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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation 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: 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. 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. 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. 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. 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. 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. 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]. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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. 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. 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. 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. Facility policy titled Meal Distribution: Infection Control Considerations, revised 9/2017 identified: 2. Durable dishware, utensils, and service ware will be provided unless indicated by the CDC guidelines. DIGNITY WITH CARES 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). 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: R12 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. R12's care plan dated 10/27/25 identified R12 required assist of two staff with bathing/showering weekly and as necessary. 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. 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. R37 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. 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. R52 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm 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. 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. R54 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. R30 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 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. 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. 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. 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. 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 needed to use the toilet which was why toileting was not offered and R30 was a little wet this morning. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 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. R31 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. 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. 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. 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. 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. 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. During observation on 12/4/25 at 11:40 a.m., R31 was again seen in her room, in a hospital gown. 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. 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. 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 ideas were discussed during R31's last care conference. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Activities of Daily Living (ADLs), Supporting, revised March 2018 stated: 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	**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 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

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	245289	A. Building 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 Crystal, MN 55422

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 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. Findings include: R1 R1's quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, identified R1 had intact cognition. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with DM on 12/8/25 at 12:33 p.m., DM stated she agreed that food served to 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. 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.