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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8912

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: **7** (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) 4/15/2013

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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
From (a) :
To (b) :

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria King Unit Supervisor 04/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath Program Specialist 05/22/2013 (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.
03001
(L31)

30. REMARKS
Posted 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **S TATE AGENCY REMARKS**

On April 15, 2013, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on and on March 29, 2013, the Department of Public Safety completed PCR to verify correction of deficiencies issued pursuant to the February 21, 2013 standard survey. Based on the plan of correction, it was determined the deficiencies were corrected as of March 24, 2013. Refer to the CMS 2567b for both health and life safety code.

Effective March 24, 2013, the facility is certified for 52 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5425

May 22, 2013

Ms. Shanna Eckberg, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, Minnesota 56007

Dear Ms. Eckberg:

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 March 24, 2013 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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

April 16, 2013

Ms. Shanna Eckberg, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, Minnesota 56007

RE: Project Number S5425024

Dear Ms. Eckberg:

On March 8, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 21, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 15, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 29, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 21, 2013, effective March 24, 2013 and therefore remedies outlined in our letter to you dated March 8, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245425	A. Building B. Wing	4/15/2013

Name of Facility	Street Address, City, State, Zip Code
THORNE CREST RETIREMENT CENTER	1201 GARFIELD AVENUE ALBERT LEA, MN 56007

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**03/21/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**03/24/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**03/24/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/21/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245425	01 - MAIN BUILDING 01	3/29/2013

Name of Facility	Street Address, City, State, Zip Code
THORNE CREST RETIREMENT CENTER	1201 GARFIELD AVENUE ALBERT LEA, MN 56007

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0054	**03/14/2013**	ID Prefix Reg. # **NFPA 101** LSC K0056	**03/18/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 04/16/2013	Signature of Surveyor: 25822	Date: 03/29/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/20/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8912

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 **02/21/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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
From (a) :
To (b) :

12.Total Facility Beds **52** (L18)

13.Total Certified Beds 52 (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

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):

At the time of the February 21, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NEII 03/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/05/2013 (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
(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.
03001
(L31)

30. REMARKS
Posted 4/5/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9363

March 8, 2013

Ms. Shanna Eckberg, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, Minnesota 56007

RE: Project Number S5425024

Dear Ms. Eckberg:

On February 21, 2013, a standard 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789

Telephone: (507) 344-2716
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 2, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 2, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 21, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 August 21, 2013 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

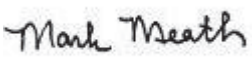
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5425s13.rtf

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 _____	02/21/2013

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
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	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.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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	F 156	**F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES** Thorne Crest has and always will treat the rights of its residents with respect. It is the policy of Thorne Crest to notify the residents of their status of Medicare benefits at least 48 hours prior to the benefits ending. Effective immediately, Thorne Crest will assure that all residents receiving benefits from Medicare will receive their denial notice of coverage at least 48 hours prior to the benefits ending. To ensure this, an audit will be completed on a weekly basis x 4 weeks at the weekly Medicare meeting and for three months thereafter with results being reported to the QAPI committee. To enhance our compliance, our Medicare team will be viewing a webinar about Medicare Notification Process and Outcomes on March 21st, 2013.	

POC accepted. mtg ej 3/28/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joanna Fahlberg	Administrator	3/21/13

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.

MAR 2 2 2013

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 _____	02/21/2013

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
F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156		

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 _____	02/21/2013

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
F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide at least 48-hours notice of denial of Medicare benefits for 1 of 3 Medicare beneficiaries (R58) in the sample. Findings include:	F 156		

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 _____	02/21/2013

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
F 156	Continued From page 3 R58 did not receive notice 48 hours prior to denial of Medicare benefits. R58 was admitted to the facility on 10/2/12. The resident was provided notice and signed the Medicare Provider Non-Coverage notice on 10/16/12, indicating services would end that same day. R58 continued to reside in the facility until discharge on 10/20/12. During an interview at 11:26 a.m. on 2/21/13, registered nurse (RN)-A verified the findings and indicated the notice should have been given two days prior but was not provided as required.	F 156		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	**F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Thorne Crest has and always will ensure that its residents' drug regimens are free from unnecessary drugs. Resident #39 - Individualized non verbal expressions of pain have been approved by nurse practitioner to be used to determine Resident #39's pain and need for PRN pain administration . Thorne Crest's Administering of Pain Medication Policy was updated to include individualized pain indicators of those who are unable to communicate pain AND parameters must be obtained by attending physician when two or more PRN pain medication are ordered which will instruct the nurse on which medication to administer.	

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 _____	02/21/2013

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
F 329	Continued From page 4 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 6 of 10 residents (R39, R50, R3, R5, R46 and R26) in the sample whose medications were reviewed. Findings include: R39 utilized as needed (PRN) pain medications without parameters specified for use. R39 was admitted to the facility on 12/28/12, with diagnoses including: closed fracture of wrist, anxiety state, persistent mental disorder and senile dementia. R39's record was reviewed. Current physician orders indicated the resident utilized acetaminophen 650 mg (milligrams) orally four times a day and had additional orders for acetaminophen 650 mg twice a day PRN, and ultram 50 mg orally every 4 hours PRN, for pain related to a closed fracture of the wrist. There had been no parameters identified or documented in the record to indicate when to use which pain medication. The medication administration record (MAR) for December 2012 identified that R39 had utilized	F 329	Resident #50 -Care plan has been modified and monitoring is in place, as of 2/22/2013, for adverse drug reactions with the use of Reglan. The AIMS was completed and will continue in coordination with her assessment process. Resident # 3 -Parameters have been received from nurse practitioner on 2/22/13 to indicate which pain medication to use. Resident # 5 -Has an appropriate diagnosis of dementia with behavioral problems per notification from attending physician on 2/22/2013. Resident # 46 -Has expired. Resident # 26 -On 2/21/2013 residents attending physician addressed: rationale for continued use without gradual dose reduction, lab related to Lipitor use, and Celexa use indicating no clinical indication to reduce Celexa since it would be detrimental to the resident. This information was provided to the surveyor on 2/21/2013. Resident has had labs drawn on March18th, 2013 and monthly thereafter. DON or designee will review all residents on a pain regimen to ensure parameters are in place.	

