DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 31P4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00833

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245425**
2. STATE VENDOR OR MEDICAID NO. (L2) **144343700**
3. NAME AND ADDRESS OF FACILITY
(L3) **THORNE CREST RETIREMENT CENTER**
(L4) **1201 GARFIELD AVENUE**
(L5) **ALBERT LEA, MN** (L6) **56007**
4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **10/27/2021** (L34)
7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **08/31**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

12. Total Facility Beds **52** (L18)
13. Total Certified Beds **52** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 11/03/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/03/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **00131** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **10/28/2021** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2021

CMS Certification Number (CCN): 245425

Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 1, 2021 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2021

Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

RE: CCN: 245425
Cycle Start Date: August 20, 2021

Dear Administrator:

On September 14, 2021, we notified you a remedy was imposed. On October 27, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 1, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 14, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 29, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00833

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1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2021** (L34)

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2 AOA 3 Other

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01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
08/31

11. .LTC PERIOD OF CERTIFICATION
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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
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* Code: **B*** (L12)

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(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 10/16/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/28/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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(L24)

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(L41)

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(L27)

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A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

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(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 14, 2021

Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

RE: CCN: 245425
Cycle Start Date: August 20, 2021

Dear Administrator:

On August 20, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 29, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 29, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Thorne Crest Retirement Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 29, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 20, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245425	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 8/20/2021
NAME OF PROVIDER OR SUPPLIER **THORNE CREST RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1201 GARFIELD AVENUE ALBERT LEA, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 623

Notice Requirements Before Transfer/Discharge
CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245425	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 8/20/2021
NAME OF PROVIDER OR SUPPLIER **THORNE CREST RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1201 GARFIELD AVENUE ALBERT LEA, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written notification of reason for transfer to a hospital was provided to the resident or resident representative for 2 of 3 residents (R25 and R43) reviewed for transfer/discharge.

Findings include:

R25's Admission Record printed 8/20/21, indicated diagnoses including urinary tract infection and sepsis due to pseudomonas. The Admission Record further indicated a most recent hospital stay from 8/2/21 -8/11/21.

R25's progress note dated 8/2/21, at 1:45 a.m. indicated R25 was transported to the emergency department (ED) for a change in condition. R25's progress note dated 8/2/21, at 5:04 a.m. indicated the ED nurse contacted the facility informed of R25's diagnosis of sepsis and subsequent transfer to another acute care facility. R25's medical record lacked evidence a written notice for transfer was provided in writing to R25 and/or R25's representative

R43's Admission Record printed 8/20/21, indicated R43's diagnoses included myocardial infarction (heart attack), muscle weakness, urinary tract infection, and chronic obstructive pulmonary disease (respiratory disease).

R43's progress note dated 5/27/21, indicated R43 was admitted to the hospital for heart failure. The provider was notified of R43's change in cognition, increased edema [swelling] and weight, anxiety, and restlessness. R43's medical record lacked evidence a written notice for transfer was provided in writing to R43 and/or R43's representative.

On 8/19/21, at 1:45 p.m. an interview with social services (SS) confirmed a written notice was not provided to R25 and R43 or resident representative, and further verified it was not the facility's practice to provide a written notice of transfer to residents and/or resident representatives. SS stated going forward the facility would utilize the form when residents were transferred.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245425	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: **8/20/2021**
NAME OF PROVIDER OR SUPPLIER **THORNE CREST RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1201 GARFIELD AVENUE ALBERT LEA, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 On 8/19/21, at 1:48 p.m. the administrator indicated she could not find the discharge transfer was completed for R25 or R45 and expected the facility would complete and provide the discharge transfer form to the resident or resident's family. Policy titled Transfer policy undated, failed to indicate a transfer would be provided to the resident and/or resident representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING ______ B. WING ______	C 08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNE CREST RETIREMENT CENTER	**1201 GARFIELD AVENUE** **ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/16/21 - 8/20/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/16/21 - 8/20/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5425029C (MN00073686 and MN00073719) and H5425030C (MN00059662 and MN00059734). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2021

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.

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and obtain a physician order to self-administer a pain relieving gel medication (Arctic Ice) for 1 of 1 resident (R345) observed with medication kept at the bedside. Findings include: R345's Order Summary Report printed 8/20/21, indicated an admission date of 8/5/21, and included an order for Arctic Ice pain reliever - apply to joints three times daily as needed. On 8/16/21, at 3:36 p.m. a container of Arctic Ice pain relieving gel observed on R345's bedside table. When interviewed at that time the resident confirmed she utilized to ointment for muscle pain. The container of Arctic Ice was also observed on R345's bedside table on 8/18/21, at 9:32 a.m., and 8/20/21, at 10:11 a.m. When interviewed on 8/20/21, at 10:11 a.m. licensed practical nurse (LPN)-B confirmed she had obtained a telephone order from the physician for R345's Arctic Ice pain reliever and thought she had written the order to be kept at the resident's bedside. LPN-B reviewed the telephone order dated 8/5/21, and confirmed the order did not indicate the medication could be kept at the resident's bedside.	F 554	F 000 Correction Date Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal regulations of participation, this response and plan of correction constitutes the facility s allegation of compliance in accordance with the State Operations Manual. Thorne Crest has and always assure its residents have the right to self-administer medications as long as it has been determined by the interdisciplinary team (IDT) that it is clinically appropriate to do so. It is the policy of Thorne Crest to complete a self-administration assessment of medications with new admissions, upon request from any resident, and at least quarterly with the MDS cycle.	10/1/21

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F 554	Continued From page 2 On 8/20/21, at 11:35 a.m. the director of nursing (DON) confirmed if medication was kept at the resident bedside an assessment would need to be completed and a physician order obtained. Facility policy titled Self-Administration of Drugs, revised August 2006, indicated as part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications.	F 554	Thorne Crest will complete the self-administration of medications assessment on R345 to assure clinically appropriate to self-administer medications. Completed on 9/21/2021. 100% of the residents will be assessed and if deemed appropriate and willing will self-administer their medications. Thorne Crest will implement the self-administration of medications assessment for all new admissions moving forward, upon request from any resident, and at least quarterly with MDS cycle to assure residents rights are being met. Director of Clinical Services provided training and education of self-administration medication policy and procedure to MDS Coordinator on September 17th, 2021. To ensure this, an audit has been initiated on 9/24/2021 by MDS Coordinator/designee daily (M-F) x 2 weeks, on all new admissions and MDS cycle, then weekly basis x 4 weeks, and monthly for one month with results being reported to the QAPI committee.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 582		10/1/21

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F 582	Continued From page 3 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F 582		

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F 582	Continued From page 4 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-10055) to 2 of 2 residents (R7 and R32) reviewed whose Medicare A coverage ended and the residents remained in the facility. The facility further failed to ensure the required Notice of Medicare Non-Coverage (NOMNC, form CMS-10123) was provided upon termination of Medicare A benefits for 1 of 3 residents (R32) reviewed for liability notices. Findings include: The admission record printed on 8/20/21, indicated R7 was admitted on 2/9/21, with diagnoses including cerebral infarction (stroke), dementia and repeated falls. The brief interview for mental status dated 5/6/21, indicated R7 had severe cognitive impairment. R7's progress note dated 2/25/21, indicated on 2/24/21 at 12:00 noon, R7's family representative was called and informed the resident no longer met the criteria for continued coverage with financial liability beginning 2/26/21. R7's family representative received and signed the Notice of Medicare-Non-Coverage (CMS-10123) form, though did not receive the Skilled Nursing Facility	F 582	Thorne Crest has and always will ensure that it informs each resident before, or at the time of admission, and periodically during the resident s stay of services available in the facility and charges for those services, including those not covered by Medicare/Medicaid or by the facility s per diem rate using appropriate forms as required by state and federal law. R7 a Medicare Part C Insurance (Medicare Advantage Plan) has not assume financial responsibility and did not receive a SNF ABN due to Medicare requires SNFs to issue the SNF-ABN to Traditional Medicare Part A. R7 has a Medicare Part C (Medicare Advantage Plan). R32 a Traditional Medicare Part A beneficiary did not assume financial responsibility due to not receiving the SNF-ABN and or NOMNC, CMS-10123 forms. As of 9/17/2021 all residents before, or at the time of admission, and periodically during their stay will be given all required	

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F 582	Continued From page 5 Advanced Beneficiary Notice (SNF ABN, form CMS-10055) as required. R7's Census List printed on 8/20/21, identified on 2/26/21, R7's payer source changed from Medicare Part A to Medicaid and remained in the facility. The admission record printed on 8/20/21, indicated R32 was admitted on 4/8/21, with diagnoses including dementia with behavioral disturbance and muscle weakness. The brief interview for mental status dated 7/1/21, indicated R32 had severe cognitive impairment. R32's Census List printed on 8/20/21, identified on 4/28/21, R32's payer source changed from Medicare Part A to private pay and remained in the facility. R32's medical record did not include evidence R32 or their representative had received the required SNF ABN, form CMS-10055 or NOMNC, CMS-10123 forms. On 8/18/21, at 3:05 p.m. the administrator confirmed being unable to locate the required CMS-10055 form for R7 and R32. Administer further confirmed being unable to locate the required CMS-10123 form for R32. Administrator indicated being new to the position and further indicated the staff that had been responsible for providing these forms no longer worked at the facility. A facility policy related to beneficiary notices was requested but not provided by the end of the survey.	F 582	forms to assure they are informed of their benefit changes which includes charges for those services not covered by Medicare/Medicaid or by the facility s per diem rate. During the Medicare meeting, or as needed, the MDS Coordinator, or designee, will review if any residents are changing coverage, in benefits, the appropriate form is used and will ensure communication is being given to the resident or responsible party. Director of Clinical Services provided training and education on Due issuance of Medicare/Medicaid required forms to MDS Coordinator on 9/21/21. Audits are being conducted bi-weekly during Medicare Meeting to determine discharge dates and appropriate denial paperwork. Once paperwork has all required signatures, forms are uploaded into PCC. See Attachment F582-NOMNC Audits were conducted by HIM of other residents that may have been impacted. To ensure this, The MDS Coordinator/designee will initiate on 9/24/2021, daily (M-F) x 2 weeks, on any changes of services, or benefits, then weekly basis x 4 weeks, and for one month with results being reported to the QAPI committee.	
F 641 SS=D	Accuracy of Assessments	F 641		10/1/21

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F 641	Continued From page 6 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the current status and needs for 1 of 2 residents (R4) reviewed for hearing. Findings include: R4's quarterly Minimum Data Set (MDS) dated 8/5/21, indicated the resident had severe cognitive impairment and had minimal difficulty hearing. The MDS further indicated diagnoses including Alzheimer's disease. R4's care plan printed 8/20/21, indicated a potential for alteration in perception related to Alzheimer's disease. The care plan further indicated R4 had minimal difficulty hearing, was deaf in the right ear, and had no hearing aid. On 8/16/21, at 7:21 p.m. staff were observed attempting to speak with R4. Staff asked the resident if she needed help. R4 indicated not being able to hear what the staff were saying; staff member then was observed to walk away from the resident. On 8/19/21, at 9:10 a.m. R4 was observed in room lying in bed. Upon approaching resident, she indicated needing to use the bathroom. Surveyor informed R4 they would put resident's	F 641	Thorne Crest has and always will ensure that assessments accurately reflect each resident s status. R4 s hearing status was assessed with the care plan being updated on 9/20/2021. All like residents hearing status were re-assessed on 9/20/2021 with care plans updated on 9/20/2021. MDS s were corrected, submitted and accepted on 9/20/2021. Upon admission, as needed, and MDS cycle residents will be assessed for hearing impairment to ensure the highest quality of care is provided by the facility. Director of clinical services trained and educated the MDS Coordinator on these steps to ensure compliance on 9/17/2021. An audit has been initiated on 9/24/2021 by the MDS Coordinator/ designee for all new admissions will be completed daily (M-F) for 2 weeks, weekly for 4 weeks and then monthly thereafter for one month with results being reported to QAPI.	

