 p.m., R30 stated he did not wear any boots while in, or out of, bed and was not observed with any boots on his feet.During observation on 12/04/2025 at 7:44 a.m., nursing assistant (NA)-E provided morning cares to R30, including peri cares and transferring to his electric wheelchair, alone and did not implement the care plan intervention of cares in pairs.During an interview on 12/4/25 at 11:35 a.m., licensed practical nurse (LPN)-D stated she had noticed yesterday the care planned interventions for R30 to wear boots but had never seen R30 wear any type of special boots and was planning to follow up with registered nurse and nurse manager (RN)-A.During an interview on 12/5/25 nurse manager and RN-A stated offloading boots in bed were initiated for all residents who could not move well in bed to prevent pressure injuries. RN-A stated it was a preventative measure and confirmed she was aware R30 was not wearing in boots in, or out of, bed. RN-A further confirmed all staff were aware, and expected to, provide all cares to R30 in pairs due to R30 being verbally abusive to staff and making false accusations.During an interview on 12/5/25 at 12:05 p.m., trained medication aide (TMA)-C confirmed it was care planned for R30 to receive cares in pairs because he would get verbally aggressive with cares. A facility policy titled Care Plan, Comprehensive Person-Centered, dated 2/2022, indicated care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to provide the opportunity for 2 of 2 residents (R1, R31) reviewed to participate in care planning and care conferences.Findings include:<br><br>R1<br><br>R1's quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, identified R1 had intact cognition, and demonstrated no delusional thinking. Further, the MDS identified R50 as having a primary medical condition of, Medically Complex Conditions, along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and respiratory failure. Previous MDS assessments were dated 7/31/25 and 9/30/25.<br><br>R1's progress notes, dated 9/1/25 to 12/5/25, were reviewed. Progress notes lacked evidence of R1 having a care conference during that time. A note on 10/3/25 indicated a care conference was scheduled for 10/10/25 but no follow up or indication the care conference was completed.<br><br>R5's assessment tab in the electronic medical record (EMR) reviewed for care conferences. The last completed care conference assessment was completed on 8/7/25.<br><br>During an interview on 12/1/25 at 3:55 p.m., R1 stated she didn't know that last time she had a care conference. R1 stated she hadn't been to any.<br><br>During an interview on 12/4/25 at 9:33 a.m. nursing assistant (NA)-H stated they are not involved cares conferences except to get a resident dressed and ready for the care conference.<br><br>During an interview on 12/5/25 at 10:32 a.m., R1's family member (FM)-B stated they were R1's emergency contact, the healthcare and financial power of attorney. FM-B stated they did not receive many updates from the facility. FM-B stated they had not had a care conference since at least July. FM-B verified that R1 started on hospice on 9/22/25 after returning from the hospital.<br><br>During an interview on 12/5/25 at 10:08 a.m., registered nurse manager (RN)-A stated care conferences were scheduled by the social worker and were done quarterly and as needed such as a significant change. RN-A stated care conferences were documented in the progress notes of the electronic medical record (EMR). RN-A reviewed R1's medical record and stated on 10/3/25 a progress note indicated a planned care conference for 10/10/25. RN-A stated there was no documentation in the medical record if the care conference was completed, what was discussed at the care conference or who attended the care conference. RN-A verified R1 started on hospice on 9/22/25 and stated R1 should have a care conference since that was a significant change. RN-A stated R1 did not have a care conference and should have had a care conference.<br><br>During an interview on 12/5/25 at 10:54 a.m., director of social services (DDS) stated social services sets up care conferences on admission, at MDS assessments and at discharge. DDS stated care conference notes were found under the assessment tab in the EMR. DDS reviewed R1's EMR and stated the last care conference was 8/7/25. DDS stated there was a progress note on 10/3/25 indicating a planned care conference for 10/10/25 but no follow up on whether that care conference was completed. DDS stated R1 should have had a care conference the beginning of October when she (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | returned from the hospital and signed onto hospice. DDS was going to follow up to see if there was additional information regarding if a care conference was held on 10/10/25. No additional information was provided.<br><br>R31<br><br>R31's quarterly MDS, dated [DATE], indicated R31 was admitted to the care center on 1/15/25 and was cognitively intact.