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 _____	02/21/2013

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
F 329	Continued From page 5 the ultram 2 times and the acetaminophen 3 times. In January 2013, R39 had utilized the ultram 3 times and the acetaminophen 4 times. The February 2013 MAR indicated the physician had ordered routine acetaminophen 325 mg 2 tablets by mouth four times daily, and kept the PRN dosage available for use. The February MAR indicated the resident had only used the routine Tylenol and had not used the prn ultram or prn acetaminophen. The minimum data set (MDS) dated 1/4/13 identified R39 as rarely understanding or being understood and having severe decision making capabilities. She had not been on a scheduled pain regimen until February 2013, and received PRN (as needed) pain medications. A pain interview had been attempted with R39 during the MDS assessment, but she had not been able to answer the questions. During an interview with licensed practical nurse (LPN)-A on 2/20/13 at 2:32 p.m., LPN-A verified there were no defined parameters for when to use which of the PRN medications for R39. She stated that if a resident had pain, they would rate it on a 1-10 pain scale. LPN-A said she would, for example, use the acetaminophen if the resident's pain fell between 1-4 on the pain scale, and would use the ultram if the resident rated her pain from 5-10. LPN-A verified however, that R39 was not interviewable and could not express or comprehend the 1-10 pain scale. During an interview with LPN-B on 2/21/13 at 9:30 a.m., she stated that if more than one PRN medication were ordered for pain she would ask the resident what their pain scale rating was on a	F 329	All residents on a drug regimen will be reviewed by a consultant pharmacist by March 24, 2013. The report will include any irregularities and unnecessary drugs identified and that information will be given to the attending physician and director of nursing. Findings will be acted upon Nurses will be educated on unnecessary drugs by March 24th, 2013. It has been our procedure that all residents on anti-psychotics will be reviewed by IDT along with their assessment process and results will be reported to the attending physician for their review. It will be monitored monthly through QAPI committee.	

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 _____	02/21/2013

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
F 329	Continued From page 6 scale of 1-10. She further added that if the pain was below 5 she would give the lesser potent of the medications and if the pain scale rating was above 5 she would administer the stronger pain medication. LPN-B further added that if the resident was a fresh surgical she would automatically give the stronger pain medication. When asked how she would determine which medication to use for a resident such as R39, who was not cognizant, she stated she would assess for non verbal indications of pain and give the medication accordingly. A request was made for a policy regarding specifications/parameters for use of PRN medications, however, nothing further was provided. R50 utilized Reglan (used to treat stomach issues) on a regular basis. Reglan is known to contain metoclopramide which is known to cause potentially harmful side effects. The facility was not monitoring for the potential side effects. R50's record was reviewed. The resident had been admitted to the facility on 6/27/11 with a diagnosis of gastroparesis. Review of the February 2013 physician orders indicated the resident was routinely utilizing the oral medication Reglan 10 mg (milligrams) TID for the treatment of gastroparesis. No monitoring was identified in R50's record of the efficacy of the medication, nor monitoring for tardive dyskinesia (involuntary/repetitive body movements). On February 27, 2009, the Federal Drug	F 329		

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 _____	02/21/2013

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
F 329	Continued From page 7 Administration (FDA) ordered a "black box" warning for medications that contained metoclopramide. The warning highlighted the risk of tardive dyskinesia or involuntary and repetitive movements of the body, with long-term or high-dose usage, even after the drugs are no longer taken. Tardive dyskinesia is characterized by involuntary, repetitive movements of the extremities, lip smacking, grimacing, tongue protrusion, rapid eye movements or blinking, puckering, pursing of the lips, or impaired movement of the fingers. The warning indicated these symptoms are rarely reversible and there is no treatment, and indicated the development of tardive dyskinesia is directly related to the length of time a patient is taking the medication and the number of doses taken. Those at greatest risk were identified to include the elderly, especially older women. R3 utilized more than one pain medication and there were no parameters established to differentiate when which medication should be utilized. R3 was readmitted to the facility on 2/4/13 following a hip fracture. In addition, R3 had the following diagnoses: closed fracture of the femur and vertebral column, osteoarthrosis, osteoporosis and senile dementia. The annual minimum data set (MDS) dated 1/28/13, identified the resident as having a brief interview for mental status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS also indicated R3 was on a scheduled pain medication regimen, received as needed (PRN) pain medications as well as non	F 329		

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 _____	02/21/2013

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
F 329	Continued From page 8	F 329		

medication interventions for pain. The MDS identified a pain assessment as being completed which showed R3 had pain almost constantly, and that the pain limited the resident's day to day activities. The resident's pain was rated as severe. A pain assessment dated 2/8/13 indicated that R3 had expressed moderate pain of the hip daily. The assessment identified the use of narcotics for pain control and indicated the resident was, "unable to describe pain, becomes restless, will occ. (occasionally) say hip hurts and has been waking at night and meds (medications) given."

The current physician order sheet indicated, "oxycodone 5 mg po (by mouth) q 4 hours PRN for closed fracture of unspecified part of femur, unspecified osteoporosis, closed fracture unspecified part of vertebral column and pathologic fracture of vertebrae". The order for the Tylenol indicated, "500 mg 2 tabs po q 6 hours PRN closed fracture of unspecified part of femur." There were no parameters established for when to use the Tylenol and when to use the oxycodone.

The medication administration sheet (MAR) identified that R3 utilized a 25 microgram (mcg) fentanyl (narcotic pain medication) patch that was changed every three days. In addition, R3 had an order for Tylenol 1000 mg (milligrams) q (every) 6 hours PRN, and oxycodone (narcotic pain medication) 5 mg q 4 hours PRN. Review of the MAR's from December 2012 indicated the resident had utilized oxycodone 24 times and Tylenol 1 time; the January 2013 MAR indicated the resident had utilized oxycodone 25 times and Tylenol 5 times; the February 2013 MAR through

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 _____	02/21/2013

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
F 329	Continued From page 9 2/20/13, indicated the oxycodone had been given 17 times and the Tylenol given just 2 times. During interview with RN-A on 2/21/13 at 10:00 a.m., she stated that staff should try the Tylenol for pain first and if no relief was given, then should use the oxycodone. She stated some physicians have defined parameters of 1-5 and 6-10 for use of different medications but did not know why there were none in place for R3. During an interview with LPN-A on 2/21/13 at 10:10 a.m., she verified that there were no defined parameters for use of the Tylenol or the oxycodone. She further added that she would use her nursing judgement. She stated she would ask what their pain rating was (scale of 1-10 with 10 most severe) and if it was a 1-5 she would give Tylenol and if it was a 6-10 she would give the oxycodone. R5 received an antipsychotic medication without an appropriate diagnosis for use. R5's record was reviewed. R5 had been admitted to the facility 6/27/12 with diagnoses including anxiety state and senile dementia. The resident received the antipsychotic medication Seroquel 12.5 mg everyday. No appropriate diagnoses was found for the use of this antipsychotic medication. The care plan dated 1/11/13 indicated R5 utilized psychotropic medications for diagnoses including; depression, dementia and anxiety. During interview with RN-A on 2/20/13 at 2:15 p.m., she stated that the diagnoses for the use of the antipsychotic medication for R5 were anxiety and senile dementia.	F 329		