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F 641	Continued From page 7 call light on and look for staff to assist her. R4 turned her head so left ear was exposed as she couldn't hear what the surveyor said. Surveyor again told R4 of the plan; R4 appeared confused and shook her head as could not hear the surveyor. On 8/19/21, at 9:53 a.m. surveyor attempted to interview R4 in her room. Surveyor spoke into R4's left ear but the resident couldn't understand. R4 eventually stated, "I just can't hear." When interviewed on 8/19/21, at 9:59 a.m. licensed practical nurse (LPN)-B and nursing assistant (NA)-C confirmed R4 was extremely hard of hearing. NA-C further indicated staff utilized a white board to write on and communicate with the resident. NA-C further indicated R4 utilized amplifying headphones when family visited. When interviewed on 8/20/21, at 11:35 a.m. the director of nursing confirmed R4 was extremely hard of hearing and further confirmed the resident's MDS and care plan were inaccurate related to hearing status.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of daily living (ADLs) were provided, including nail	F 677	Thorne Crest has and always will ensure that any resident unable to carry out activities of daily living (ADL s) will	10/1/21

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F 677 Continued From page 8

care, for 1 of 4 residents (R25) reviewed who were dependant on staff for activities of daily living.

Findings include:

R25's significant change Minimum Data Set (MDS) assessment dated 6/30/21, indicated the resident had severe cognitive impairment and required extensive assistance from staff for personal hygiene.

R25's care plan printed 8/20/21, directed staff to trim fingernails and toenails with weekly bath and as needed.

On 8/16/21, at 6:03 p.m. R25 was observed in the dayroom/activity area with long fingernails with black debris under several of the nails. R25's fingernail remained long and soiled through all days (8/16/21-8/20/21) of the survey.

When interviewed on 8/19/21, at 1:45 p.m. nursing assistant (NA)-C confirmed nail care was completed on resident's bath day. NA-C further verified completing morning cares for R25 earlier that day. NA-C observed R25's fingernails with surveyor and confirmed they were long with debris under the nails. NA-C stated the facility had been so short staffed lately that NA's struggled to get everything done for the residents. NA-C further stated though trimming and cleaning fingernails was important , they needed to prioritize overall cares like toileting and repositioning in order to get cares completed.

When interviewed on 8/20/21, at 11:35 a.m. the director of nursing (DON) confirmed if a resident's fingernails were long and/or soiled, staff should

F 677

receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

R25 s nails are clean and free of debris.

All resident nails for proper hygiene were reviewed to ensure they were clean and free of debris. Findings were reviewed and addressed on 9/17/2021.Needs audits will continue to occur to ensure residents cares are being completed per care plan. Any issues noted are addressed immediately.

The Activities of Daily Living (ADLs), Supporting policy and procedure was reviewed with all nursing staff by 9/22/2021 to ensure that residents are supported with ADL s at that time, including bath day to assure nails are clean and free of debris.

Care Plans and care sheets were reviewed and determined to be accurate.

An audit conducted by the SSD or designee has been initiated on 9/21/2021 to ensure all residents nails are in clean and the length resident desires daily (M-F) for 2 weeks, then weekly for 4 weeks, and monthly for one month with results being reported to QAPI.

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F 677	Continued From page 9 not wait until bath day to complete nail care. Policy titled Activities of Daily Living (ADLs), Supporting, dated March 2018, indicated: 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.	F 677		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to ensure the dialysis access site was consistently monitored and assessed for 1 of 1 resident (R12) reviewed for dialysis. Findings include: R12's quarterly Minimum Data Set (MDS) assessment dated 6/3/21, indicated no cognitive impairment, required one person physical assistance with dressing, bathing, and received dialysis. R12's Transfer/Discharge Report printed 8/18/21, indicated R12 was admitted to the facility on 12/7/20, and diagnosis included kidney disease, history of falling, type 2 diabetes, weakness, and moderate protein-calorie malnutrition.	F 698	Thorne Crest has and always will ensure that residents who require dialysis will have their access site monitored and assessed. R12 dialysis site was assessed by the DON. No signs or symptoms of infection noted. DON updated the treatment administration record and physician order obtained on 8/25/2021. There are no other like residents receiving dialysis. The policy and procedure for dialysis care was reviewed with no changes noted on 9/21/2021.	10/1/21

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F 698	Continued From page 10 R12's care plan printed on 8/17/21, indicated R12 needed hemodialysis related to renal failure, check dressing daily at access site, notify dialysis if dressing was not clean, dry and, intact. Monitor/document/report signs and symptoms of infection to access site: redness, swelling, warmth or drainage. Bruit checked daily for thrill (bruit and thrill indicate a dialysis site is working. Thrill is a vibration that is felt. Bruit is a swishing sound heard with a stethoscope), if not felt, call dialysis unit, monitor skin with all cares provided, always report any changes in skin to charge nurse for assessment. Watch for red areas, open areas, bruising, swelling, rashes or any other skin concerns noticed. R12's order summary report printed 8/18/21, indicated an order dated 12/7/20, check dialysis site q [every] shift and monitor for signs and symptoms of infection or other complications. On 8/16/21, at 4:51 p.m. and interview with R12 stated she received dialysis on Monday, Wednesday, Fridays at an outside dialysis center. R12 stated the dialysis center provided the dressing changes and the facility staff did not monitor or assess her dialysis site or dressing. R12's treatment administration record (TAR) dated 8/1/21-8/31/21, indicated staff initials on the TAR identifying R12's dialysis site was checked q [every] shift and monitored for signs and symptoms of infection or other complications. However, through the interview on 8/17/21, at 2:51 p.m. with licensed practical nurse (LPN)-A verified R12 received dialysis, but did not have dialysis catheters, tubing, or current dressings checked. LPN-A further indicated she checked	F 698	Training and education was completed with all licensed nurses by DON or designee on 9/22//2021. Training was provided to all Licensed Nurses that included assessing the active dialysis site every shift. This includes location and type of access. To assure the correct site is being assessed the order has been changed to the following: Check hemodialysis catheter every shift and monitor for signs and symptoms of infection or other complications. If a dialysis access is changed, nurses are to obtain an order to reflect the assessment of the new access site. See Attachment F698 EMAR was adjusted to verify proper location and procedure. An audit conducted by the DON/designee has been initiated on 9/24/2021 to ensure all residents with a dialysis port/fistula access have the proper site/type/and assessment daily (M-F) for 2 weeks, then weekly for 4 weeks, and monthly for one month with results being reported to QAPI.	

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F 698	Continued From page 11 R12 arms every shift, but did not check her skin towards her neck or under her collar bone and stated R12 was not required to have skin checks. On 8/17/21, at 3:00 p.m. LPN-A was re-interviewed and when shown the TAR documentation, LPN-A verified she had completed R12's documentation to check the dialysis site on 8/5/21, 8/6/21,8/7/21, 8/11/21. LPN-A further verified she had not checked the right subclavian (upper neck area) dialysis site that was currently used for dialysis. LPN-A stated the TAR documentation referred to R12's skin on her arms assessed, and LPN-A confirmed she was not aware of a dressing on the subclavian tunneled dialysis site. On 8/18/21, at 07:09 a.m. an interview with LPN-B indicated she was not aware of R12's right subclavian dialysis site and dressing. LPN-B stated R12 dialysis was done in her lower arms and the skin was checked for signs of swelling or redness, and was not aware R12's arms were not the current dialysis site. On 8/18/21, at 9:00 a.m. R12 stated she had a dialysis catheter on her upper right chest area, and R12 pulled down her top and revealed a right tunneled catheter placed near the right subclavian (upper neck area) covered with a transparent dressing. R12 indicated the dialysis clinic monitored her dialysis site and she further indicated the facility staff still had not monitored her access site. On 8/18/21, at 11:41 a.m. an interview with the director of nursing (DON) stated she she expected nursing staff to be aware of R12's dialysis access site location and monitor the site	F 698		

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F 698	Continued From page 12 for signs and symptoms of infection. On 8/18/21, at 12:40 p.m. interview with registered nurse (RN)-B stated she was an RN at the dialysis facility R12 received dialysis at on Monday, Wednesdays, Friday. RN-B indicated R12's dialysis access site was a right tunneled subclavian catheter placed 8/13/19, and indicated the dialysis nursing staff change R12's dressing. RN-B further indicated the facility staff were expected to assess the dialysis site daily for signs and symptoms of infection and ensure the dressing was intact and notify dialysis of concerns. R12's Hemodialysis Catheter Permanent (tunneled, implanted) Right Internal Jugular document from local hospital, printed 8/18/21, indicated right internal jugular permanent catheter was exchanged on 8/13/19. Document (from local clinic/hospital) identified dialysis services, patients who are resident in long term care facilities/nursing homes dated 12/2/2020, indicated special attention should be paid to the vascular access so that it does not clot. Patients can experience infections of these fistulas, grafts, or intravenous catheters. If there is any unusual redness, swelling, temperature greater than 100.5 F or other problems, contact the patients dialysis unit immediately.	F 698		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		10/1/21

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F 725	Continued From page 13 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficient staffing to ensure residents received care and assistance as needed. These deficient practices had the potential to affect all 40 residents who resided in the facility. Findings include:: Refer to F677. The facility failed to ensure activities of daily living (ADLs) were provided, including nail care, for 1 of 4 residents (R25) reviewed who were dependant on staff for activities of daily living.	F 725	Thorne Crest has and always will ensure that there are sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services to assure resident safety and highest practicable physical, mental, and psychosocial well-being of each resident. Facility Assessment was updated on 9/21/2021 to accurately reflect resident population care and service needs. Nursing Staff policy was reviewed on 9/20/2021 with no changes noted.	

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F 725	Continued From page 14	F 725		

F 725 — Summary Statement of Deficiencies:

Refer to F698: The facility failed to ensure the dialysis access site was consistently monitored and assessed for 1 of 1 resident (R12) reviewed for dialysis.