<br><br>R31's electronic medical record (EMR) indicated the most recent care conference R31 has was dated 7/11/25.<br><br>During an interview on 12/15/25 at 3:30 p.m., R31 stated she could not remember when her last care conference was offered or had one.<br><br>During an interview on 12/5/25 at 10:41 a.m., the director of social services (DSS) stated the expectation was every resident had a care conference quarterly, with staff meeting without the resident if they refused. The DSS confirmed she missed R31's care conference because R31 did not one.<br><br>A policy titled Care Conference Policy, reviewed 12/9/25, identified care conference shall be held at all required intervals, promptly after significant changes, and at any time upon request. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, interview and document review, the facility failed to ensure effective collaboration between the facility and a contracted hospice organization that affected 1 of 1 residents (R1) reviewed for hospice services. Findings include: R1's quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, identified R1 had intact cognition, and demonstrated no delusional thinking. Further, the MDS identified R50 as having a primary medical condition of, Medically Complex Conditions, along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and respiratory failure and indicated R1 was on hospice.R1's hospice chart included a blank calendar; however, it lacked identification of planned hospice visits. The chart included a section for hospice staff to use for collaboration of care between the hospice staff and facility staff. This section lacked any coordination from the hospice social worker. R1's Provider Orders for Life-Sustaining Treatment (POLST), signed and dated by R1 on 9/22/25, indicated R1's wishes DNR (Do Not Resuscitate) with comfort focused treatment was signed by hospice provider on 9/23/25. A copy of this was not located in the hospice binder.R1's facility care plan, printed 12/5/25, identified R1 was on hospice and provider's name, contact number and address. Furthermore, instructed staff to call hospice with new physician orders and to coordinate care with hospice. R1's care plan lacked hospice services provided, frequency of visits or disciplines visiting R1. Furthermore, R1's care plan indicated resident has signed Do Not Resuscitate (DNR) Orders with a creation date of 9/22/25. R1's Interdisciplinary Group Meeting (IGM) note which included R1's hospice care plan, dated 11/18/25, indicated R1 code status as DNR. Furthermore, the document included the following current orders for disciplines: -social worker 1-2 times a month for 3 months starting 10/1/25, -chaplain 1-2 times a month for 3 months starting 10/1/25, -skilled nursing 1-2 times a week for 13 weeks starting 9/22/25, -skilled nursing 4 as needed visits starting 9/22/25, -aid 1 time a week for one week then twice a week for 12 weeks starting 9/22/25. R1's December Medication Administration Record (MAR/TAR), included the following order: -pt admitted to [name of hospice] hospice with primary diagnosis of COPD (chronic obstructive pulmonary disease). Please call hospice 24/7 at [contact number] with any change in condition, falls, med refills and death with a start date of 9/23/25. R1's MAR/TAR lacked evidence of frequency of visits provided to R1. R1's progress notes, dated 11/1/25 to 12/3/25, were reviewed and revealed the following:-12/1/25: hospice returned called and stated the case worker would come to the facility tomorrow-12/1/25: called hospice to update that R1 signed a new POLST (Physician's Orders for Life Sustaining Treatment)-11/29/25: per resident hospice did wound careR1's progress notes lacked evidence of frequency of hospice visits, planned hospice visits, services hospice providing or notes after disciplines provided services to R1 from hospice. During an interview on 12/1/25 at 3:56 p.m., R1 stated she currently worked with hospice and they had been coming at least twice a week. R1 did not state what days of the week they came or who came to see her from hospice. During an interview on 12/1/25 at 7:36 p.m. licensed practical nurse manager (LPN)-B verified R1 signed onto hospice on 9/22/25 and a new POLST would typically be completed upon admission to hospice. LPN-B stated he could not find that a POLST had been completed since admission to hospice and should be something that is followed up on. LPN-B verified the POLST on facility file was dated 11/12/24.During an interview on 12/2/25 at 12:27 p.m., RN-C verified they were R1's case manager. RN-C stated R1 signed a POLST upon admission with hospice which indicated R1's wishes to be DNR comfort focused treatment. RN-C stated another nurse had completed R1's admission but the process would be a signed copy of the POLST would be provided to the facility. RN-C stated she was not aware that the facility had R1 listed as a full code in their medical records as