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 _____	02/21/2013

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
F 329	Continued From page 10 R46 received an antipsychotic medication but did not have an appropriate diagnosis for the use of the medication. R46's record was reviewed. The resident had been admitted to the facility 9/27/13 with diagnoses including senile dementia and vascular dementia. Review of the medical record revealed that R46 received the antipsychotic medication Seroquel 12.5 mg every afternoon, and 25 mg every evening. No appropriate diagnoses was found for the use of the antipsychotic medication. The care plan dated 1/23/13, indicated R46 received psychotropic medications to treat a diagnosis of dementia. During interview with RN-A on 2/20/13 at 1:30 p.m., RN-A stated that the diagnosis for the use of the antipsychotic medication was senile dementia, and confirmed there were no other appropriate diagnoses identified. R26 received a proton pump inhibitor (omeprazole) with no attempt at a gradual dose reduction (GDR) or rationale for continued use at the current dosage, a cholesterol lowering statin medication (lipitor) without laboratory studies to monitor efficacy and side effects, and an antidepressant (celexa) without any attempts at a dosage reduction or justification for lack of a dose reduction. R26 was admitted to the facility 3/13/07 with diagnoses including but not limited to; senile	F 329		

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 _____	02/21/2013

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
F 329	Continued From page 11 dementia, depression, atrial fibrillation, acute kidney failure, esophageal reflux, anemia, and hyperlipidemia. Review of the physician orders revealed R26 had received omeprazole 40 milligrams (mg) one tab daily since 6/13/11, without adequate monitoring for effectiveness, without attempts to reduce the dose, and without a physician statement to justify the continued use of the medication at the same dose. Review of the physician progress notes for the past year revealed no information regarding the resident's continued use of the omeprazole. The continued use of a proton pump inhibitor has been associated with increased incidence of hip, wrist or spine fractures as well as increased risk of infections such as pneumonia and clostridium difficile. The physician orders also indicated R26 took Lipitor 20 mg orally every bedtime. Review of the record failed to include any laboratory monitoring related to the use of this medication. According to the medication leaflet, patients using lipitor should have laboratory tests, including blood cholesterol levels, creatine phosphokinase (CPK) levels, and liver function, performed while using lipitor in order to monitor the reisdent's condition or check for side effects. During an interview with the director of nursing (DON), on 2/21/13 at 11:51 a.m., she confirmed that no laboratory blood work had been performed to monitor the resident's condition or to monitor for side effects in the past year.	F 329		

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 _____	02/21/2013

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
F 329	Continued From page 12 R26 had also been receiving Celexa (an antidepressant) 20 mg daily since 12/19/11, without a reduction in the dosage or a physician statement to justify the continued use of the medication at the same dose. Review of the medical record revealed a Minimum Data Set (MDS) assessment dated 2/4/13, which indicated R26 had scored a 1 on the PHQ 9 (a geriatric depression scale test). The score of 1 indicated mild depression. Data on the MDS indicated depressed or hopeless feelings occurred never, or 1 day in the assessment reference period (ARD). During an interview with the DON on 2/21/13 at 11:51 a.m., she confirmed that a GDR was not attempted on R26's celexa, nor could she locate documentation of physician justification to continue the celexa at the current dose.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	F 428	**F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON** Residents #'s 39, 50, 3, 5, 46, and 26 -Each resident's drug regimen will be reviewed for unnecessary medication usage by a consultant pharmacist on March 21st and 22nd. The report will include any irregularities and unnecessary drugs identified and that information will be given to the attending physician and director of nursing. Findings will be acted upon. Irregularities will be reviewed by DON and attending physician.	

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 _____	02/21/2013

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
F 428	Continued From page 13 consultant pharmacist failed to make recommendations for clinical monitoring, and/or diagnoses specifications, for 6 of 10 residents (R39, R50, R3, R5, R46 and R26) in the sample reviewed for unnecessary medication usage. Findings include: R39 utilized as needed (PRN) pain medications without parameters specified for use. R39 was admitted to the facility on 12/28/12, with diagnoses including: closed fracture of wrist, anxiety state, persistent mental disorder and senile dementia. R39's record was reviewed. Current physician orders indicated the resident utilized acetaminophen 650 mg (milligrams) orally four times a day and had additional orders for acetaminophen 650 mg twice a day PRN, and ultram 50 mg orally every 4 hours PRN, for pain related to a closed fracture of the wrist. There had been no parameters identified or documented in the record to indicate when to use which pain medication. The medication administration record (MAR) for December 2012 identified that R39 had utilized the ultram 2 times and the acetaminophen 3 times. In January 2013, R39 had utilized the ultram 3 times and the acetaminophen 4 times. The February 2013 MAR indicated the physician had ordered routine acetaminophen 325 mg 2 tablets by mouth four times daily, and kept the PRN dosage available for use. The February MAR indicated the resident had only used the routine Tylenol and had not used the prn ultram	F 428	Our policy on "Administering Pain Medications" was reviewed and revised on March 18th, 2013 to include a pain scale, *Wong Baker FACES Pain Scale,* and individualized pain scale parameters for those unable to express their pain. If more than pain PRN medication is ordered, parameters will be ordered by the physician to instruct the nurse on which pain medication to administer based on pain intensity. Nurses will be educated on changes in policy by March 24th, 2013. DON or designee will review all residents on a pain regimen to ensure parameters are in place. Results will be reported to the QAPI.	