A resident group interview was completed on 8/17/21, at 10:08 a.m. with residents R10, R12, R30, R31, R37 and stated concerns the facility was short staffed. The residents indicated on a consistent basis they wait wait 40 minutes and up to one hour for staff assistance. The residents further indicated staff hurry and rush with cares related with dressing, bathing, and toileting. The residents stated more falls have occurred in the facility due to the shortage of staff and staff were not available to assist with resident needs.

On 8/16/21, at 4:00 p.m. an interview with licensed practical nurse (LPN)- C indicated the staffing schedule was consistently not filled and she could pick up a shift anytime she wanted. LPN-C stated today her shift ended at 2:30 p.m. and the evening shift was short staffed, and she would work until 4:00 p.m. LPN-C stated she worked 14 and 1/2 hours the last weekend on Saturday and Sunday, due to the facility short staffed a nurse. LPN-C indicated on a routine basis she stayed late to complete resident treatments. LPN-C stated the restorative aide position was eliminated, and now the residents range of motion was not completed on a consistent basis. LPN-C stated resident's may not get a bath when there was a shortage of staff on that shift. LPN-C indicated an increase with falls was related to the staff storage and inability to monitor and assist residents, and further stated residents received medications late and treatments delayed due to the short staffing.

F 725 — Provider's Plan of Correction:

Daily work assignments policy has been removed from use effective 9/17/2021.

Facility has contracted with AMH Staffing Agency, LLC on 9/8/2021 for temporary staffing coverage. They are providing facility with CNA coverage as of 9/10/2021.

The measure that has been taken to ensure that the problem does not reoccur is we will continue to staff nursing department with agency until permanent staff can be hired and properly trained. Admissions are determined according to current staffing levels.

Needs audits will continue to occur to ensure resident cares are being completed per care plan. These audits include call lights answered in a timely manner. Any issues noted are addressed immediately.

Sampling of resident population will be interviewed by Director of Social Services or designee on or before 9/24/2021 to ensure their care needs are met.

Residents needs audit will be conducted by the Director of Social Service/ designee initiated on 9/24/2021 daily (M-F) for 2 weeks, then weekly for 4 weeks, and monthly thereafter with results being reported to QAPI.

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F 725	Continued From page 15 On 8/18/21, at 7:18 a.m. an interview with LPN-B indicated the facility was short staffed today, stated she was the only nurse today and there should be two nurses. LPN-B stated there were no other staff not working that were available to call to assist with nursing. LPN-B stated she was the only nurse available to complete treatments today. LPN-B indicated she was the only nurse yesterday and was not able to complete all the charting. LPN-B stated out of a two week pay period she stayed late half the time to cover shifts, complete orders, and chart. LPN-B stated residents falls have increased due to not enough staff to answer call lights and then the resident self transfers. LPN-B stated residents baths were missed on occasion due to shortage of staff to complete the ADL's On 8/18/21, at 8:25 a.m. an interview with the social services stated and confirmed the facility is short staff, and residents bring up concerns about the staffing shortage. On 8/19/21, at 8:32 a.m. an interview with nursing assistant (NA)-A stated she worked a double shift once a week because of the lack of nursing staff. NA-A indicated the residents don't receive the restorative range of motion, increased resident falls, call lights were not answered timely, and residents not toileted per the schedule due to the facility shortage of staff. NA-A stated she felt bad for the residents because of the facility's shortage of staff and resident's activities of daily living care were not consistently completed. On 8/19/21, at 8:49 AM an interview with NA-B stated due to staff shortage she had to stay 2 out of the 7 days she worked, and consistently stayed	F 725		

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late every other weekend. NA-B indicated residents baths were not completed, residents were left on the bed pan for extended times, increase in falls, and rushed care due to the shortage of nursing staff.

On 8/19/21, at 9:01 a.m. an interview with NA-C stated she stayed late once a week due to the shortage of staff. NA-C stated the shortage of staff has caused residents bath missed, increased falls, delay in call lights answered, residents declining because there were not staff available to walk them, residents were not toileted per the schedule. NA-C further indicated staff struggle to get everything done for the residents.

On 8/19/21, at 9:16 a.m. an interview with the administrator stated the facility was short staffed 25 % of the time and confirmed increased facility fall rates and stated staff bring her concerns related to staffing. The administrator stated she was notified of residents baths not completed and was aware the residents were not being walked all the time and further stated, they should be. The administrator indicated more staff were hired and needed to be trained. The administrator indicated the current openings included 1 full-time day NA, 2 full time evening NA's, 1 full time night NA, and stated the facility sporadically used agency NA's. The administrator stated the current process for identifying staffing levels was based on census, though she felt they attempted to take resident acuity into account. She indicated the facility had been trying to recruit staff and have had difficulty in retaining staff and hiring staff. The administrator stated the facility was currently accepting admissions. The administrator stated

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she was not aware resident needs were not consistently met. She further indicated the facility continued to work on achieving and maintaining staffing levels

On 8/19/21, at 10:08 a.m. an interview with the director of nursing (DON) stated on a routine basis staff bring her concerns in regards to the low staff numbers of staff. The DON confirmed there were gaps in the nursing schedule and stated the facility does not have a registered nurse scheduled to work the floor. The DON indicated staffing expectations included day shift 4 NA's, 1 bath aide, 2 LPN's, and 1 RN; evenings 4 NA's, 1 bath aide, 2 LPN's; and overnights 2 NA and 1 LPN. The DON stated she was an RN, but was not put on the schedule as an RN. The DON verified staffing was a problem and was aware of residents baths not completed, increased falls, and further stated the increase of falls and resident's bath not completed were because the facility was short staffed.

The following were examples of the facility's nurse staffing for an average census of 40 residents. These included but were not limited to the following:

On 8/18/21,8/17/21, one LPN for day shift for the facility.

On 8/15/21,8/14/21, 7/31/21, 8/1/21, 8/7/21, 8/8/21 three NA's for the day shift.

On 7/20/21, 7/21/21, 7/22/21, 7/23/21, 7/24/21, 7/26/21, 7/27/21, 8/3/21, 8/2/21, 8/6/21, 8/7/21, 8/8/21 and 8/13/21 three NA's for the evening shift.

F 725 Continued From page 18 F 725

On 8/19/21, at 10:37 a.m. an interview with social worker verified grievance concerns with staffing, call lights, and kitchen. Review of the documents titled Grievance/Complaint Form dated 5/25/21, 5/10/21, 5/24/21, 6/2/21, 7/27/21, 8/10/2, 8/9/21, indicated residents and family members filed grievances related to baths not received, call lights not answered timely, and staffing shortage.

Review of the Facility Assessment Tool dated 9/22/20, provided by the facility revealed the following: one resident who was dependent on staff for dressing, 36 residents who were assist of one or two for dressing; one resident dependent to staff for transfers, 36 residents who were assist of one or two staff for transfers; one resident who was dependent on staff for bathing; 37 residents who were assist of one or two for bathing; 4 residents who were dependent on staff for toilet use, 33 residents who were assist of one or two staff for toilet use; one resident dependent on staff for eating; 26 residents who were assist of one or two for eating.

Review of the alarm history report provided by the facility revealed numerous occasions of longer than 15 minutes wait times. The following were examples of the long wait times. These included but were not limited to the following:

On 8/11/21-8/16/21, indicated room 9 longest wait times were 1 hour 2 minutes, 43 minutes, 38 minutes, and 37 minutes.

On 8/11/21-8/16/21 indicated room one longest wait times were 32 minutes, 1 hour 13 minutes, and 32 minutes.

On 8/12/21, at 4:30 a.m. room three wait time of

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F 725	Continued From page 19 1 hour and 10 minutes. On 8/10/21, at 7:11 a.m. room 22 wait time of 1 hour and 4 minutes. On 6/11/21-8/7/21, room 11 longest wait times were 38 minutes, 49 minutes, 47 minutes, 49 minutes, and 20 minutes. On 5/6/21-5/28/21 room 12 longest wait times were 59 minutes, 32 minutes, 37 minutes, 28 minutes, 21 minutes, 23 minutes, 40 minutes, 55 minutes, and 33 minutes. On 6/11/21-6/20/21 room 27 longest wait times were 47 minutes and 32 minutes, Document titled Throne Crest Fall Prevalence Rate printed 8/19/21, indicated August 2021, 23 falls; July 2021, 40 falls; June 2021, 25 falls; May 2021, 30 falls; April 2021, 30 falls; March 2021, 32 falls; Feb 2021, 20 falls; January 2021, 7 falls; December 2020, 14 falls. Resident Matrix printed 8/16/21, indicated 2 residents fall with major injury and 12 residents with falls. In addition, there were were three residents with excessive weight loss without prescribed weight loss program. Policy titled Nurse Staffing dated October 2017, indicated -Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. Staffing requirements :a nursing home must have on duty at all times of sufficient number of	F 725		

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F 725	Continued From page 20 qualified nursing personnel including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of all the residents at the nurses station . Policy titled daily work assignments dated August 2006, indicated -All nursing service personnel shall follow daily work assignments and perform assigned duties in accordance with professional standards of practice and facility policy. Work assignments are prepared from their residence care plan by the nurse supervisor charge nurse Certified nursing assistants (CNAs)and trainees are expected to carry out their assignments in a professional manner and in accordance with the established nursing procedures	F 725		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than five percent (%). The facility had a medication error rate of 7.14% with 2 errors out of 28 opportunities for error involving 2 of 4 residents (R9 and R41) who were observed during the medication pass. Findings include: R9's Diagnosis Report printed 8/18/21, included a	F 759	Thorne Crest has and always will ensure that its medication error rates are not 5% or greater R9 medications were reviewed and any medication that did not have a date of when open have been replaced. R9 has not suffered any ill effects. R41 medications were reviewed and any medication that were expired were	10/1/21

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F 759 Continued From page 21

diagnosis of type 2 diabetes mellitus without complications.

R9's Order Summary Report (physician's orders), included an order for Novolog (insulin) solution 100 unit/ml (units per millimeter). Inject 10 units subcutaneously two times a day related to type 2 diabetes mellitus without complications.

On 8/16/21, at 4:59 p.m. licensed practical nurse (LPN)-A was observed drawing up R9's Novolog insulin, 10 units, to be administered prior to the supper meal. Upon observing R9's Novolog vial, and box the vial came in, there was no date indicated when the vial had been opened; the date received on the label was 7/10/21. LPN-A confirmed there was no date when opened on the Novolog vial but chose to administer insulin to R9 anyway. After administration, surveyor asked LPN-A what the expectation was if an insulin vial was not dated when opened. LPN-A confirmed she would need to discard the insulin and obtain a new vial.

When interviewed on 8/20/21, at 11:35 a.m. the director of nursing confirmed once an insulin vial had been opened staff should follow the manufacturer's instructions on when to discard. DON confirmed when LPN-A had been prompted that R9's insulin was not dated when opened, she should have discarded the medication immediately, and not administer the undated insulin.

The policy titled Insulin Administration, revised September 2014, indicated to check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer

F 759

replaced. R41 has not suffered any ill effects.

