Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 2, 2024

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

RE: CCN: 245425
Cycle Start Date: October 26, 2023

Dear Administrator:

On December 20, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
November 16, 2023

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

RE: CCN: 245425
Cycle Start Date: October 26, 2023

Dear Administrator:

On October 26, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by January 26, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by April 26, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING _____ B. WING _____	C 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/23/23 - 10/26/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/23/23 - 10/26/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54256643C (MN95634), H54256647C (MN96259), H54256646C (MN93017), H54256644C (MN93018), H54256642C (MN93019), H54256645C (MN95712), H54256834C (MN96737). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/24/2023

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		12/15/23

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F 622	Continued From page 2 discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F 622		

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F 622	Continued From page 3 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate and required information was documented and communicated to a receiving healthcare facility to ensure continuity of care when transferred emergently to the hospital for 1 of 2 residents (R3) reviewed for hospitalizations. Finding include: R3 was admitted to the facility on 11/15/21. R3's diagnoses listed on face sheet received on 10/27/23, included Alzheimer's disease (abnormal brain disorder), type 2 diabetes mellitus ((DM)-abnormal blood sugar), muscle weakness, spondylosis (spinal degeneration), chronic kidney disease (CKD), difficulty walking, history of falling, transient ischemic attack ((TIA)-stroke), major depressive disorder (mood disorder), neuromuscular dysfunction of bladder (bladder dysfunction), fatigue, and physical debility. R3's quarterly minimum data set (MDS) assessment dated 7/27/23, identified R3 had intact cognition, had clear speech, was able to understand others and was understood by others. R3 required substantial/maximal assistance from	F 622	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal regulations of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with the State Operations Manual. Thorne Crest has and always will permit each resident to remain in the facility, and not transfer of discharge the resident from the facility unless the transfer/discharge is necessary for the resident□s welfare and the resident□s needs cannot be met in the facility. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The health of individuals in the facility would	

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F 622	Continued From page 4 1 staff member for all activities of daily living (ADLs), had no impairment of extremities, and used a walker and wheelchair for mobility. Nursing progress noted date 9/7/23 at 5:36 a.m., indicated R3 observed to have very dark colored urine, possible blood present, vital signs (VS) stable. Staff to encourage R3 to push fluids. Nursing progress note dated 9/7/23 at 10:29 a.m., indicated R3 had a change in condition, R3 exhibiting symptoms of confusion, inability to speak clearly, had to be assisted by 2 staff for transfers, needed staff assistance with feeding breakfast, had shortness of breath (SOB), and had tachycardia (fast heart rate). Nursing staff transported R3 per facility vehicle to emergency room (ER) for further evaluation. R3's representative was notified of R3's change in condition and transfer to ER. Nursing progress noted dated 9/7/23 at 2:49 p.m. indicated R3 was admitted to hospital for sepsis (blood infection), acute kidney injury, and urinary tract infection (UTI). Review of R3's medical record indicated provider was notified of R3's change in condition and need for hospital transfer for further evaluation of symptoms, verbal order authorized per physician on 9/7/23. Review of R3's medical record lacked sufficient documentation that a notice of transfer had been provided and/or communicated to receiving hospital including physician caring for R3, resident's emergency contact information, and relevant information including (usual physical/mental functioning, advance directive,	F 622	otherwise be endangered. R3□s notice of transfer or discharge was signed on 9/7/2023. Notice was faxed to Ombudsman on 9/11/2023. See Attachment A-1 Transfer or Discharge Documentation Policy was reviewed. No changes are needed. See Attachment A-2 Whole house audit conducted. No other residents were identified during the audit. See Attachment A-4 To ensure all residents in similar situations are protected the facility will review all transfers/discharges daily (M-F) to verify appropriate paperwork has been completed and scanned into individual Electronic Health Records. A Notice of Transfer/Discharge Log has been developed and implemented to monitor that pertinent information is sent and shared with the receiving facility. All transfers/discharges log will be reviewed daily (M-F) to verify copies of the notice is given to the resident, receiving facility, scanned into resident Electronic Health Records, and faxed to Ombudsman. See Attachment A-5 To ensure that this problem does not recur all Transfer/Discharge forms will be scanned into Electronic Health Records upon transfer/discharge to the hospital. Education provided to nursing department	