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 _____	02/21/2013

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
F 428	Continued From page 14 or prn acetaminophen. The minimum data set (MDS) dated 1/4/13 identified R39 as rarely understanding or being understood and having severe decision making capabilities. She had not been on a scheduled pain regimen until February 2013, and received PRN (as needed) pain medications. A pain interview had been attempted with R39 during the MDS assessment, but she had not been able to answer the questions. During an interview with licensed practical nurse (LPN)-A on 2/20/13 at 2:32 p.m., LPN-A verified there were no defined parameters for when to use which of the PRN medications for R39. She stated that if a resident had pain, they would rate it on a 1-10 pain scale. LPN-A said she would, for example, use the acetaminophen if the resident's pain fell between 1-4 on the pain scale, and would use the ultram if the resident rated her pain from 5-10. LPN-A verified however, that R39 was not interviewable and could not express or comprehend the 1-10 pain scale. During an interview with LPN-B on 2/21/13 at 9:30 a.m., she stated that if more than one PRN medication were ordered for pain she would ask the resident what their pain scale rating was on a scale of 1-10. She further added that if the pain was below 5 she would give the lesser potent of the medications and if the pain scale rating was above 5 she would administer the stronger pain medication. LPN-B further added that if the resident was a fresh surgical she would automatically give the stronger pain medication. When asked how she would determine which medication to use for a resident such as R39,	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 15 who was not cognizant, she stated she would assess for non verbal indications of pain and give the medication accordingly. A request was made for a policy regarding specifications/parameters for use of PRN medications, however, nothing further was provided. A telephone interview with the consulting pharmacist on 2/21/13 at 11:46 a.m., verified that R39 had more than one medication ordered for pain and there had been no parameters identified to determine which pain medication to administer. The pharmacist verified there had been no recommendations related to these concerns in the monthly pharmacy reviews for R39. R50 utilized Reglan (used to treat stomach issues) on a regular basis. Reglan is known to contain metoclopramide which is known to cause potentially harmful side effects. The facility was not monitoring for the potential side effects. R50's record was reviewed. The resident had been admitted to the facility on 6/27/11 with a diagnosis of gastroparesis. Review of the February 2013 physician orders indicated the resident was routinely utilizing the oral medication Reglan 10 mg (milligrams) TID for the treatment of gastroparesis. No monitoring was identified in R50's record of the efficacy of the medication, nor monitoring for tardive dyskinesia (involuntary/repetitive body movements). On February 27, 2009, the Federal Drug	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 16 Administration (FDA) ordered a "black box" warning for medications that contained metoclopramide. The warning highlighted the risk of tardive dyskinesia or involuntary and repetitive movements of the body, with long-term or high-dose usage, even after the drugs are no longer taken. Tardive dyskinesia is characterized by involuntary, repetitive movements of the extremities, lip smacking, grimacing, tongue protrusion, rapid eye movements or blinking, puckering, pursing of the lips, or impaired movement of the fingers. The warning indicated these symptoms are rarely reversible and there is no treatment, and indicated the development of tardive dyskinesia is directly related to the length of time a patient is taking the medication and the number of doses taken. Those at greatest risk were identified to include the elderly, especially older women. During interview with the consultant pharmacist at 11:46 a.m. on 2/21/13, the pharmacist stated she was fully aware of the FDA black box warning but stated the reglan was the most effective medication to treat R50's gastroparesis. The pharmacist confirmed that although she had conducted monthly pharmacy reviews, she had not made any recommendations regarding monitoring for tardive dyskinesia related to R50's routine reglan use. R3 had several pain medications ordered without parameters for use. R3 was readmitted to the facility on 2/4/13 following a hip fracture and had the following	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 17 diagnoses, closed fracture of the femur and vertebral column, osteoarthrosis, osteoporosis and senile dementia. The annual minimum data set (MDS) dated 1/28/13 identified the resident as having a brief interview for mental status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS also indicated R3 was on a scheduled pain medication regimen, received as needed (PRN) pain medications as well as non medication interventions for pain. The MDS identified a pain assessment as being completed which showed R3 had pan almost constantly, and the pain limited the residents day to day activities. The pain was rated as severe. A pain assessment dated 2/8/13, completed upon return from the hospital indicated that R3 identified daily, moderate pain of the hip. The assessment identified the use of narcotics for pain control and indicated the resident was "unable to describe pain, becomes restless, will occ. (occasionally) say hip hurts and has been waking at night and meds given" The medication administration sheet (MAR) identified that R3 was receiving a 25 microgram (mcg) Fentanyl (narcotic pain medication) patch that was changed every three days. R3 also had an order for Tylenol (non narcotic pain medication) 1000 mg (milligrams) q (every) 6 hours PRN and Oxycodone (narcotic pain medication) 5 mg q 4 hours PRN. Review of the MAR's from December 2012 identified Oxycodone given 24 times and Tylenol 1 time, the January 2013 MAR indicated Oxycodone was given 25 times and Tylenol 5 times and February 2013 MAR indicated Oxycodone was	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 18 given 17 times and Tylenol 2 times. The current physician order sheet reads "Oxycodone 5 mg po (by mouth) q 4 hours PRN for closed fracture of unspecified part of femur, unspecified osteoporosis, closed fracture unspecified part of vertebral column and pathologic fracture of vertebrae. The order for the Tylenol reads 500 mg po q 6 hours PRN 2 tabs po q 6 hours PRN closed fracture of unspecified part of femur." No parameters for the use of the Tylenol and Oxycodone was identified. No pharmacy recommendations were made for adding parameters for the use of the pain medications. During an interview with licensed practical nurse A (LPN)-A on 2/21/13 at 10:10 a.m. verified that there were no defined parameters for use of the Tylenol and Oxycodone. She further added that she would use her nursing judgement. She stated she would ask what their pain rating was and if it was a 1-5 she would give Tylenol and if it was a 6-10 she would give the Oxycodone. Interview with registered nurse A (RN)-A on 2/21/13 at 10:00 a.m. stated that staff should try the Tylenol for pain first and if no relief then use the Oxycodone. She stated some physicians have defined parameters of 1-5 and 6-10 for use of different medications but did not know why there were none in place for R3. . During a telephone interview with the consulting pharmacist on 2/22/13 at 11:32 a.m. verified that R3 orders lacked parameters for determining the use of PRN Tylenol and Oxycodone for pain .	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 19 R5 received an antipsychotic medication with no appropriate diagnosis. R5 was admitted to the facility 6/27/12 with diagnoses including anxiety state and senile dementia. Review of the medical record revealed that R5 received the antipsychotic medication Seroquel 12.5 mg (milligrams) everyday. No appropriate diagnoses was found for the use of the antipsychotic medication. The care plan dated 1/11/13 indicated R5 utilized psychotropic medications for diagnosis of depression, dementia and anxiety. Telephone interview with the consultant pharmacist on 2/22/13 at 11:32 a.m. verfied that the diagnosis for R5 (senile dementia) was not appropriate for the use of an antipsychotic. R46 received an antipsychotic medication with no appropriate diagnoses. R46 was admitted to the facility 9/27/13 with diagnoses including senile dementia and vascular dementia. Review of the medical record revealed that R46 received the antipsychotic medication Seroquel 12.5 mg every afternoon and 25 mg every evening. No appropriate diagnoses was found for the use of the antipsychotic medication. The care plan dated 1/23/13 indicated R46 received psychotropic medications for diagnosis of dementia. Telephone interview with the consulting	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 20 pharmacist on on 2/22/13 at 11:32 a.m.verified that the diagnosis for R46 (vascular dementia) was not appropriate for the use of an antipsychotic. R26 received a proton pump inhibitor with no attempt of a gradual dose reduction (GDR) or rationale for continued use at the current dosage. R26 was admitted to the facility 3/13/2007 with diagnoses including but not limited to, senile dementia, depression, atrial fibrillation, acute kidney failure, esophageal reflux, anemia, and hyperlipidemia. Review of the physician orders revealed R26 received the same dose of omeprazole (a proton pump inhibitor used to treat gastritis) 40 milligrams (mg) one tab daily since 6/13/11 without a reduction in the dose, or a physician statement to justify the continued use of the medication at the same dose. Review of the physician progress notes for the past year revealed no information regarding the resident's continued use of the proton pump inhibitor. The continued use of a proton pump inhibitor has been associated with increased incidence of hip, wrist or spine fractures as well as increased risk of infections such as pneumonia and Clostridium difficile. During an interview with the pharmacist on	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 21 2/22/13 at 11:32 a.m., she confirmed that no irregularity had been identified for physician review related to the continued routine use of this medication. R26 also received lipitor 20 mg once a day for elevated lipids. During an interview with the director of nursing (DON), on 2/21/13 at 11:51 a.m., she confirmed that a lipid panel to monitor the effectiveness of the medication, had not been completed in the last year. During an interview with the pharmacist on 2/22/13 at 11:32 a.m., she stated that a request for a lipid panel had been communicated to the facility on 3/31/12. The facility was unable to locate the consultant pharmacist's documentation of the notification of this irregularity. R26 also received celexa (an antidepressant) 20 mg one tab daily since 12/19/11 without a reduction in the dose, or a physician statement to justify the continued use of the medication at the same dose. Review of the medical record revealed a Minimum Data Set (MDS) assessment dated 2/4/13, which indicated R26 had scored a 1 on the PHQ 9 (a geriatric depression scale test), which indicated mild depression. Data on the MDS indicated depressed or hopeless feelings had occurred never, or 1 day in the assessment reference period (ARD). During an interview with the DON on 2/21/13 at 11:51 a.m., she confirmed that a GDR had not	F 428		