All medications in medication carts will be reviewed by MDS Coordinator or designee by 9/21/2021 for being opened without dates and or expired have been discarded and replace.

Nurses and Trained Medication Aides received education on safe medication pass that includes inspecting the medications prior to administering to ensure they are not expired and proper dates of when opened by 9/22/2021.

An audit of medication carts will be conducted by MDS Coordinator or designee on 9/24/2021 daily (M-F) for 2 week, then weekly for 4 weeks, and then monthly thereafter for 3 months with results being reported to QAPI.

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F 759	Continued From page 22 recommendations for expiration after opening). R41's Order Summary Report printed 8/20/21, included and order for levocetirizine dihydrochloride (an antihistamine) 5 mg one time daily for seasonal allergies. On 8/18/21, at 7:28 a.m. trained medication aide (TMA)-A was observed setting up R41's morning medications which included levocetirizine dihydrochloride 5 mg. After dishing up the medication it was noted by the surveyor that the levocetirizine dihydrochloride had expired on 7/9/21. TMA-A confirmed the medication had expired and removed it from the medication cup, then notified the charge nurse. Policy titled Administering Medications, revised April 2007, indicated to check the expiration date on the medication label. When opening a multi-dose container, place the date on the container.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		10/1/21

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F 761	Continued From page 23 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure accurate reconciliation of a schedule II narcotic medication (morphine sulfate) to reduce the risk for theft and diversion for 1 of 3 residents (R28) reviewed with a PRN (as needed) narcotic order; failed to obtain the correct dosage of an anti-anxiety medication (lorazepam) when the order changed for 1 of 1 resident (R32) reviewed who utilized an anti-anxiety medication stored in the Starlight hall medication cart. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 7/8/21, indicated the resident had moderate cognitive impairment, was dependent on staff for transfers, and required extensive assistance with all other activities of daily living (ADLs). The MDS further indicated R28 was receiving hospice services. R28's Order Summary Report (physician orders) printed 8/20/21, included an order dated 4/12/21, for morphine sulfate (concentrate) solution 20	F 761	Thorne Crest has and always will ensure that all drugs and biologicals be labeled in accordance with currently accepted professional principles, include accessory and cautionary instructions, and expiration date when applicable. R32 s lorazepam medication has been re-dispensed by the pharmacy to reflect the current order on the label. The orders have been reconciled on 8/20/2021. R32 has had no ill effects from this. R28 Morphine Sulfate proof of use has been reconciled on 8/20/2021. R28 has had no ill effects from this. All schedule II or higher medications in use were compared against the physician order, label and proof of use on 9/21/2021. If noted incorrect new blister packs and or liquids were reconciled by 2 RN s and if needed destroyed and reissued by pharmacy.	

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F 761	Continued From page 24 mg/ml (milligrams per milliliter), give 0.25 ml by mouth every 2 hours as needed for moderate to severe pain or SOB (shortness of breath). On 8/19/21, at 3:44 p.m. the medication cart for the Starlight hall was observed with trained medication aide (TMA)-B. Review of R28's Individual Narcotic Record sheet for morphine sulfate, indicated the resident initially received 30 ml of the medication from the pharmacy on 4/9/21. The amount remaining indicated 28.75 ml. The record did not indicate when the five missing doses had been administered or by whom. TMA-B reviewed the bound narcotic book and confirmed the record did not contain when or if the missing doses had been administered to R28. When interviewed on 8/20/21, at 11:35 a.m. the director of nursing (DON) reviewed the current and retired bound narcotic books and confirmed she was unable to locate evidence of R28 receiving the missing morphine sulfate doses. Upon further review of R28's past electronic medical records (eMAR), DON was able to confirm R28 had received morphine sulfate 0.25 mg on 4/25/21, 5/3/21, 5/16/21, 5/27/21, and 6/2/21. DON confirmed the doses should have been documented in the bound narcotic record book. A policy on storage of narcotic medication was requested but not received by the end of the survey. R32's Admission Record (face sheet) indicated an admission date of 4/8/21. R32's Order Summary Report (physician orders)	F 761	The Medication Ordering and Receiving From Pharmacy: Medication Labels, Medication Storage in the Facility: Storage of Medications Medication Storage in the Facility: Controlled Substance Storage and Disposal of Medications and Medication-Related Supplies: Controlled Substance Disposal P&P were reviewed with no changes on 8/21/2021. Training and education on the above P&P s with all licensed nurses and trained medication aides was completed by the DON on 9/22/2021. An audit completed by the DON and or Designee for reviewing the proof of use sheet against the physician order, physical bottle of liquid schedule II or higher and blister packaging has been initiated on 9/24/2021 and will continue daily (M-F) for 4 weeks, weekly for 4 weeks, and then monthly x1 month thereafter for three months thereafter with results reported to the QAPI.	

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F 761	Continued From page 25	F 761		

signed 4/14/21 indicated to reduce lorazepam to 0.5 mg by mouth at bedtime (previous order was lorazepam 1.0 mg by mouth at bedtime as needed).

R32's fax Request for CIII-V Continuance of Therapy Prescription, received from pharmacy provider on 4/14/21, indicated a request for refill for R28's lorazepam 0.5 mg -take one tablet by mouth at bedtime. The form indicated the request was faxed back to the pharmacy on 4/16/21, with a signed written prescription from the medical provider dated 4/16/21, for 30 tablets with three refills.

R32's current Order Summary Report printed 8/20/21, indicated the order for lorazepam 0.5 mg by mouth at bedtime had remained unchanged and still active since 4/14/21.

On 8/19/21, at 3:44 p.m. the medication cart for the Starlight hall was observed with TMA-B. When reviewing the medications in the locked narcotic box section of the cart, it was noted there were two blister pack cards of lorazepam 1.0 mg for R32. The card with a received date of 1/12/21, had 18 tabs remaining; two of the 18 tabs had been broken in half where scored, with tape on the back of the card holding the broken pills in place. There was hand writing next to the label on the card indicating to give 1/2 tab only. The other card with a received date of 2/11/21, had one half tab remaining. The tab had been broken in half and there was tape on the back of the card holding the pill in place. The card had a post-it note attached to it with a hand written note with the current order to give lorazepam 0.5 mg by mouth at bedtime.

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F 761	Continued From page 26 When interviewed on 8/20/21, at 12:50 p.m. DON confirmed when R32's lorazepam order was changed, nursing should have worked with the pharmacy to return the medication and receive the correct dosage and new order label. DON further confirmed staff should not be writing out the new order, halving the medication and taping the medication back into the blister pack card of the previously ordered medication. The DON stated her understanding was that whenever a medication order changed, the pharmacy provider was faxed and notified of the change. The DON reviewed R32's record and confirmed the lorazepam order had changed on 4/14/21. Policy titled Controlled Substance Disposal, revised August 2014, indicated: B. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of [two licensed nurses], and the disposal is documented on the accountability record/book on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason. C. All controlled substances remaining in the facility after a resident has been discharged, or the order is discontinued, are disposed of: 1) In the facility by the [administrator], director of nursing and/or consultant pharmacist (or others as allowed by state law); OR 2) By returning to the Drug Enforcement Administration (DEA); OR 3) By retaining for destruction by an agent of the DEA; OR 4) By sending to the appropriated state agency, as directed by state laws, regulations, and/or the DEA.	F 761		

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F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents were consistently offered and provided a substantial evening snack for 5 of 5 residents (R10, R12, R30, R31, R37) who voiced a concern and had the potential to affect all 40 residents residing in the facility. Findings include: A resident group interview was completed on 8/17/21, at 10:08 a.m. with residents R10, R12, R30, R31, R37 and stated evening snacks were not offered every evening.	F 809	Thorne Crest has and always will ensure that each resident receives at least three meals/day at regular times comparable to mealtimes in the community or accordance with resident needs, preferences, requests and plan of care. Snacks are available at all times to residents consistent with residents choices and their plan of care. Meal Times and Frequency Policy was reviewed and updated to reflect meal times and snack times on 9/17/2021 reviewed.	10/1/21

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F 809	Continued From page 28 On 8/17/21, at 10:10 a.m. R21 stated a snack was not offered every evening before bedtime and stated snacks were previously available in the dining room and were no longer available. On 8/18/21, at 8:00 a.m. an interview with cook-C stated she was not aware of any evening snacks offered to the residents, and further stated snacks previously were available in the dining room for the residents, but the snacks were removed because of residents "hoarding" the snacks. Cook-C stated the residents would have to ask for a snack if the residents wanted a snack. On 8/18/21, at 9:15 a.m. an interview with the dietary supervisor stated dietary staff were responsible for the residents snacks. The dietary supervisor indicated an evening snack was not offered to the residents and does not have a location where snacks are available to the residents. The dietary supervisor stated the snacks were removed from the from the dining room and were no longer available for residents to independently obtain a snack. On 8/19/21, at 1:41 p.m. and interview with the administrator stated she expected all residents to be offered an evening snack and was not aware snacks were not provided to the residents and further indicated she would follow up with dietary. On 8/20/21, at 10:14 a.m. and interview with the the director of nursing (DON) stated she expected all residents to be offered an evening snack. A facility policy related to offering residents evening snacks was requested but not provided by the end of survey.	F 809	All dietary staff were trained and educated on the policy and procedure by 10/1/2021. Evening Cook hours have been adjusted to allow the needed time to pass additional snacks above and beyond the items offered from Activity Department. This will be audited through Resident Council as a follow up each month. An audit will be completed by Register Dietitian and/or designee 9/23/2021 to ensure snacks are being offered completed daily (M-F) for 2 weeks, and weekly for 4 weeks, then monthly for three months thereafter with results being reported to QAPI.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored, failed to ensure food temperatures were consistently monitored. Furthermore, the facility failed to ensure an adequately trained dietary supervisor oversaw and supervised all aspects of dietary services and ensured dietary cooks and aides received comprehensive training upon hire and on-going. This had the potential to affect all 40 residents who were served food from two kitchens. Findings include: Dishwashing sanitization:	F 812	Thorne Crest has and always will ensure that the dishwashing sanitization was appropriately monitored and food temperatures are consistently monitored. It strives to ensure an adequately trained dietary supervisor is in place to monitor and supervise all staff within the dietary department. The policy on Dish Machine Temperature Logs, Sanitation of Dishes/Dish Machine, Cleaning Dishes/Dish Machine, Maintenance of Dish Machine, Cleaning Dishes/Manual Dishwashing, and Food Temperatures was reviewed and updated on 9/17/2021.	10/1/21