the facility should have been provided the POLST indicating R1 wishes. RN-C stated R1 had been listed as DNR in their system since admission to hospice. RN-C stated they typically visited R1 twice a week but sometimes another nurse visited R1. During an interview on 12/3/25 at 11:31 a.m., nursing assistant (NA)-A stated hospice just show up and hospice did not have<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a calendar for when they came. NA-A stated on the shower calendar, on some floors, the hospice showers wwere be in parentheses. NA-A reviewed R1's shower schedule and stated R1's shower was not done by hospice as her room number was not in parentheses. During a follow up interview on 12/2/25 at 3:20 p.m. LPN-B stated he was not able to locate a copy of the POLST signed when R1 was admitted to hospice indicating R1 wished to be DNR comfort focused treatment, however verified that a POLST was signed upon admission to hospice. During a follow up interview on 12/3/25 at 11:57 a.m., LPN-B reviewed R1's hospice binder and documents within. LPN-B verified IGM's notes listed above were in R1's hospice binder. LPN-B stated it was a team approach, shared between nursing and social work, to ensure that coordination was done between hospice and the facility, and nursing and social work reviewed documents within the hospice binder.During an interview on 12/3/25 at 11:36 a.m., RN-D stated each resident on hospice had a hospice binder which should include a calendar indicating when each discipline would be scheduled to see the resident. RN-D reviewed R1's hospice binder and stated R1's binder did not have a calendar or schedule of when hospice was scheduled to see R1. RN-D reviewed notes and verified there were only notes from nursing assistants and nursing. RN-D verified there were not notes from social work or any other discipline. RN-D verified there were also no scheduled visits listed on the communication notes in the binder. During an interview on 12/3/25 on 11:57 a.m., licensed practical nurse manager (LPN)-B stated each hospice resident should have a calendar in their hospice binder that indicated their hospice visits. LPN-B reviewed R1's hospice binder and stated there was no calendar within the binder and the communication did not indicate the next visit either. LPN-B stated it was unknown when the nurse, social worker, and nursing assistant came or were scheduled to come to visit R1. During an interview on 12/03/25 at 1:45 p.m., director of admissions with hospice (AD)-A stated when a resident admitted to hospice, their POLST was reviewed to ensure it matched their current wishes, and if they did not have a POLST, one would be completed. AD-A stated POLST's were signed using docu-sign (a platform used to obtain electronic signatures) by residents/POA/guardians then transferred to the provider to sign within 24 hours. AD-A stated after the provider signed the POLST's they were faxed from their EMR system to the facility for their records. AD-A stated R1 signed a new POLST upon admission with hospice on 9/22/25, and verified it was signed by their provider. AD-A stated it should have been sent to the facility after the physician signed the POLST. During an interview on 12/5/25 at 10:04 a.m., nurse manager (RN)-A stated the expectation would be a calendar for all scheduled hospice visits would be in the hospice binder.A facility policy titled Hospice Program identified coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure nursing staff were appropriately trained and competent in the use of a cough assist machine for 1 of 1 resident (R78) reviewed for the use of a cough assist machine. Findings include: R78's diagnosis list dated 11/26/25, indicated R78 was admitted to the facility on [DATE] and was diagnosed with chronic obstructive pulmonary disease (COPD), diabetes, quadriplegia (paralysis affecting all limbs), and a history of pneumonia. R78's screening tool dated 11/26/25, indicated R78 was oriented to self, place, and time. The tool indicated R78 was able to make his needs known and had the ability to understand others. The tool indicated R78 required maximum assistance from staff for bed mobility and dressing. R78's hospital paperwork dated 11/26/25, indicated R78 was admitted to the hospital for pneumonia and was discharged now that he was breathing comfortably. The hospital paperwork did not address the use of a cough-assist machine. R78's medical record was reviewed and did not include an order, the instructions for the use, or monitoring related to the use of a cough assist machine before survey entrance. During an observation and interview on 12/1/25 at 1:13 p.m., R78 was observed lying in bed with a cough assist device on a dresser in the resident's room. The tubing and mask appeared clean. R78 stated he had no feeling or movement from his chest down and depended on staff for his care. R78 stated he had used the cough assist machine previously and knew how to use it but required