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 _____	02/21/2013

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
F 428	Continued From page 22 been attempted for R26's Celexa, nor could she provide documentation from the physician to support continued use at the current dose. During an interview with the pharmacist on 2/22/13 at 11:32 a.m., the pharmacist stated that a request for a GDR on R26's Celexa had been submitted to the facility on 5/13/12, and again on 1/9/13. The facility was unable to provide documentation of these recommendations.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2013**

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
K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Thorne Crest Retirement Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok FS 3-27-13 RECEIVED MAR 22 2013	

DC: 04.02.2013

EXIT: 02.21.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joanna Eckberg	Administrator	3/21/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2013**

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
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Thorne Crest Retirement Center is a 1-story building, with no basement. The facility was built in 1973 and was determined to be of Type II(111) construction. The facility is fully sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 49 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054	**K054** Thorne Crest has and always will comply with yearly testing of its fire alarm system and its bi-annual sensitivity test required by NFPA 101 Life Safety Code Standard.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2013

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
K 054	Continued From page 2 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1 and 7-5.2.2. The deficient practice could affect all 49 residents. Findings include: On facility tour between 10:00 AM and 12:30 PM on 02/20/2013, the review of the annual fire alarm system inspection / test report and the following was found: 1. The annual was not completed with-in a 12 month period. The reports from Trans Alarm indicated the 2012 was completed on 06/12/2012 and 2011 was completed on 05/11/2011. 2. No bi-annual smoke detector sensitivity test report available for review These deficient practices were confirmed by the Administrator (SE) and Environmental Services Director (EH) at the time of discovery.	K 054	Thorne Crest notified its fire alarm company to schedule an annual test and bi-annual sensitivity test to occur on March 14th, 2013. This has occurred and proper documentation supplied. Thorne Crest QAPI committee will review results of the testing at the next QAPI meeting and will assure the next tests are timely. Any discrepancies will be reported to QAPI committee.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	K056 Thorne Crest has and always will properly maintain its sprinkler system.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2013**

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
K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper installation of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7 and 1999 NFPA 13, 5-15.1.1. The deficient practice could affect all 49 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 12:30 PM on 02/20/2013, observation revealed that there is no local waterflow alarm on the exterior of the building by the fire department connection. This deficient practice was confirmed by the Environmental Services Director (EH) at the time of discovery. *TEAM COMPOSITION*	K 056	Thorne Crest has ordered a local water flow alarm for the exterior of the building that will notify the fire department of its location with its sound and light. This was installed and tested on March 18th, 2013. It is in proper working order. A quarterly test will be conducted by the fire alarm company. Results will be reported to the Thorne Crest QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2013**

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
K 056	Continued From page 4 Gary Schroeder, Life Safety Code Spc.	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9363

March 8, 2013

Ms. Shanna Eckberg, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, Minnesota 56007

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5425024

Dear Ms. Eckberg:

The above facility was surveyed on February 19, 2013 through February 21, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