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F 812	Continued From page 30 During observation and interview on 8/18/21, at 9:00 a.m., observed dietary aides (DA)-A and (DA)-B washing and putting away dishes at the commercial dishmachine in the main kitchen. Both were asked how they determined if the proper dishmachine temperature was reached when dishes went through. DA-A retrieved a clipboard from the wall which had a form attached titled "dishmachine temperature log." The form had four columns, one for the date and one for each meal - breakfast, lunch and supper. The form had seven lines, each line pre-dated 8/17, through 8/23. In the supper column for 8/17, was a small label that read: "Temp Rite Dishwasher Temp. Pass when blue bar turns orange." DA-A stated they were supposed to place one of the temperature strips through the dishmachine three times a day at each meal service but admitted it had not been done for breakfast on 8/18, and verified it had only been done one time on 8/17. DA-A then removed a dishwasher temp strip from a package (Taylor Brand Temp Rite Dishwasher temp test strips; single use) that had been laying on a cart; put it in the tines of a fork and set the fork on a crate of dishes going into the dishmachine. The package of strips was observed to have an expiration date of 6/2019, and a second package of the same strips also expired 6/2019. According to the package, to determine if proper sanitization temperature was reached during washing, the color bar on the strip was to turn bright orange. When DA-A removed the strip after going through the washing cycle, it had changed color, but instead of being bright orange, it was a dark color. DA-A was not able to say what color it was and shrugged her shoulders when asked. Observed temperature dials on dishmachine: final rinse: 180 degrees Fahrenheit	F 812	Effective 8/20/2021 thermometers were placed within the three compartment sink to assure adequate temperatures when washing and sanitizing. All dietary staff have been assigned Safe Food Handling within online education system to be completed by 10/1/2021. Entire kitchen had a full deep clean on 9/23/2021. Dish machine process for monitoring temperatures has been changed to include the appropriate temperatures for each cycle (wash, rinse tank & final rinse). Directions on log includes: If machine is not reaching the proper temperature, notifying management right away and discontinue use. Wash dishes in the three compartment sink until repaired. Temperatures are to be taken at all meals and logged. Three compartment sink process for monitoring temperatures and PPM levels were reviewed and adjusted. Dietary staff are to record the temperature and PPM levels 3 times per day. Sins posted at three compartment sink providing guidance in regards to temperatures. o Wash sink temperature needs to be 110 F or higher. If it falls below that temperature please empty it and refill. o Sanitizing sink needs to be in the range of 75F 100F. If it falls below that	

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F 812	Continued From page 31 (F), and wash tank 158 degrees F. During an interview and observation on 8/18/21, at 9:15 a.m. while at the three-sink chemical sanitation station, cook (C)-B stated pots and pans were cleaned in the sinks and sanitized with chemical. The sinks were empty. C-B stated she tested the sanitizing solution with test strips that changed color and pointed to a clipboard on the wall of the readings. Readings for July and August 2021, were all hand-written to be "200" [parts per million]. During an interview and observation on 8/18/21, at 9:38 a.m. with dietary supervisor (DS)-A in the area of the dishmachine, DS-A stated the water temperature of the dishmachine should be checked with strips once daily on the evening shift. When asked why the log indicated the water temperature would be tested three times a day with each meal service, DS-A stated "Oh I guess we're going to have to get on that." DS-A was not able to verbalize what the facility policy was on measuring dishmachine temperatures. In addition, DS-A was asked to verify the expiration date on the package of dishmachine temperature strips of 6/2019, and stated "I didn't know they had them." DS-A did not know if staff could continue to reliably use them. When asked for additional copies of the dishmachine temperature logs for previous weeks, DS-A did not know if they were kept but would look; however logs were not provided. During an interview on 8/19/21, at 8:25 a.m. registered nurse (RN)-A denied food borne illnesses had been identified with infection control surveillance in the past year. RN-A stated DS-A was responsible for infection control in the	F 812	empty and refill. When it is in range test it with test strip by holding it in for ten seconds and comparing it to the chart on the label. It should match between 150-400 ppm. Food Temperatures: Food Temperature Policy was reviewed by all cooks and acknowledged understanding of the policy. Food temp logs are being managed both in the kitchen prior to food leaving the area and upon arrival to the HCW kitchen for serving. Safe Food Handling Course was assigned to all culinary staff. This course includes the danger of food contamination with food handling, food preparation and food service. It demonstrated and explained Safe Food Handling Processes. Dietitian provided training on cleaning schedules and food temperature to culinary staff. Audits for temperatures of dish machine, 3-compartment sink, and food temperatures will be conducted by RD and/or designee 3x weekly for 2 weeks, weekly for 4 weeks, then monthly thereafter with results being reported to QAPI. An audit will be completed by Register Dietitian and/or designee beginning 9/24/2021 to ensure cleanliness of the dietary department daily (M-F) for 2 weeks, and weekly for 4 weeks, then monthly for three months thereafter with	

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F 812	Continued From page 32 kitchen, but she met with new dietary staff and covered general infection control measures, including handwashing. During an interview and observation on 8/19/21, at 8:35 a.m. with DS-A and registered nurse (RN)-A, observed the dishmachine temperature log, and observed that the dishmachine temperatures were still not being measured after each meal service. DS-A stated new temperature strips had been ordered to replace the expired strips and was waiting for them to arrive. Asked if there were other ways to ensure the proper temperatures were reached on the dishmachine in the meantime, and DS-A stated he didn't know. RN-A asked about the dials on the dishmachine and if they could be used. When DS-A was asked what the minimum temperature readings on the dials needed to be to ensure proper washing and sanitization, DS-A stated he did not know but would find out. During an interview and observation on 8/19/21, at 8:44 a.m., the three-sink sanitizing station which held water and chemical solution (pre-mixed Ecolab Oasis 146 Multi Quat) were observed with DS-A and RN-A. Package instructions for LaMotte QAC QR Test Strips with expiration date of August 2021, indicated to determine parts per million (ppm) of the sanitizing sink chemical solution, immerse the pad of a strip in solution and remove immediately. Hold the strip level for 5 seconds, shake off excess water from pad and compare pad to color chart on the container. DS-A was asked to test the solution, and obtained a reading of 100 ppm, verified by both DS-A and RN-A. When asked how many ppm the solution needed to be to sanitize dishes, DS-A stated 200, however he could not verify that	F 812	results being reported to QAPI.	

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F 812	Continued From page 33 with certainty as he was not aware of the required ppm according to Ecolab, the manufacturer of the chemical solution. DS-A then asked C-B to change the chemical solution. After the sanitizing solution was changed, DS-A was asked to test it and again the solution tested at 100 ppm verified by DS-A and RN-A. During an interview on 8/19/21, at 10:10 a.m., DS-A provided a document from the dishwasher manufacturer, American Dish Service - ADC 44, which indicated temperatures for the commercial rack conveyor dishmachine as follows: --Final sanitizing rinse, minimum temperature: 180 F --Pumped rinse tank minimum temperature: 158 F --Wash tank minimum temperature: 158 F DS-A had made a log for staff to document the temperatures from the dials attached to the dishmachine. Upon review of the log, temperature for breakfast dishes dated 8/19, indicated the wash tank minimum temperature was 150 degrees F (should have been 158 degrees F) and the the temperature for final sanitizing was 120 degrees F (should have been 180 degrees F). DS-A stated he would contact an Ecolab representative right away to service the dishmachine. During an interview on 8/19/21, at 3:30 p.m., DS-A stated the Ecolab representative had been there and adjusted the water temperature on the dishmachine and ran two loads that were up to temperature. A report from Ecolab dated 8/19/21, at 2:46 p.m., indicated "turned up wash tank temp, now the wash tank temp is 160." However, the temperature of the final sanitizing rinse was not mentioned in the report.	F 812		

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F 812	Continued From page 34 During an interview on 8/19/21, at 4:58 p.m., the administrator verified she had been informed by staff of the findings related to the dishmachine temperatures and was planning to meet with DS-A to discuss. On 8/20/21, at 8:54 a.m., the administrator came to the conference room and stated the dishmachine had not been able to hold minimum temperatures and Ecolab was called and would be at the facility in approximately two hours. In the meantime, the facility switched to paper dishes, but continued to use regular silverware which were disinfected in the chemical sanitization sink. During a telephone interview on 8/20/21, at 10:16 a.m. to Taylor (the manufacturer of Temp Rite heat testing strips), customer service representative (CSR)-C stated the expired strips were okay to use. He recommended testing them to make sure they turn color and if they no longer turned color to get new ones. CSR-C was not able to say how to test them if the dishmachine wasn't heating to proper temperature. During an interview and observation on 8/20/21, at 10:36 a.m. with the administrator and (C)-C at the sanitation sink, C-C stated the Ecolab representative provided new test strips on 8/19/21, (Hydroin QT 40 strips). C-C tested the solution in the sanitizing sink and the test strip indicated 150 - 400 ppm, which was the appropriate ppm for the Ecolab solution used, quaternary ammonium, according to facility policy titled Cleaning Dishes - Manual Dishwashing, dated 2021. In addition, the same policy indicated the temperature in the wash sink should be 110	F 812		

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degrees F and the water in the sanitizing sink should be 75 to 100 degrees F. However, the water temperatures were not being measured prior to and during use. The administrator stated she would find out the temperature of the water coming out of the water dispensers at the sanitizing sink.

On 8/20/21, at 11:20 a.m., the administrator stated the temperature of the water coming out of the water dispensers at the sanitizing sink was 123.5 degrees F, and that maintenance staff would purchase thermometers right away for dietary staff to monitor water temperatures in the sinks to ensure they remained above minimum temperatures. In addition, the administrator stated the dishmachine was 25 years old; parts were no longer available and therefore had requested a replacement as soon as possible from the corporate office.

During an interview on 8/20/21, at 1:35 p.m., DS-A admitted he had not been fully aware of, nor did he monitor dishmachine temperatures or chemical sanitization sink processes. DS-A stated he was the expert in the dietary department, but had trouble executing day to day work due to being pulled in so many directions due to being short staffed.

During an interview on 8/20/21, at 2:06 p.m., the administrator admitted that prior to the survey, she had not been aware that the operations in the kitchen related to the dishmachine and sanitizing sink were not meeting regulatory requirements and had relied on DS-A to ensure regulatory requirements were being met. The administrator added that adhering to regulatory requirements was crucial for resident safety; adding they had

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work to do and would put a training program together for DS-A and dietary staff.

Food temperature:

During interview and observation on 8/18/21, at 11:00 a.m., observed C-D in the main kitchen take temperatures of hot food without documenting the temperatures. At the end of temping food, when asked where she documented the temperatures, C-D stated she did not document the temperatures because the food was taken to the health care kitchen and temped again there and documented prior to being served to residents. During observation and interview, food temps were noted as follows:
--Hamburger patty: 141 degrees F. C-D put pan back into oven; observed temp at 193 degrees F

During observation and interview on 8/18/21, at 11:20 a.m., observed food from main kitchen taken to the heath care kitchen in pans covered with foil, on a wheeled cart, and placed in a steam table. Observed C-C temp food:
--Hamburger patty: 185 degrees F.

When C-C and DS-A were asked what the temperature should be for holding hot food, both stated they were not sure . C-C stated 165 degrees and DS-A stated 140 degrees. No food temperature references were visible in kitchen for them to refer to. DS-A took hotdogs back to the main kitchen to be heated and C-C placed omelet in the microwave for further heating.