staff assistance due to muscle weakness. R78 stated he didn't feel like staff knew how to use the machine and didn't know why there wasn't a regular schedule for using it. R78 stated he used the cough assist machine with staff assistance at least several times a day since admitting to the facility. During an interview on 12/1/25 at 1:39 p.m., licensed practical nurse (LPN)-A stated she helped R78 use a coughing machine. LPN-A stated R78 was admitted with the machine, and the only education she received on how to use it was from the nurse who worked before her. LPN-A stated this education included assisting the resident with applying the cough assist mask and turning the machine on. The LPN stated that the assessment she would perform before the use of the cough assist machine was listening to R78's lung sounds and assessing if R78 was short of breath but would look at the treatment administration record (TAR) for further assessment instruction and couldn't find any orders related to the use of the cough assist machine. During an interview on 12/2/25 at 11:57 a.m. with registered nurse (RN)-A (second floor nurse manager and acting director of nursing) and LPN-B (the third floor nurse manager), LPN-B confirmed that he had reviewed R78's medical record and did not see an order from a provider for the use of the cough assist device or instructions for the use of the machine, such as machine settings or frequency of use. LPN-B stated he believed R78 had used the cough assist machine at baseline before hospital admission and would need to get an order from the provider for continued use. LPN-B and RN-A agreed that education should have been completed prior to nursing staff assisting with the use a cough assist machine to ensure staff were using the device correctly. During an interview on 12/4/25 at 11:01 a.m., respiratory therapist (RT)-A stated that cough assist machines assisted a resident to clear their airway when they could not do it adequately themselves. RT-A stated she would expect an order to be in place for the use of the cough assist machine and include how often the cough assist machine should be used, the settings for the machine, if the use of a nebulizer was needed before the use of the machine, and how many cycles of machine use should be completed with each treatment. RT-A stated she would have expected nursing staff to be educated on how to use the device, such as completing a nebulizer prior to use of the machine, taking a full set of vital signs prior and after use, assessing breath sounds prior and after use, and assessing to see if the use of a suction device is necessary to use alongside a cough assist device. RT-A stated she was available to provide education to staff next week and had videos on how to use the device that staff could watch in the meantime. The facility's Usage and Training for Respiratory Equipment policy dated 12/8/25,<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated the registered managers were to oversee staff training, competency assessments, and device implementation. The policy indicated the general procedures for respiratory equipment use involved the interventions being approved by an appropriate healthcare professional. The policy indicated the care plan must include the device type, prescribed settings, frequency and duration of use, monitory requirements, contraindications, and escalation pathways. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R30) who had chronic pain received adequate pain control to include non-pharmacological pain interventions and appropriate communication and coordination with an outside pain provider.Findings include:R30's quarterly minimum data set (MDS), dated [DATE] indicated R30 was admitted to the care facility on 7/12/24 and was cognitively intact. The MDS further indicated R30 received scheduled and PRN pain medication and frequently had pain rated an eight out of ten. R30's diagnoses, dated 7/12/24, indicated R30 had a primary diagnosis of rheumatoid arthritis and a secondary diagnosis of chronic pain syndrome.R30's care plan, dated 7/19/25 indicated R30 had a behavior of calling police and requesting hospital transfer for pain medication without informing nursing and dated 8/26/25 indicating R30 had multiple hospitalizations for intractable headaches and chronic pain r/t rheumatoid arthritis.R30's signed physician orders, dated 12/1/25, indicated R30 had orders for non-pharmacological pain interventions to include ice, heated blankets, massage, repositioning, music, essential oils, food/drink and relaxation breathing; acetaminophen 650 milligrams (mg) every four hours as needed for mild pain rated 1-6 out of ten, aspirin 81mg one time a pain for pain, cyclobenzaprine 10mg every six hours as needed for pain, diclofenac sodium external gel to back and neck topically every six hours as needed for pain, diclofenac tablet 75mg every 24 hours as needed for pain, lidocaine patch topically every 24 hours as