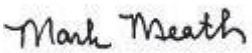
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Mankato Place 12 Civic Center Plaza Suite #2105 Mankato Minnesota 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Maria King at (507) 344-2716.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 19, 20 and 21, 2013 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 2 irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and record review, the consultant pharmacist failed to make recommendations for clinical monitoring, and/or diagnoses specifications, for 6 of 10 residents (R39, R50, R3, R5, R46 and R26) in the sample reviewed for unnecessary medication usage. Findings include: R39 utilized as needed (PRN) pain medications without parameters specified for use.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 3 R39 was admitted to the facility on 12/28/12, with diagnoses including: closed fracture of wrist, anxiety state, persistent mental disorder and senile dementia. R39's record was reviewed. Current physician orders indicated the resident utilized acetaminophen 650 mg (milligrams) orally four times a day and had additional orders for acetaminophen 650 mg twice a day PRN, and ultram 50 mg orally every 4 hours PRN, for pain related to a closed fracture of the wrist. There had been no parameters identified or documented in the record to indicate when to use which pain medication. The medication administration record (MAR) for December 2012 identified that R39 had utilized the ultram 2 times and the acetaminophen 3 times. In January 2013, R39 had utilized the ultram 3 times and the acetaminophen 4 times. The February 2013 MAR indicated the physician had ordered routine acetaminophen 325 mg 2 tablets by mouth four times daily, and kept the PRN dosage available for use. The February MAR indicated the resident had only used the routine Tylenol and had not used the prn ultram or prn acetaminophen. The minimum data set (MDS) dated 1/4/13 identified R39 as rarely understanding or being understood and having severe decision making capabilities. She had not been on a scheduled pain regimen until February 2013, and received PRN (as needed) pain medications. A pain interview had been attempted with R39 during the MDS assessment, but she had not been able to answer the questions.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 4 During an interview with licensed practical nurse (LPN)-A on 2/20/13 at 2:32 p.m., LPN-A verified there were no defined parameters for when to use which of the PRN medications for R39. She stated that if a resident had pain, they would rate it on a 1-10 pain scale. LPN-A said she would, for example, use the acetaminophen if the resident's pain fell between 1-4 on the pain scale, and would use the ultram if the resident rated her pain from 5-10. LPN-A verified however, that R39 was not interviewable and could not express or comprehend the 1-10 pain scale. During an interview with LPN-B on 2/21/13 at 9:30 a.m., she stated that if more than one PRN medication were ordered for pain she would ask the resident what their pain scale rating was on a scale of 1-10. She further added that if the pain was below 5 she would give the lesser potent of the medications and if the pain scale rating was above 5 she would administer the stronger pain medication. LPN-B further added that if the resident was a fresh surgical she would automatically give the stronger pain medication. When asked how she would determine which medication to use for a resident such as R39, who was not cognizant, she stated she would assess for non verbal indications of pain and give the medication accordingly. A request was made for a policy regarding specifications/parameters for use of PRN medications, however, nothing further was provided. A telephone interview with the consulting pharmacist on 2/21/13 at 11:46 a.m., verified that R39 had more than one medication ordered for pain and there had been no parameters identified to determine which pain medication to administer.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 5 The pharmacist verified there had been no recommendations related to these concerns in the monthly pharmacy reviews for R39. R50 utilized Reglan (used to treat stomach issues) on a regular basis. Reglan is known to contain metoclopramide which is known to cause potentially harmful side effects. The facility was not monitoring for the potential side effects. R50's record was reviewed. The resident had been admitted to the facility on 6/27/11 with a diagnosis of gastroparesis. Review of the February 2013 physician orders indicated the resident was routinely utilizing the oral medication Reglan 10 mg (milligrams) TID for the treatment of gastroparesis. No monitoring was identified in R50's record of the efficacy of the medication, nor monitoring for tardive dyskinesia (involuntary/repetitive body movements). On February 27, 2009, the Federal Drug Administration (FDA) ordered a "black box" warning for medications that contained metoclopramide. The warning highlighted the risk of tardive dyskinesia or involuntary and repetitive movements of the body, with long-term or high-dose usage, even after the drugs are no longer taken. Tardive dyskinesia is characterized by involuntary, repetitive movements of the extremities, lip smacking, grimacing, tongue protrusion, rapid eye movements or blinking, puckering, pursing of the lips, or impaired movement of the fingers. The warning indicated these symptoms are rarely reversible and there is no treatment, and indicated the development of tardive dyskinesia is directly related to the length of time a patient is taking the medication and the	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 6 number of doses taken. Those at greatest risk were identified to include the elderly, especially older women. During interview with the consultant pharmacist at 11:46 a.m. on 2/21/13, the pharmacist stated she was fully aware of the FDA black box warning but stated the reglan was the most effective medication to treat R50's gastroparesis. The pharmacist confirmed that although she had conducted monthly pharmacy reviews, she had not made any recommendations regarding monitoring for tardive dyskinesia related to R50's routine reglan use. R3 had several pain medications ordered without parameters for use. R3 was readmitted to the facility on 2/4/13 following a hip fracture and had the following diagnoses, closed fracture of the femur and vertebral column, osteoarthrosis, osteoporosis and senile dementia. The annual minimum data set (MDS) dated 1/28/13 identified the resident as having a brief interview for mental status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS also indicated R3 was on a scheduled pain medication regimen, received as needed (PRN) pain medications as well as non medication interventions for pain. The MDS identified a pain assessment as being completed which showed R3 had pan almost constantly, and the pain limited the residents day to day activities. The pain was rated as severe. A pain assessment dated 2/8/13, completed upon return from the hospital indicated that R3 identified daily, moderate pain of the hip. The assessment identified the use of narcotics for pain control and	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 7 indicated the resident was "unable to describe pain, becomes restless, will occ. (occasionally) say hip hurts and has been waking at night and meds given" The medication administration sheet (MAR) identified that R3 was receiving a 25 microgram (mcg) Fentanyl (narcotic pain medication) patch that was changed every three days. R3 also had an order for Tylenol (non narcotic pain medication) 1000 mg (milligrams) q (every) 6 hours PRN and Oxycodone (narcotic pain medication) 5 mg q 4 hours PRN. Review of the MAR's from December 2012 identified Oxycodone given 24 times and Tylenol 1 time, the January 2013 MAR indicated Oxycodone was given 25 times and Tylenol 5 times and February 2013 MAR indicated Oxycodone was given 17 times and Tylenol 2 times. The current physician order sheet reads "Oxycodone 5 mg po (by mouth) q 4 hours PRN for closed fracture of unspecified part of femur, unspecified osteoporosis, closed fracture unspecified part of vertebral column and pathologic fracture of vertebrae. The order for the Tylenol reads 500 mg po q 6 hours PRN 2 tabs po q 6 hours PRN closed fracture of unspecified part of femur." No parameters for the use of the Tylenol and Oxycodone was identified. No pharmacy recommendations were made for adding parameters for the use of the pain medications. During an interview with licensed practical nurse A (LPN)-A on 2/21/13 at 10:10 a.m. verified that there were no defined parameters for use of the Tylenol and Oxycodone. She further added that she would use her nursing judgement. She stated she would ask what their pain rating was	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 8 and if it was a 1-5 she would give Tylenol and if it was a 6-10 she would give the Oxycodone. Interview with registered nurse A (RN)-A on 2/21/13 at 10:00 a.m. stated that staff should try the Tylenol for pain first and if no relief then use the Oxycodone. She stated some physicians have defined parameters of 1-5 and 6-10 for use of different medications but did not know why there were none in place for R3. . During a telephone interview with the consulting pharmacist on 2/22/13 at 11:32 a.m. verified that R3 orders lacked parameters for determining the use of PRN Tylenol and Oxycodone for pain . R5 received an antipsychotic medication with no appropriate diagnosis. R5 was admitted to the facility 6/27/12 with diagnoses including anxiety state and senile dementia. Review of the medical record revealed that R5 received the antipsychotic medication Seroquel 12.5 mg (milligrams) everyday. No appropriate diagnoses was found for the use of the