Observed C-C document food temperatures on a sheet in a 3-ring binder, titled Food Temperature Log. The sheet did not indicate the month. The only date noted on the sheet was "15th" which

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was hand-written above "SUN" (Sunday). When asked what the blanks meant in the columns, C-C responded with a question -- that the temps weren't written down? C-C confirmed dietary staff were supposed to document the temperatures of the food on this log with each meal service.

Upon further review of food temperatures for August, July and June in the health care kitchen, temperatures were inconsistently documented or not documented at all:
August:
8/1/21: no dinner temperatures documented.
8/3: no meal temperatures (breakfast, lunch or dinner) documented.
8/4 through 8/7, 8/10 and 8/11: no dinner temperatures documented.
8/12: no meal temperatures were documented.
8/14 and 8/16: no dinner temperatures documented.

July:
7/1/21, 7/3, 7/12, 7/13, 7/14: no dinner temperatures documented
7/15: no meal temperatures documented.
7/16 and 7/17, 7/18, 7/20, 7/22 through 7/31: no dinner temperatures documented.

June:
6/1/21, 6/2, 6/4 : no dinner temperatures documented.
6/5: no lunch and dinner temperatures documented.
6/6 though 6/10: no dinner temperatures documented.
6/11 and 6/12: no meal temperatures documented.
6/13: no breakfast and lunch temperatures documented.

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6/14 through 6/17 and 6/19: no dinner temperatures documented.
6/21 though 6/26: no dinner temperatures documented.
6/27: no breakfast and lunch temperatures documented.
6/28, 6/29/, 6/30: no dinner temperature documented.

During an interview on 8/19/21, at 8:25 a.m. registered nurse (RN)-A denied food borne illnesses had been identified with infection control surveillance in the past year.

During an interview on 8/19/21, at 8:55 a.m. DS-A and C-D stated they were not required to document food temperatures taken in the main kitchen before food was transported to the health care kitchen for meal service, the rationale being that the temperatures were measured again and documented once food reached the health care kitchen. DS-A and C-D did not reply when asked how staff were held accountable for ensuring the temperature of the food leaving the main kitchen had reached appropriate temperatures. RN-A stated documenting the temperatures would be important for a look back if there were concerns related to food borne illness. A policy on documenting food temperatures was requested but not received.

During an interview on 8/20/21, at 9:58 a.m., reviewed heath care kitchen Food Temperature Logs with DS-A and asked about the blanks spots on the logs and the squiggly lines in columns where there were no temperatures recorded. DS-A assumed the squiggly lines were so staff could not go back and fill in temperatures later. When asked what he thought about the missing

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F 812	Continued From page 39 temperatures and if staff were trained to document food temperatures prior to meal service, DS-A stated he didn't know. DS-A was asked if the absence of food temperatures being recorded meant the temperatures weren't taken, or not recorded. DS-A stated he thought the temperatures had been taken, but he didn't know for sure as he wasn't there to observe staff for each meal service. DS-A admitted that residents could become sick if food was served below minimum temperatures. During an interview on 8/20/21, at 10:25 a.m., the administrator stated she expected food temperatures to be documented before food left the main kitchen and had not been aware of the current practice by cooks of not documenting the temperatures. The administrator stated the food temperatures needed to be documented in the main kitchen to verify proper temperatures were reached before food was taken to the health care kitchen. The administrator was also shown copies of food temperature logs from the health care kitchen with multiple missing entries. The administrator stated this was a concern for potential food borne illness if temperatures were not being taken, and added that practice needed to be improved. The administrator admitted that she relied on the dietary supervisor to ensure regulatory compliance was maintained with all aspects of the dietary department and stated she would need to become involved to make sure this occurred. Dietician surveys On 8/19/21, at 3:41 p.m., reviewed audits completed by dietician on a document titled Sanitation Survey, dated 8/11/20. Findings	F 812		

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included:
Ecolab strip must be done once per shift?? Only done at supper.

Sanitation Survey, dated 1/12/21. Findings included:
Temps of dishmachine needed to be taken.

Kitchen observation form (CMS-20055, 5/2017) and dated 7/6/21, indicated:
Many blank spots on dishmachine temperature log.

During an interview on 8/19/21, at 4:31 p.m., DS-A stated he was aware of the dietician's audits dated 7/6/21, 1/12/21, and 8/11/20. The Sanitation Survey forms each had a column titled "DM (dietary manager) Initials/Comments" but the columns were blank. When asked if he had addressed the dietician's findings, DS-A stated he had not, as neither he nor the dietary staff had time to address the findings.

Training:

During an interview on 8/18/21, at 9:38 a.m. DS-A stated he had been in his position for a little over a year, and that he had "no schooling for the job." DS-A added that he took a food manager class with the State which was a one day class. DS-A provided his certification from State of Minnesota Department of Health for Food Manager certification; expiration date 10/20/21. Prior experience included working in a similar role for about a year in an assisted living facility in the metro area. DS-A stated he had worked with the facility dietician (D-D) to learn his role when he was hired. When asked how he ensured competency of the dietary staff, DS-A stated he

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F 812	Continued From page 41 did this by watching them; looked for food to taste right and temperatures to be right. DS-A stated he had hired a few dietary workers and the new employees were trained by another employee who had worked in the dietary department for awhile. When asked if he used a training or orientation list for new employees to ensure all elements of food safety and sanitation were covered, DS-A stated he did not. DS-A stated that in addition to working with another dietary employee, new employees completed online modules via Health Care Academy (HCA). Facility culinary director job description, (which was provided when DS-A's job description was requested) dated 4/25/2013, was reviewed. The job description indicated the dining services director assured compliance with standards of practice and regulatory requirements for Safe Food Handling and Storage. Established sanitation standards, staffing and staff development. Assured compliance with established standards of practice and State and Federal Regulatory Guidelines. This was a management level position, supervising and coordinating daily activities which included guidance of semi-skilled workers. This position reported to the administrator. --Essential duties and responsibilities included providing dietary department orientation and job-specific training and policies to all production staff. Plan, conduct and oversee continuous employee training and competencies. Makes frequent inspections of all work to determine that regulations are followed. --Qualifications included performing each essential duty satisfactorily. Previous supervisory experience in healthcare operations was desired. --Minimum education was certified dietary	F 812		

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F 812	Continued From page 42 manager or bachelor degree in food services. Certification in approved sanitation course (ServSafe certification) per state requirements. Education background in food service management was desired. Home economics or food management or enrolled in or had completed, at a minimum a dietary manager course. Facility cook job description, dated 10/1/2018, was reviewed and included responsibility for maintaining accurate meal documentation records, ensure and assist with cleaning and sanitizing equipment and work areas, ensure policies and procedures were implemented, maintain a sanitary environment following all food-safety standards, policies and procedures, clean dishes, equipment and work area according to procedures and schedules. Experience: one year cooking in a restaurant, health care or senior services setting. Facility dietary aide job description, dated 9/22/2015, was reviewed and included responsibilities to assist the cook in preparing food in accordance with sanitary regulations, established policies and procedures, clean dishes, equipment and work area according to established procedures and schedules, maintain a sanitary environment following all food-safety standards, policies and procedures. During a telephone interview on 8/19/21, at 9:38 a.m., with D-D, when asked if she provided DS-A with training on general department cleanliness, dishmachine temperatures for sanitation, or chemical sanitation when he was hired, D-D stated "no, my understanding was that DS-A had been doing most things at his previous positions.	F 812		

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I just went over day-to-day things - how things work at this facility - employees, and roles and vendors. So, to answer your question, probably not because of his previous experience."

During an interview on 8/19/21, at 11:55 a.m., DS-A was asked for training records completed upon hire for employees on duty that day: C-D (hired in 2012), DA-B (hired in 2020), C-B (hired in 1980), DA-A (hired in 2018), C-C (hired in 2014), and (DA)-E (hired in 2019). DS-A stated there were no records available for staff who had worked at the facility for a long time. Registered nurse (RN)-A, who was also present confirmed there were no department training/orientation records available for any dietary staff, only annual online training modules through HCA.

During an interview on 8/19/21, 3:43 p.m., when asked for dietary training records for four of seven dietary employees hired in 2021, RN-A stated there were no training or orientation records for these employees, only online training via HCA:
--(DA)-C, hired 4/16/21; online training related to dietary role: Safe Food Handling was completed over a month later on 5/26/21.
--(DA)-D, hired 5/26/21; online training related to dietary role: Safe Food Handling was completed 5/30/21.
--(C)-E, hired 4/7/21; online training related to dietary role: Safe Food Handling was completed over two months later on 6/14/21.
--(C)-F, hired 6/7/21; online training related to dietary role: Safe Food Handling was completed 6/16/21.

During the same interview with RN-A, initial training records were requested for DS-A. RN-A

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stated there were no training or orientation records for DS-A, only online training via HCA which included the 1.5 hour Safe Food Handling module, completed on 6/23/20.

The Safe Food Handling course through HCA, provided 1.5 contact hour(s) and objectives were: 1) List four ways to minimize the danger of food contamination with food handling. 2) Identify four ways to minimize food contamination with food preparation. 3) Select four ways to minimize the danger of food contamination with food service.

During a telephone interview on 8/19/21, at 3:56 p.m., C-F stated she worked at facility from 2019, to 2021; she quit in 2021 and returned two months later. Asked to describe her orientation and training when hired in 2019, and C-F stated she worked with another person who showed her what to do. C-F denied orientation and training included review of food service policies and procedures, such as food safety and temping food; "just what the other employee showed me or told me." Denied being trained on cleaning in the department, such as fans, floors, ice machine, refrigerators; "No, I just cleaned up after myself." C-F's prior food/dietary experience was working at a day care center.

During an interview on 8/19/21, at 4:04 p.m., when asked what her role was in orientation of new employees, the human resource director stated she went over portions of the orientation checklist such as employee handbook, call-in policy, HIPAA, and behavior standards. The human resource director stated she had not been directed to guide department supervisors or managers in ensuring new employees received a comprehensive orientation -- "it's left up to

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department managers."

During an interview on 8/20/21, at 10:08 a.m., C-D stated he had worked at the facility in 2017, and left and returned in 2021. C-D stated DS-A had trained him but didn't recall if DS-A used a training list. When asked what he recalled about training, C-D stated "food prep and temps." C-D stated he had no formal cook or kitchen training prior to be hired.

During an interview on 8/20/21, at 1:55 p.m., DS-A believed he had adequate education, training and support for his role as dietary supervisor and had knowledge of policies, procedures and regulatory requirements. DS-A stated he did not have time to do the day-to-day work that was required of him, and that his boss, the administrator, was aware of this, as was the administrator before her. When asked if survey findings were a surprise to him, such as dish sanitation, cleanliness and staff training, DS-A stated "yes and no" -- adding that he was the expert in the dietary department, but had trouble executing day-to-day work due to being pulled in many directions and being short staffed.