needed for pain, muscle run cream to painful areas topically every 12 hours as needed for pain, oxycodone with acetaminophen 10-325mg every eight hours as needed for pain, prednisone 10mg once a day for severe rheumatoid arthritis, and pregabalin 150mg three times a day for pain.R30's November medication and treatment record indicated R30 received 5 doses of as needed acetaminophen, 7 doses of as needed cyclobenzaprine, one dose of as needed diclofenac cream and tablet, zero doses of lidocaine patch or muscle rub, 26 doses of as needed oxycodone with acetaminophen. The November medication and treatment record further indicated R30 received non-pharmacological pain interventions on only two days of the month, with the other days indicating none needed despite numerous uses of as needed pain medications.R30's December medication and treatment record (12/1 - 12/5) indicated R30 received zero doses of as needed acetaminophen, one dose of as needed cyclobenzaprine, zero doses of diclofenac cream or tablet, zero doses of lidocaine patch or muscle rub, 4 doses of oxycodone with acetaminophen and had received other types of non-pharmacological on just two days with the other three days stating non needed despite use of PRN pain medications. R30's progress notes lacked information regarding any non-pharmacological pain interventions that were attempted, given, refused, effective or ineffective.R30's electronical medical record (EMR) lacked evidence of collaboration with R30's outside pain provider. During an interview on 12/1/25 at 6:15 p.m., R30 stated he had been to the hospital multiple times for is rheumatoid arthritis pain, stating he took pain meds, but he had a lot of pain, and it is not helping. R30 further stated staff will give him his as needed pain medication and not tell him or not assess him for pain or offer non-pharmacological pain interventions. During observation on 12/1/25 at approximately 6:30 p.m., trained medication aide (TMA)-C gave R30 his requested PRN Oxycodone without offering non-pharmacological interventions.Durin observation on 12/04/2025 at 7:44 a.m., an unnamed trained medication aide (TMA) entered R30's room with his medications and stated, I got your oxy [Oxycodone] in here too. No pain assessment was completed, or non-pharmacological interventions offered. During an interview on 12/4/25 at 11:35 a.m., licensed practical nurse (LPN)-D stated the expectation when a resident asked for an as needed pain medication was for staff to ask the resident their pain level and complete a progress note of their paining rate and why they are getting as needed medication. LPN-D stated R30 wouldn't let us [staff] try anything else [other than his Oxycodone]. LPN-D stated R30 saw an outside pain provider approximately every other month, but the facility had a hard time communicating with the provider and (continued on next page) |

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| | 245289 | A. Building<br>B. Wing | 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>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.

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | did not get collaboration notes, stating if R30 received a new prescription for his pain they had to call the pharmacy to get the order. LPN-D stated R30 doesn't appear in pain but will call 911 on his own due to his perceived uncontrolled pain and self-reported 10/10 pain. LPN-D stated R30 did not like the lidocaine patch but would occasionally use the muscle rub.During an interview on 12/4/25 at 10:45 a.m., nursing assistant (NA)-E stated R30 had not complained about pain directly to her, but he did hear him complain to others or ask for pain medication.During an interview on 12/5/25 at 8:38 a.m., nurse manager and registered nurse (RN)-A stated the expectation would be for staff to offer a non-pharmacological pain intervention with every as needed pain medication. RN-confirmed R30 went to an outside pain provider but that communication was challenging and most often then had to call the pharmacy to get updates on any new prescriptions received and did not receive post visit collaboration notes, stating communication with R30's outside pain provider was challenging.The facility Pain Assessment and Management policy dated 3/2020, indicated the pain management program was based on a facility-wide commitment to appropriate assessments and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include:a. Environmental adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.;b. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.;c. Exercise range of motion exercises to prevent muscle stiffness and contractures; andd. Cognitive or Behavioral - relaxation, music, diversions, activities, etc. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure nursing staff were appropriately trained and competent in the use of a cough assist machine for 1 of 1 resident (R78) reviewed for the use of a cough assist machine. Findings include: R78's diagnosis list dated 11/26/25, indicated R78 was admitted to the facility on [DATE] and was diagnosed with chronic obstructive pulmonary disease (COPD), diabetes, quadriplegia (paralysis affecting all limbs), and a history of pneumonia. R78's screening tool dated 11/26/25, indicated R78 was oriented to self, place, and time. The tool indicated R78 was able to make his needs known and had the ability to understand others. The tool indicated R78 required maximum assistance from staff for bed mobility and dressing.R78's hospital paperwork dated 11/26/25, indicated R78 was admitted to the hospital for pneumonia and was discharged now that he was breathing comfortably. The hospital paperwork did not address the use of a cough-assist machine. R78's medical record was reviewed and did not include an order, the instructions for the use, or monitoring related to the use of a cough assist machine before survey entrance. During an observation and interview on 12/1/25 at 1:13 p.m., R78 was observed lying in bed with a cough assist device on a dresser in the resident's room. The tubing and mask appeared clean. R78 stated he had no feeling or movement from his chest down and depended on staff for his care. R78 stated he had used the cough assist machine previously and knew how to use it but required staff assistance due to muscle weakness. R78 stated he didn't feel like staff knew how to use the machine and didn't know why there wasn't a regular schedule for using it. R78 stated he used the cough assist machine with staff assistance at least several times a day since admitting to the facility. During an interview on 12/1/25 at 1:39 p.m., licensed practical nurse (LPN)-A stated R78 used a coughing machine that she would help him use. LPN-A stated R78 was admitted with the machine, and the only education she received on how to use it was from the nurse who worked before her. LPN-A stated this education included assisting the resident with applying the cough assist mask and turning the machine on. The LPN stated that the assessment she would perform before the use of the cough assist machine was listening to R78's lung sounds and assessing if R78 was short of breath but would look at the treatment administration record (TAR) for further assessment instruction and couldn't find any orders related to the use of the cough assist machine. During an interview on 12/2/25 at 11:57 a.m. with registered nurse (RN)-A (second floor nurse manager and acting director of nursing) and LPN-B (the third floor nurse manager), LPN-B confirmed that he had reviewed R78's medical record and did not see an order from a provider for the use of the cough assist device or instructions for the use of the machine, such as machine settings or frequency of use. LPN-B stated he believed R78 had used the cough assist machine at baseline before hospital admission and would need to get an order from the provider for continued use. LPN-B and RN-A agreed that education should have been completed prior to nursing staff assisting with the use a cough assist machine to ensure staff were using the device correctly. During an interview on 12/4/25 at 11:01 a.m., respiratory therapist (RT)-A stated that cough assist machines assisted a resident to clear their airway when they could not do it adequately themselves. RT-A stated she would expect an order to be in place for the use of the cough assist machine and include how often the cough assist machine should be used, the settings for the machine, if the use of a nebulizer was needed before the use of the machine, and how many cycles of machine use should be completed with each treatment. RT-A stated she would have expected nursing staff to be educated on how to use the device, such as completing a nebulizer prior to use of the machine, taking a full set of vital signs prior and after use, assessing breath sounds prior and after use, and assessing to see if the use of a suction device is necessary to use alongside a cough assist device. RT-A stated she was available to provide education to staff next week and had videos on how to use the device that staff could watch in the<br>(continued on next page) |

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| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>Crystal, MN 55422 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | meantime. The facility's Usage and Training for Respiratory Equipment policy dated 12/8/25, indicated the registered managers were to oversee staff training, competency assessments, and device implementation. The facility was to ensure only trained and competent staff were to operate respiratory equipment. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 1 of 1 resident (R31) reviewed received appropriate behavior health management to address continued rejection of care and behaviors of urinating and defecating in inappropriate places.Findings include:R31's quarterly minimum data set (MDS), dated [DATE], indicated R31 was admitted to the care facility on 1/14/25 and was cognitively intact. The MDS further indicated R31 did not have any rejection of care within the lookback period but needed partial to moderate assistance with most activities of daily living (ADLs) and bathing did not occur.R31's diagnosis list, dated 1/15/25, indicated R31 had several medical diagnoses including schizophrenia and patient's noncompliance with other medical treatment and regiment due to unspecified reason.R31's Orders, dated 2/6/25, directed facility staff to write a progress note every shift regarding R31's behaviors including throwing her meal tray, dishes, trash, or linen on the floor, urinating on the floor and destroying property. R31's orders did not address monitoring for R31's repeated refusals of care.R31's hospital note, dated 4/10/25, indicated R31 had a diagnosis of schizophrenia with behaviors of urinary and fecal incontinence - voluntary urinary and fecal incontinence (stooling and urinating on the floor)R31's November and December Treatment Administration Record (TAR) indicated R31 had no behaviors, to include throwing her meal tray, dishes, trash, or linen on the floor, urinating on the floor and destroying property.R31's Weekly Bath Audits, from the past four months, dated 8/5, 8/12, 8/19, 9/9, 9/23, 9/30, 10/7, 10/21, 10/29, 11/4, and 11/25 all indicated R31 had refused a shower and body audit, with the exception of 10/29 in which none was selected for bathing type.R31's progress notes, dated 10/1/25 through 12/5/25 lacked any documentation of refusals of care or behaviors as listed above despite staff confirming R31 had daily refusals of care and related behaviors.R31's Associated Clinic of Psychology (ACP) note, dated 10/15/25, indicated it may be of consideration to create a behavioral plan for a behavior that the facility wants to try to reduce [i.e.] property destruction behavior and provide incentives to her when she does not engage in those behaviors. If a behavioral program is done, making sure that there is a visual aide to show how long she has to not engage in property destruction and how long she has been able to not engage in the target behavior. The note went on to list several strategies R31, and staff, could use to help with emotional regulation and relaxation techniques.R31's ACP notes lacked any mention of refusal of cares or inappropriate urination or defecation.R31's care plan, printed 12/5/25, indicated R31 was resistive to care, initiated 2/6/25, with various interventions that had not been updated since it was initiated. The care plan further indicated R31 had a behavioral care plan for throwing linen, meal trays/dishes, trash, liquids and urinating on the floor, however there had been no new interventions to the care plan to address these concerns since 2/18/25. The care plan further lacked any evidence of ACP recommendations listed above.During observation on 12/1/25 at 3:30 p.m., R31 was lying in bed in a hospital gown. Her room appeared unsanitary, with a sticky, dirty floor covered in dark buildup, trash scattered around, and old food trays left out. There was a notable foul odor.During an interview on 12/2/25 at 12:40 p.m., the facility ombudsman stated R31's room was disgusting, stating R31 peed on the floor and threw food all over the floor.During an interview on 12/4/25 at 10:45 a.m., nursing assistant (NA)-E stated staff would assist R31 with cleaning her room sometimes five times a day but minutes later it would be dirty again as R31 would just keep throwing things and peeing on the floor. During an interview on 12/4/25 at 11:35 a.m., licensed practical nurse (LPN)-D stated R31 would not let us [staff] do anything and would refuse her showers and her body audits. LPN-D stated R31 sees ACP (associated clinic of psychology) but would refuse that at times too. LPN-D stated R31 pees everywhere but the toilet and would not keep a brief on. During an interview on 12/5/25 at 8:03 a.m., trained medication aide (TMA)-C also stated R31 refused everything. TMA-C stated R31 took a shower about two months ago, but she believes that was the<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | last shower R31 received. TMA-C stated, I think she [R31] is just lazy. TMA-C stated R31 will throws things in her room and at staff and would pee everywhere, in her wheelchair, in her bed. TMA-C stated when R31 was out of her room she would have urine dripping out of her wheelchair as she moved throughout the facility. TMA-C stated they had not attempted to put a pad or barrier in her wheelchair to contain urine, stating she [R31] won't let us [staff] do anything. TMA-C stated R31 will also have a bowel movement in bed or her wheelchair and only let staff clean her when the smell gets bad enough. TMA-C stated she can at times use nicotine gum to bribe R31 into showering or cleaning her room although the intervention was not care planned. During an interview on 12/5/25 at 8:38 a.m., registered