antipsychotic medication. The care plan dated 1/11/13 indicated R5 utilized psychotropic medications for diagnosis of depression, dementia and anxiety. Telephone interview with the consultant pharmacist on 2/22/13 at 11:32 a.m. verfied that the diagnosis for R5 (senile dementia) was not appropriate for the use of an antipsychotic. R46 received an antipsychotic medication with no appropriate diagnoses. R46 was admitted to the facility 9/27/13 with	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 9 diagnoses including senile dementia and vascular dementia. Review of the medical record revealed that R46 received the antipsychotic medication Seroquel 12.5 mg every afternoon and 25 mg every evening. No appropriate diagnoses was found for the use of the antipsychotic medication. The care plan dated 1/23/13 indicated R46 received psychotropic medications for diagnosis of dementia. Telephone interview with the consulting pharmacist on on 2/22/13 at 11:32 a.m.verified that the diagnosis for R46 (vascular dementia) was not appropriate for the use of an antipsychotic. R26 received a proton pump inhibitor with no attempt of a gradual dose reduction (GDR) or rationale for continued use at the current dosage. R26 was admitted to the facility 3/13/2007 with diagnoses including but not limited to, senile dementia, depression, atrial fibrillation, acute kidney failure, esophageal reflux, anemia, and hyperlipidemia. Review of the physician orders revealed R26 received the same dose of omeprazole (a proton pump inhibitor used to treat gastritis) 40 milligrams (mg) one tab daily since 6/13/11 without a reduction in the dose, or a physician statement to justify the continued use of the medication at the same dose. Review of the physician progress notes for the past year revealed no information regarding the resident's continued use of the proton pump	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 10 inhibitor. The continued use of a proton pump inhibitor has been associated with increased incidence of hip, wrist or spine fractures as well as increased risk of infections such as pneumonia and Clostridium difficile. During an interview with the pharmacist on 2/22/13 at 11:32 a.m., she confirmed that no irregularity had been identified for physician review related to the continued routine use of this medication. R26 also received lipitor 20 mg once a day for elevated lipids. During an interview with the director of nursing (DON), on 2/21/13 at 11:51 a.m., she confirmed that a lipid panel to monitor the effectiveness of the medication, had not been completed in the last year. During an interview with the pharmacist on 2/22/13 at 11:32 a.m., she stated that a request for a lipid panel had been communicated to the facility on 3/31/12. The facility was unable to locate the consultant pharmacist's documentation of the notification of this irregularity. R26 also received celexa (an antidepressant) 20 mg one tab daily since 12/19/11 without a reduction in the dose, or a physician statement to justify the continued use of the medication at the same dose. Review of the medical record revealed a Minimum Data Set (MDS) assessment dated 2/4/13, which indicated R26 had scored a 1 on the PHQ 9 (a geriatric depression scale test), which indicated mild depression. Data on the MDS indicated depressed or hopeless feelings	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21530	Continued From page 11 had occurred never, or 1 day in the assessment reference period (ARD). During an interview with the DON on 2/21/13 at 11:51 a.m., she confirmed that a GDR had not been attempted for R26's Celexa, nor could she provide documentation from the physician to support continued use at the current dose. During an interview with the pharmacist on 2/22/13 at 11:32 a.m., the pharmacist stated that a request for a GDR on R26's Celexa had been submitted to the facility on 5/13/12, and again on 1/9/13. The facility was unable to provide documentation of these recommendations. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assign the interdisciplinary team to review the appropriateness of current medications for all residents, and refer any concerns to the attending physician and/or the consulting pharmacist. The quality assurance committe could randomly audit residents' drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 12 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 6 of 10 residents (R39, R50, R3, R5, R46 and R26) in the sample whose medications were reviewed. Findings include: R39 utilized as needed (PRN) pain medications without parameters specified for use. R39 was admitted to the facility on 12/28/12, with diagnoses including: closed fracture of wrist, anxiety state, persistent mental disorder and senile dementia. R39's record was reviewed. Current physician orders indicated the resident utilized acetaminophen 650 mg (milligrams) orally four times a day and had additional orders for acetaminophen 650 mg twice a day PRN, and	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 13 ultram 50 mg orally every 4 hours PRN, for pain related to a closed fracture of the wrist. There had been no parameters identified or documented in the record to indicate when to use which pain medication. The medication administration record (MAR) for December 2012 identified that R39 had utilized the ultram 2 times and the acetaminophen 3 times. In January 2013, R39 had utilized the ultram 3 times and the acetaminophen 4 times. The February 2013 MAR indicated the physician had ordered routine acetaminophen 325 mg 2 tablets by mouth four times daily, and kept the PRN dosage available for use. The February MAR indicated the resident had only used the routine Tylenol and had not used the prn ultram or prn acetaminophen. The minimum data set (MDS) dated 1/4/13 identified R39 as rarely understanding or being understood and having severe decision making capabilities. She had not been on a scheduled pain regimen until February 2013, and received PRN (as needed) pain medications. A pain interview had been attempted with R39 during the MDS assessment, but she had not been able to answer the questions. During an interview with licensed practical nurse (LPN)-A on 2/20/13 at 2:32 p.m., LPN-A verified there were no defined parameters for when to use which of the PRN medications for R39. She stated that if a resident had pain, they would rate it on a 1-10 pain scale. LPN-A said she would, for example, use the acetaminophen if the resident's pain fell between 1-4 on the pain scale, and would use the ultram if the resident rated her pain from 5-10. LPN-A verified however, that R39 was not interviewable and could not express	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 14 or comprehend the 1-10 pain scale. During an interview with LPN-B on 2/21/13 at 9:30 a.m., she stated that if more than one PRN medication were ordered for pain she would ask the resident what their pain scale rating was on a scale of 1-10. She further added that if the pain was below 5 she would give the lesser potent of the medications and if the pain scale rating was above 5 she would administer the stronger pain medication. LPN-B further added that if the resident was a fresh surgical she would automatically give the stronger pain medication. When asked how she would determine which medication to use for a resident such as R39, who was not cognizant, she stated she would assess for non verbal indications of pain and give the medication accordingly. A request was made for a policy regarding specifications/parameters for use of PRN medications, however, nothing further was provided. R50 utilized Reglan (used to treat stomach issues) on a regular basis. Reglan is known to contain metoclopramide which is known to cause potentially harmful side effects. The facility was not monitoring for the potential side effects. R50's record was reviewed. The resident had been admitted to the facility on 6/27/11 with a diagnosis of gastroparesis. Review of the February 2013 physician orders indicated the resident was routinely utilizing the oral medication Reglan 10 mg (milligrams) TID for the treatment of gastroparesis. No monitoring was identified in R50's record of the efficacy of the medication, nor monitoring for tardive	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 15 dyskinesia (involuntary/repetitive body movements). On February 27, 2009, the Federal Drug Administration (FDA) ordered a "black box" warning for medications that contained metoclopramide. The warning highlighted the risk of tardive dyskinesia or involuntary and repetitive movements of the body, with long-term or high-dose usage, even after the drugs are no longer taken. Tardive dyskinesia is characterized by involuntary, repetitive movements of the extremities, lip smacking, grimacing, tongue protrusion, rapid eye movements or blinking, puckering, pursing of the lips, or impaired movement of the fingers. The warning indicated these symptoms are rarely reversible and there is no treatment, and indicated the development of tardive dyskinesia is directly related to the length of time a patient is taking the medication and the number of doses taken. Those at greatest risk were identified to include the elderly, especially older women. R3 utilized more than one pain medication and there were no parameters established to differentiate when which medication should be utilized. R3 was readmitted to the facility on 2/4/13 following a hip fracture. In addition, R3 had the following diagnoses: closed fracture of the femur and vertebral column, osteoarthrosis, osteoporosis and senile dementia. The annual minimum data set (MDS) dated 1/28/13, identified the resident as having a brief interview for mental status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS also indicated R3 was on a scheduled	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 16	21535		