During an interview on 8/20/21, at 2:06 p.m., the administrator who was new to the facility in 6/2021, stated she was not aware of f DS-A's specific education and qualifications. It was her expectation that DS-A was the culinary expert and leader; that she was responsible for overseeing his performance. The administrator stated she recognized now that DS-A needed additional training and would put a training program together for DS-A, the current dietary staff and new hires, including competencies. The administrator admitted that being new to her role,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 46 she made assumptions that DS-A had trained new staff, was guiding current staff, was aware of regulatory requirements and had been adhering to them. "I now know that is not the case." Facility policy titled Cleaning Dishes/Dish Machine, dated 2021, indicated: The dish machine will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. Thermal strips may be used as verification that the temperature is adequately hot, but cannot verify actual temperatures. High temperature dishwater wash temperature should be 150 to 165 degrees F. Final rinse temperature should be 180 degrees F. Facility policy titled Cleaning Dishes - Manual Dishwashing, dated 2021, indicated: Dishes and cookware would be cleaned and sanitized after each meal. Sink 1: Wash. Water should be at 110 degrees F. Sink 2: Rinse. Sink 3: Sanitize. Water should be 75 to 100 degrees F. If using quaternary ammonium, strength to be 150 to 200 ppm. Facility policy titled Resource Sample HACCP (hazard analysis critical control point) Recipe for grilled ham and cheese sandwich, dated 2021, indicated food is cooked to minimum of 155 degrees F, held at minimum of 135 degrees F and served at minimum of 135 degrees F. (Note: this was the policy provided when asked for facility policy on taking food temperatures).	F 812		
F 868 SS=C	QAA Committee	F 868		10/1/21

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F 868	Continued From page 47 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance program (QAA) held meetings with the required members, including medical director or designee, at a minimum on a quarterly basis.. The medical director is responsible for the overall medical care provided and the implementation of all resident care policies in the facility. This had the potential to affect all 40 residents who resided at the facility. Findings include: During interview on 8/20/21, at 2:32 p.m. the administrator reviewed the QAA sign in sheets and confirmed the medical director did not consistently attend meetings on a regular basis. The administrator further confirmed the only	F 868	Thorne Crest has and always will ensure that that it maintains a quality assessment and assurance committee that consists of at least a Director of Nursing, Medical Director, and three other members of the facility s staff that are: administrator, owner, board member or leadership team member. The policy QAPI-Governance was reviewed and no changes were noted 9/21/2021. Training and education on the policy and expectations were reviewed with the QAPI committee, including the medical director, on 9/21/2021 by the administrator.	

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F 868	Continued From page 48 documented meetings the medical director had signed in on over the past two years, were on 9/24/20, 2/18/21, and 6/15/21. Administrator acknowledged documentation reviewed lacked evidence that the medical director attended the QAA meetings quarterly. Policy titled Quality Assurance Performance Improvement Plan, revised December 2009, indicated the administrator is responsible for assuring that this facility's Quality Assurance Performance Improvement Committee complies with federal, state, and local regulatory agency requirements.	F 868	Please see attached documentation of training provided. (Attachment F868) Attachment includes email training provided to Medical Director dated 9/20/21. Medical Director did attend QAPI Meeting held on 9/21/21 at which time Administrator reviewed the QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)483.75(g) guideline with all in attendance as outlined in 2567. An audit will be conducted by Administrator monthly for six month to ensure compliance. Results will be reported at the QAPI committee meeting.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		9/28/21

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F 880	Continued From page 49	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 50 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 40 residents residing in the facility as well as facility staff. Findings include: Upon entrance to the facility on 8/16/21, at 1:30 p.m. the director of nursing (DON) and the administrator indicated there were 4 residents (R28 R30 R39 R347) residing in the facility, who had not been vaccinated against COVID-19. The DON and the administrator also indicated there was 1 staff person that tested positive for COVID-19, that morning. Later at 2:00 p.m. the DON and the administrator indicated another staff person had tested positive for COVID-19. The facility Infection Control (IC) records confirmed the positive COVID testing results. Observation on 8/16/21, at 5:00 p.m. residents were eating supper in the dining room. Residents were sitting at tables with 4 or more residents. The residents were not 6 feet apart. There were no residents that were wearing a mask. R30 R39 and R347 were noted to be at tables with other (vaccinated) residents, sitting next to them. R30, R39, and R347 were not wearing a mask	F 880	Thorne Crest has and always will ensure that it has an established, and it maintains, an infection prevention and control program (IPCP). R28 Is unvaccinated and has not contracted COVID-19, care plan has been revised with new interventions to prompt the resident to put on the mask when not eating and drinking, and to prompt R28 to stay 6 feet away from others when not wearing a mask. The electronic health record has been updated under special care notes to alert the staff of unvaccinated status R31 Is unvaccinated and has not contracted COVID-19, care plan has been revised with new interventions to prompt the resident to put on the mask when not eating and drinking, and to prompt R31 to stay 6 feet away from others when not wearing a mask. The electronic health record has been updated under special care notes to alert the staff of unvaccinated status R30 noted in 2567 is fully vaccinated. R31 is the resident in question who was not vaccinated. R39 has been discharged.	

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F 880	Continued From page 51 throughout the meal, (when not eating) and sitting about 2-3 feet apart from a unvaccinated resident. Interview on 8/16/21, at 6:00 p.m. registered nurse (RN)-A indicated she did not know if there were any residents that were unvaccinated for COVID-19. RN-A indicated that kind information does not get communicated to the nursing staff. RN-A also indicated she was not aware of any restrictions for a resident that was unvaccinated. Interview on 8/16/21, at 6:15 p.m. nursing assistant (NA)-A and NA-B were not aware of any residents that were unvaccinated for COVID-19. They both confirmed this was not communicated to nursing staff. NA-A and NA-B were not aware of any restrictions for unvaccinated residents. Interview on 8/16/21, at 7:00 p.m. facility dietary manager (DM) indicated he was not aware of any residents that were unvaccinated for COVID-19. The DM also indicated he was not aware of any restrictions in the dining room during meal time, for residents who were not vaccinated. COVID specimen collection/testing During observation on 8/16/21, at 5:30 p.m. to 6:00 p.m. the director of nursing (DON) and the infection control preventionist (ICP) was observed from the dining room during supper (in a room with windows connected to the dining room) collecting nasal specimens from residents. The door to the testing room was open so residents could enter and leave when needed. The DON and ICP were collecting nasal specimens from residents to test for COVID-19. Residents were leaving the dining room and waiting in line, back	F 880	R347 has been discharged All current residents are vaccinated. Dining tables have been marked to visually show 6 feet apart and can accommodate 4 residents at each table. Signs are posted at tables in dining room instructing the use of masks until meals arrive. Audits are being conducted by IP to assure residents are wearing face masks while out in the common areas. Ongoing education is provided to residents when observed not wearing masks. All departments have a list of unvaccinated residents (2 resident currently) to assist with 6 feet apart and prompting residents to put their mask on when not eating or drinking. COVID-19 testing of residents are done in the resident s rooms or designated private areas of community. COVID testing is being audited by IP by-weekly. Notification is being sent to individuals who fail to test the date of testing and are required to test prior to the beginning of their next shift. Per the Directed Plan of Correction: The QAPI committee, with assistance from an Infection Preventionist, will conduct a root cause analysis (RCA) to determine why facility was cited in F880	

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F 880	Continued From page 52 to back to be tested. There were 2 residents that were coughing without covering their face. There were no residents wearing mask. The DON was collecting the specimen and the ICP was documenting the specimen. The ICP was not wearing eye protection at this time. After 15 minutes the ICP left the room and returned with eye protection. Interview with the DON and the ICP on 8/16/21, at 6:00 p.m. indicated they were testing residents and staff for COVID-19, because there were 2 staff that had tested positive earlier that day. The DON and ICP confirmed residents should have been 6 feet apart and wearing a mask, when questioned by the surveyor. The DON and ICP both stated they thought it would be more convenient to test residents, after they were leaving the dining room. The ICP also confirmed full PPE should be implemented when collecting nasal specimens from residents, that included eye protection. Interview on 8/17/21, at 2:30 p.m. DON and ICP indicated they did not realize the nursing staff were not aware of residents that were unvaccinated. They both indicated this should be communicated to the staff through management, but failed to do so. The DON and ICP confirmed staff should be aware, so that restrictions could be implemented. This included sitting 6 feet apart when in the dining room and wearing a mask when out of their room. Facility policy COVID-19- Testing Residents dated 8/20, indicated when collecting diagnostic respiratory specimens from a person with possible COVID-19, the procedure should be performed in a residents room or other	F 880	on or before 9/28/2021. The following policies and procedures were reviewed by the DON and infection preventionist: Universal Mask, Extend and Reuse of PPE Policy and Standard and transmission-based precautions competency on 9/17/2021. Training and education on the above policies for staff providing direct care to resident and all staff entering resident s rooms with attestations statement of completion verified by the DON, Medical Director, or Infection Preventionist by 9/28/2021. An online infection prevention training course has been assigned as of 9/17/2021 and will be completed by staff who providing direct care to resident and all staff entering resident s rooms before 9/28/2021. CMS Core Principles of infection control have been mailed to all responsible parties on 9/24/21, posted throughout the facility, verbally explained to all cognoscente residents and ongoing verbal prompts if the resident is cognitive impaired as needed. An audit will be initiated on 9/24/2021 by the DON, Infection Preventionist or designee to assure compliance on all shifts, 4 times a week for one week, two times weekly for one week until 100% is reached for source control masking for	

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F 880	Continued From page 53 designated space with the door closed. The staff collecting the specimens should wear personal protective equipment (PPE), that includes a mask, gloves, gown and eye protections. When collecting specimens persons should be 6 feet apart. A policy on guidance for unvaccinated resident's was requested, but not provided by the end of survey.	F 880	staff, visitors, and residents; proper use of gowns in real time. Results will be reported to QAPI There are no residents on aerosolized generating procedures. See Attachment F880	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fans used in 2 of 2 kitchens and floor fans used in 2 of 3 resident hallways, were kept in a clean and sanitary manner and free of dust and debris. In addition the facility to ensure cleanliness of 1 of 1 ice machines and 1 of 2 kitchen floors, In addition, the facility failed to ensure resident bathroom exhaust vents were maintained in a clean manner for 6 of 40 resident rooms (R3, R21,R21,R22, R32, and R4). This had the potential to affect all 40 residents residing in the facility. Findings include: During an observation and interview on 8/18/21, at 9:25 a.m. in main kitchen with cook (C)-D, observed a white box fan on a metal shelf next to	F 921	Thorne Crest has and always will ensure that the environment is safe, functional, sanitary, and comfortable for the residents, staff and the public. Fans in the kitchen were cleaned. Fans in the resident hallways were cleaned. Ice Machine was cleaned, kitchen floors were cleaned. All mats in kitchen were removed when floor was cleaned by 8/20/2021 Bathroom exhaust vents in R3, R21, R22, R32, and R4 were cleaned 8/20/2021 All other resident bathroom exhaust vents were checked and cleaned if needed by 8/26/2021. Bathroom exhaust vents are on a	10/1/21