nurse and nurse manager (RN)-A stated R31's refusals of care and behaviors were all related to her schizophrenia diagnosis stating they had tried all they could to encourage her. RN-A stated staff were expected to write a progress note with any behaviors including urinating in inappropriate places, throwing trash or food on her floors and refusals of care, stating the interdisciplinary team would then review. RN-A confirmed there were no progress notes on R31's behaviors in the past 90 days despite confirming she was aware R31 refused cares, continued to urinate in inappropriate places and threw trash and food around her room. RN-A confirmed the last documented shower was 4/15/25, but she was aware staff had showered R31 about 2 months ago. RN-A stated R31's behaviors should have been discussed and documented during quarterly care conferences, confirming it was not documented what ideas were discussed during R31's last care conference. RN-A stated staff were encouraged to use care planned interventions with R31 such as maintaining a positive attitude, anticipating R31's needs, creating a warm atmosphere such as saying hi so when approached later R31 may be more welcoming, educating R31 to call for help, using a trash bucket instead of the floor and praise for doing things (i.e. clean her room) and negotiating appropriate time for cares despite these intervention not being updated in since 2/2025 and not being effective. RN-A stated R31 should have been comprehensively assessed, and her behaviors and refusal of cares should have been discussed at her last care conference dated 7/11/25, stating I guess it didn't work (since R31 was still having daily behaviors). RN-A also confirmed R31's TAR documentation was inaccurate, and she reports knowing R31 continues to have behaviors daily despite them not being documented, admitting it would be challenging to assess and address behaviors and interventions if they were not being properly documented. RN-A stated social services was responsible for reviewing APC notes and implementing any new recommendations.During an interview on 12/5/25 at 10:41 p.m., social service director (SSD) stated it was her responsibility to update the resident behavior care plans with any new ACP recommendations. The SSD stated she would investigate why R31 did not have updated behavior interventions despite recommendations from ACP and R31 having continued, uncontrolled behaviors. The facility Behavioral Assessment, Intervention, and Monitoring policy dated 3/2019, included behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to monitor for potential side effects for 1 of 3 residents (R3) reviewed who received an anticoagulant (blood thinner) medication. Findings include:R3's admission minimum data set (MDS) dated [DATE], indicated R3 had intact cognition and was receiving anticoagulant medication. R3's order summary dated 9/19/25, indicated R3 had an order for five milligrams (mg) of apixaban (an anticoagulant) two times a day. R3's diagnosis summary dated 10/15/25, indicated R3 had a history of blood clots and a stroke.R3's progress note dated 11/24/25 at 9:39 a.m., indicated R3 was on apixaban related to a history of blood clots.R3's medical record (including the care plan) was reviewed and did not include instructions for staff to monitor R3 for side effects of apixaban use. During an observation and interview on 12/1/25 at 1:52 p.m., R3 was observed sitting up in bed. R3 did not have any observable signs of bleeding or bruising. R3 confirmed that she had not had any bleeding or bruising recently. During an interview on 12/2/25 at 11:51 a.m., licensed practical nurse (LPN)-A stated she checked R3 for any signs of bleeding or bruising every time she worked with her and had not noticed anything. LPN-A stated she would expect monitoring to be ordered in the treatment administrator record (TAR), where she could document that monitoring had occurred. LPN-A stated she did not see that any monitor was in place, so she was unsure if other staff had been completing this monitoring. During an interview on 12/2/25 at 11:53 a.m., LPN-B ( the nurse manager for the floor) stated he had reviewed R3's medical record and did not see that any monitoring was in place or documentation that it had been completed related to R3's anticoagulant. LPN-B stated he would expect nursing staff to monitor for things such as bleeding, bruising, or blood in the stool. During an interview on 12/4/25 at 10:45 a.m., registered nurse (RN)-A (the second-floor nurse manager and acting director of nursing) stated she would expect nursing staff to monitor for things such as bleeding, bruising, or anything like that and that should be documented on the TAR and be noted on the care plan. The facility's Anticoagulation- Clinical Protocol policy dated 11/18, indicated the staff and physician will monitor for possible complications of anticoagulant use such as signs of excessive bruising or evidence of bleeding. |