pain medication regimen, received as needed (PRN) pain medications as well as non medication interventions for pain. The MDS identified a pain assessment as being completed which showed R3 had pain almost constantly, and that the pain limited the resident's day to day activities. The resident's pain was rated as severe. A pain assessment dated 2/8/13 indicated that R3 had expressed moderate pain of the hip daily. The assessment identified the use of narcotics for pain control and indicated the resident was, "unable to describe pain, becomes restless, will occ. (occasionally) say hip hurts and has been waking at night and meds (medications) given."

The current physician order sheet indicated, "oxycodone 5 mg po (by mouth) q 4 hours PRN for closed fracture of unspecified part of femur, unspecified osteoporosis, closed fracture unspecified part of vertebral column and pathologic fracture of vertebrae". The order for the Tylenol indicated, "500 mg 2 tabs po q 6 hours PRN closed fracture of unspecified part of femur." There were no parameters established for when to use the Tylenol and when to use the oxycodone.

The medication administration sheet (MAR) identified that R3 utilized a 25 microgram (mcg) fentanyl (narcotic pain medication) patch that was changed every three days. In addition, R3 had an order for Tylenol 1000 mg (milligrams) q (every) 6 hours PRN, and oxycodone (narcotic pain medication) 5 mg q 4 hours PRN. Review of the MAR's from December 2012 indicated the resident had utilized oxycodone 24 times and Tylenol 1 time; the January 2013 MAR indicated the resident had utilized oxycodone 25 times and Tylenol 5 times; the February 2013 MAR through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 17 2/20/13, indicated the oxycodone had been given 17 times and the Tylenol given just 2 times. During interview with RN-A on 2/21/13 at 10:00 a.m., she stated that staff should try the Tylenol for pain first and if no relief was given, then should use the oxycodone. She stated some physicians have defined parameters of 1-5 and 6-10 for use of different medications but did not know why there were none in place for R3. During an interview with LPN-A on 2/21/13 at 10:10 a.m., she verified that there were no defined parameters for use of the Tylenol or the oxycodone. She further added that she would use her nursing judgement. She stated she would ask what their pain rating was (scale of 1-10 with 10 most severe) and if it was a 1-5 she would give Tylenol and if it was a 6-10 she would give the oxycodone. R5 received an antipsychotic medication without an appropriate diagnosis for use. R5's record was reviewed. R5 had been admitted to the facility 6/27/12 with diagnoses including anxiety state and senile dementia. The resident received the antipsychotic medication Seroquel 12.5 mg everyday. No appropriate diagnoses was found for the use of this antipsychotic medication. The care plan dated 1/11/13 indicated R5 utilized psychotropic medications for diagnoses including; depression, dementia and anxiety. During interview with RN-A on 2/20/13 at 2:15 p.m., she stated that the diagnoses for the use of the antipsychotic medication for R5 were anxiety and senile dementia. R46 received an antipsychotic medication but did	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 18 not have an appropriate diagnosis for the use of the medication. R46's record was reviewed. The resident had been admitted to the facility 9/27/13 with diagnoses including senile dementia and vascular dementia. Review of the medical record revealed that R46 received the antipsychotic medication Seroquel 12.5 mg every afternoon, and 25 mg every evening. No appropriate diagnoses was found for the use of the antipsychotic medication. The care plan dated 1/23/13, indicated R46 received psychotropic medications to treat a diagnosis of dementia. During interview with RN-A on 2/20/13 at 1:30 p.m., RN-A stated that the diagnosis for the use of the antipsychotic medication was senile dementia, and confirmed there were no other appropriate diagnoses identified. R26 received a proton pump inhibitor (omeprazole) with no attempt at a gradual dose reduction (GDR) or rationale for continued use at the current dosage, a cholesterol lowering statin medication (lipitor) without laboratory studies to monitor efficacy and side effects, and an antidepressant (celexa) without any attempts at a dosage reduction or justification for lack of a dose reduction. R26 was admitted to the facility 3/13/07 with diagnoses including but not limited to; senile dementia, depression, atrial fibrillation, acute kidney failure, esophageal reflux, anemia, and hyperlipidemia. Review of the physician orders revealed R26 had received omeprazole 40 milligrams (mg) one tab daily since 6/13/11, without adequate monitoring	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 19 for effectiveness, without attempts to reduce the dose, and without a physician statement to justify the continued use of the medication at the same dose. Review of the physician progress notes for the past year revealed no information regarding the resident's continued use of the omeprazole. The continued use of a proton pump inhibitor has been associated with increased incidence of hip, wrist or spine fractures as well as increased risk of infections such as pneumonia and clostridium difficile. The physician orders also indicated R26 took Lipitor 20 mg orally every bedtime. Review of the record failed to include any laboratory monitoring related to the use of this medication. According to the medication leaflet, patients using lipitor should have laboratory tests, including blood cholesterol levels, creatine phosphokinase (CPK) levels, and liver function, performed while using lipitor in order to monitor the reisdent's condition or check for side effects. During an interview with the director of nursing (DON), on 2/21/13 at 11:51 a.m., she confirmed that no laboratory blood work had been performed to monitor the resident's condition or to monitor for side effects in the past year. R26 had also been receiving Celexa (an antidepressant) 20 mg daily since 12/19/11, without a reduction in the dosage or a physician statement to justify the continued use of the medication at the same dose. Review of the medical record revealed a Minimum Data Set (MDS) assessment dated 2/4/13, which indicated R26 had scored a 1 on	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21535	Continued From page 20 the PHQ 9 (a geriatric depression scale test). The score of 1 indicated mild depression. Data on the MDS indicated depressed or hopeless feelings occurred never, or 1 day in the assessment reference period (ARD). During an interview with the DON on 2/21/13 at 11:51 a.m., she confirmed that a GDR was not attempted on R26's celexa, nor could she locate documentation of physician justification to continue the celexa at the current dose. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21800	Continued From page 21 provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to provide at least 48-hours notice of denial of Medicare benefits for 1 of 3 Medicare beneficiaries (R58) in the sample. Findings include: R58 did not receive notice 48 hours prior to denial of Medicare benefits. R58 was admitted to the facility on 10/2/12. The resident was provided notice and signed the Medicare Provider Non-Coverage notice on 10/16/12, indicating services would end that same day. R58 continued to reside in the facility until discharge on 10/20/12. During an interview at 11:26 a.m. on 2/21/13,	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	02/21/2013

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) COMPLETE DATE
21800	Continued From page 22 registered nurse (RN)-A verified the findings and indicated the notice should have been given two days prior but was not provided as required. SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate designated staff members on the appropriate process for Medicare liability and appeal notice and timeframes. The administrator or designee could develop monitoring systems to ensure ongoing compliance with the Medicare denial process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		