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F 921	Continued From page 54 refrigerator #5, and approximately four feet off the floor. The fan blades had dark fuzzy material on all five outer edges. The fan was not in operation, but C-D stated the fan was used by employees when the kitchen was warm. Observed an ice machine dispenser sitting counter height off the floor, with white corroded material oozing out of a seam on the right side of the machine, and a narrow ledge above the door to the ice had debris accumulated on it, which looked like food crumbs. Observed black rubber grate-style fatigue mats on the floor in-between the oven/stove and food preparation counter were sticky as bottom of shoes felt sticky when walked across. When asked who was responsible for cleaning in the kitchen, C-D stated "we all are; we clean when we can." During an interview on 8/18/21, at 9:38 a.m. dietary supervisor (DS)-A stated kitchen staff cleaned when they had time as they were short staffed by three or four dietary aids. DS-A stated the ice machine was cleaned and maintained by a local company every six months and was due to be serviced this month. DS-A admitted dietary staff should clean the outside of the ice machine during routine cleaning. DS-A stated dietary staff were responsible for cleaning floors and fatigue mats and maintenance staff were responsible for cleaning fans. Facility cleaning instructions for the ice machine dated 2021, indicated staff were to clean the exterior of the machine with a detergent solution daily. During an observation and interview on 8/18/21, at 11:20 p.m. in the health care kitchen, the kitchen from where food was plated and served to residents in an adjacent dining room, was a small round, teal colored fan on floor blowing	F 921	maintenance check and cleaning schedule to be done at least monthly or more frequently as needed. Fans have been placed on an Electronic Preventative Maintenance program which will notify maintenance when these items are due for cleaning. Floors & Floor Mats have been added to the Kitchen Cleaning Schedule. Kitchen Cleaning Schedule will be monitored weekly for compliance by Dietary Director or designee. Cleaning of the Ice Machine has been added to the Kitchen Cleaning Schedule. Outside of ice machine will be wiped down three times a week. Ice will be removed and inside of ice machine will be thoroughly cleaned the last Thursday of each month. Kitchen Cleaning Schedule will be monitored weekly for compliance by Dietary Director or designee. Education was provided to maintenance staff by Maintenance Director. An audit will be performed by Maintenance Director or designee put in place to assure fans, ice machines, kitchen floors, and mats are clean daily (M-F) for 2 weeks, then weekly for 4 weeks and for one month thereafter with results being reported to QAPI.	

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F 921	Continued From page 55 towards resident food while it was being plated by C-C. While oscillating, dark fuzzy material on the front grate was visible. When DS-A was asked if that was acceptable, he replied "not so much," unplugged it and moved it to another location in the kitchen and stated it would be cleaned. When asked why not, DS-A stated it was potentially blowing germs in the direction of resident food. During an interview on 8/19/21, at 8:55 a.m., DS-A provided kitchen cleaning schedule sheets. There were 10 cleaning sheets for each week, individualized by dietary staff role. Each sheet had between 5 and 22 specific daily, weekly and after-each-use tasks listed -- the majority of which were cleaning tasks. The sheets showed that cleaning was done inconsistently or not at all. When asked who was responsible to make sure cleaning was done, DS-A stated dietary staff were. DS-A admitted he was ultimately responsible for making sure staff completed the cleaning and was aware it was not always being done. DS-A admitted that the lack of proper cleaning in the kitchen could impact the health of residents. Cleaning schedules for one and one half weeks indicated the following: For the week of 8/16 to 8/22 (dates reviewed were 8/16, 8/17 and 8/18): -A.M. dietary aide [D] indicated no cleaning for any days. Tasks included wiping down outside of ice machine, dust fans 2x monthly and as needed. -P.M. cook indicated no cleaning was completed for three out of three days: 8/16, 8/17 and 8/18. Tasks included sweep floor and remove and wash floor mats in cook area. .	F 921		

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F 921	Continued From page 56 -Kitchen ice machine: indicated no cleaning was completed for three out of three days: 8/16, 8/17 and 8/18. For the week of 8/9 to 8/15/21 -A.M. dietary aide [C] and [D] sheets indicated no cleaning was completed for any of the days. Tasks included wipe down outside of ice machine, dust fans 2x monthly and as needed. -P.M. cook indicated cleaning was completed for one out of seven days: 8/10. Tasks included sweep floor and remove and wash floor mats in cook area. -Kitchen ice machine: indicated no cleaning was completed for any of the days. On 8/19/21, at 3:41 p.m., reviewed audits completed by dietician on a document titled Sanitation Survey, dated 8/11/20. Findings included: --Fan was dusty by meat slicer. --Floor under coffee machine needed attention. --Cleaning schedule for ice machine?? Sanitation Survey, dated 1/12/21. Findings included: Floor needed sweeping and mopping. Kitchen observation form (CMS-20055, 5/2017) and dated 7/6/21, indicated: Lime/scale build up on ice machine. During an interview on 8/19/21, at 4:31 p.m., DS-A stated he was aware of the dietician's audits dated 7/6/21, 1/12/21, and 8/11/20. The Sanitation Survey forms each had a column titled "DM (dietary manager) Initials/Comments" but the columns were blank. When asked if he had addressed the dietician's findings, DS-A stated he	F 921		

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F 921	Continued From page 57 had not, as neither he nor the dietary staff had time to address the findings. Fans in hallway: During observations on 8/16, 8/17, 8/19 and 8/20/21, a black Lasko-brand floor fan, approximately 24 inches in diameter and located in a hallway between resident rooms 3 and 4 was oscillating at high speed toward the hallway as residents passed by. Fuzzy gray material had accumulated on both the front and back grills of the fan. A fan of the same description, also with fuzzy gray material on the front and back grills was observed by the craft room. This fan was oscillating at high speed and blowing toward a medication cart, nurses station, and residents who passed by in the hallway. During an interview on 8/20/21, at 12:12 p.m., maintenance employee (ME)-A stated maintenance staff were responsible for cleaning floor fans on a monthly basis and they were due to be cleaned the following week. ME-A looked at the fans and observed the fuzzy gray material and stated they were cleaned monthly, but it didn't take long for dust to accumulate on them. During an interview on 8/20/21, at 12:15 p.m., registered nurse (RN)-A observed both fans and stated it was not acceptable to have dust build-up on the fans and potentially blowing dust toward residents and the medication cart. She immediately asked a housekeeper to help remove the fans to clean them, adding they probably needed to be cleaned more than once a month and would speak to the maintenance department about this.	F 921		

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	245425	A. BUILDING ______ B. WING ______	C 08/20/2021

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F 921	Continued From page 58	F 921		

Facility policy titled Health Care Fan Cleaning, undated, indicated a brief process of taking the fan apart, cleaning the grill and blades with QT (a concentrated hospital-grade disinfectant/detergent, cleaner), drying the parts and putting the fan back together.

Bathroom ceiling vents:

On 8/16/21, at 6:18 p.m. observed resident rooms 1, 2, 3, 4, 6, and 25 bathroom ceiling exhaust vents were covered with thick, gray dust and dirt collected on the vent cover.

On 8/18/21, at 8:25 a.m. an interview with the housekeeping supervisor stated she expected housekeeping staff to check the bathroom vents daily for dust and debris and clean as needed.

On 8/18/21, at 1:34 p.m. observed resident room 3 with maintenance employee (ME)-A and bathroom ceiling vent grate slats were covered with thick gray, dusty, and greasy material. ME-A verified the vents were not clean and further stated he was not aware if the vents were ever cleaned, and indicated he would add the vents to the scheduled cleaning.

On 8/19/21, at 8:46 a.m. an interview with ME-A confirmed R21's bathroom vent was dirty and not clean, and stated he was aware the resident's bathroom vents facility wide needed to be cleaned. Maintenance staff stated the vents should be cleaned regularly and further indicated going forward the bathrooms exhaust fan would be put on a cleaning schedule.

On 8/19/21, at 11:50 a.m. RN-A went into room 7 and looked at the bathroom exhaust vent and

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F 921	Continued From page 59 stated the cleanliness of the vent was not acceptable. When asked the risks of an unclean bathroom vent, RN-A stated unclean vents were an environmental concern with breathing unclean air. A facility policy for cleaning resident bathroom exhaust vents was requested but not provided.	F 921		

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	245425	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/17/2021

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/017/2021. At the time of this survey, THORNE CREST RETIREMENT CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2021

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THORNE CREST RETIREMENT CENTER is a 1-story building with no basement. The building was constructed in 1953 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 45 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain security and physical accessibility to an electrical panel in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/17/2021 between 09:00 AM to 02:00 PM, it was revealed during the walk-thru of the facility	K 511	Thorne Crest has and always will comply with using equipment that complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Electrical panel in the dining room was immediately locked. All other electrical panels in the facility were checked immediately and none were found to be unlocked. An Audit will be performed by Maintenance Director and/or designee to assure that all electrical panels are locked	8/17/21

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K 511	Continued From page 3 that the electrical panel in the Dining Room, readily accessible to residents, was unsecured. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 511	daily (M-F) for 2 weeks, then weekly for 4 weeks and for one month thereafter with results being reported to QAPI.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to include the transmission of a fire alarm signal when conducting fire drills, in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/17/2021 between 12:00 AM to 05:00 PM, it was revealed during documentation review that the facility was not including the transmission of a fire alarm signal for 3rd shift fire drills after conducting silent drills.	K 712	Thorne Crest has and always will comply with Fire Drills CFP(s): NFPA 101 in regards to including the transmission of a fire alarm signal and simulation of emergency fire conditions. The transmission of a fire alarm signal will be conducted the following day after 3rd shift fire drills are completed and documented. Monthly audits will be conducted by the Maintenance Director and/or designee for 6 months with results being reported to QAPI.	8/20/21

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K 712	Continued From page 4 This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		9/23/21

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K 918	Continued From page 5 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6, These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 08/17/2021, between 09:00 AM to 02:00 PM, it was revealed that the installation date of the battery for the emergency power supply system was APRIL 2018. 2. On 08/17/2021, between 09:00 AM to 02:00 PM, it was revealed that a remote manual stop station for the emergency power supply system could not be located. These deficient conditions were verified by the Maintenance Director.	K 918	Thorne Crest has and always will comply with Life Safety Codes set in NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13 and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6. A remote manual stop station for the emergency power supply system has been installed. A new battery for the emergency power supply system has been installed. See Attachments	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of	K 920		8/17/21

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K 920	Continued From page 6 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement and use power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/17/2021 between 09:00 AM to 02:00 PM, it was revealed in the Health Info Manager's office, an appliance connected to a power strip. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 920	Thorne Crest has and always will comply with Life Safety Codes in regards to the use of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70 (2011 edition), National Electrical Code, sections 400-8, 590.3(D). Appliance connected to power strip in HIM office has been relocated and plugged into outlet in office. Power strip has been removed. An Audit will be performed by Maintenance Director and/or designee to assure that all power strips are being utilized correctly daily (M-F) for 2 weeks, then weekly for 4 weeks and for one month thereafter with results being reported to QAPI.	

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