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F 622	Continued From page 5 diagnosis, allergies, medication administration record (MAR), treatment administration record (TAR), care plan, discharge summary, and any special instructions). During an interview on 10/26/23 at 9:07 a.m., licensed practical nurse (LPN)-A indicated process for resident emergent transfer to hospital consisted of notifying the physician to update on status concerns and request orders to transfer resident to hospital for further evaluation. LPN-A stated staff were to fill out a transfer packet, located in transfer book behind nursing station. LPN-A indicated transfer packet consisted of the resident's face sheet, provider orders for life-sustaining treatment (POLST), a transfer checklist, ambulance questionnaire, a bed hold form, and a communication form for hospital titled Mayo Clinic SNF to Hospital Referral. LPN-A stated resident representative was contacted to update on resident status change and need for hospital transfer. LPN-A indicated transfer packet completed prior to resident transfer, packet provided to emergency medical services (EMS) at time of transport. LPN-A stated staff do not typically keep a copy of the communication form provided to receiving hospital, indicated information provided to receiving hospital should be documented in nursing progress notes. LPN-A reviewed R3's nursing progress notes in medical record from 9/7/23 hospital transfer, confirmed progress notes lacked documentation of the communication provided to receiving hospital. While interviewed on 10/26/23 at 12:47 p.m., the assistant director of nursing (ADON), indicated staff were to complete a transfer packet when sending residents emergently to hospital, and	F 622	on 11/1/23 and 11/8/23. Education included scanning documents into resident electronic medical records upon completion i.e.: Notice of transfer/discharge forms, CODE status T.O□s, POLST□s once signed and bed holds. See Attachment A-3 The Assistant Director of Nursing provided training and education of Transfer or Discharge Documentation Policy to Licensed Nurses on 11/01/2023. See Attachment A-3 To ensure compliance, Social Services Director/designee has initiate audits to ensure all residents are provided Transfer/Discharge Notice according to guidelines daily (M-F) for 2 weeks, then weekly for 4 weeks, and monthly for one month with results being reported to QAPI. See Attachment A-4	

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F 622	Continued From page 6 further stated transfer packet could be found in transfer book located behind nursing station. The ADON reported transfer packet contained resident's face sheet, resident's POLST, a bed hold form, an ambulance form, and a hospital transfer communication form. The ADON indicated it was her expectation for staff to keep a copy of transfer form provided to receiving hospital and document details in nursing progress note of communication provided to receiving hospital. The ADON reviewed R3's medical record, confirmed unable to find 9/7/23 hospital transfer communication form, verified nursing progress notes from 9/7/23 lacked documentation of the communication provided to receiving hospital. The facility Transfer or Discharge Documentation policy revised 12/16, indicated when a resident is transferred or discharged, details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. 4) When a resident is transferred or discharged from the facility, the following will be documented in the resident's medical record a. The basis for the transfer or discharge b. That an appropriate notice was provided to the resident and/or legal representative c. The date and time of the transfer or discharge d. The new location of the resident e. The mode of transportation f. A summary of the resident's overall medical, physical, and mental condition 7) Should a resident be transferred or	F 622		

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F 622	Continued From page 7 discharged for any reason, the following information will be communicated to the receiving facility or provider a. The basis for the transfer or discharge b. Contact information of the practitioner responsible for the care of the resident c. Resident representative information including contact information d. Advance directive information e. All special instructions or precautions for ongoing care, as appropriate f. Comprehensive care plan goals, and g. All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the current status and needs for 1 of 1 resident (R9) reviewed for accuracy of the MDS. Findings include: R9 was admitted to the facility on 12/21/22, with diagnoses (located on the face sheet) dated 10/26/23, including radial nerve lesion (injury to the nerve in the arm that may cause pain,	F 641	Thorne Crest has and always will ensure that the Minimum Data Set (MDS) accurately reflects the current status and needs of all residents. R9□s Minimum Data Set (MDS) was corrected on 10/27/2023. See Attachment B-4 for correction ensuring MDS is accurate. See Attachment B-1 All like residents have been reviewed. No other residents were identified during the	12/15/23

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F 641	Continued From page 8 weakness, numbness and tingling) of the upper left arm and muscle weakness. Interview and observation on 10/25/23, at 9:30 a.m. R9 was observed to have a splint on her left hand/arm. R9 stated she wears a splint during the day, to hold her arm in place due to weakness. R9 was unable to lift her arm, more than an inch off the armrest of the chair. R9 indicated she has not been able to use her left arm for at least the past year, due to weakness. R9 also was unable to open her fingers, without using her right hand to manually open. R9's occupational therapy (OT) discharge note dated 7/19/23, indicated R9 received OT services to strengthen ROM in the left upper extremity. The note indicated R9 utilizes a left hand splint. R9's significant change Minimum Data Set (MDS) dated 7/27/23, indicated R9 required extensive assistance with all activities of daily living (ADL's). The MDS indicated R9 did not have any upper extremity impairment, related to a decrease in range of motion (ROM). Although R9 had been identified as having limited ROM in the upper left extremity prior to the MDS assessment, the MDS had been coded incorrectly by not identifying R9's impairment. Interview on 10/26/23 at 1:00 p.m., the MDS coordinator confirmed an error in coding had been made on the current MDS, and had not identified R9's impairment in ROM. The MDS coordinator further indicated, did not realize he coded this incorrectly. Interview on 10/26/23 at 1:30 p.m., the assistant	F 641	audit. See Attachment B-3 To ensure that this problem does not recur all residents with splints/assistive devices will be reviewed bi-weekly at PDPM Meeting to determine the need for therapy referral accuracy of the functional ability assessment and Care Plan. Comprehensive Assessment Policy reviewed. No changes are needed. See Attachment B-2 To ensure compliance, the Director of Nursing/designee has initiate audits to verify accuracy of a splint/assistive devices assessment weekly x4 weeks, monthly x2 months then quarterly with MDS schedule with results being reported to the QAPI committee.	

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	245425	A. BUILDING _____ B. WING _____	C 10/26/2023

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F 641	Continued From page 9 director of nursing (ADON) confirmed the above coding error on R9's current MDS. A policy was requested, but none provided.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		12/15/23

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F 656	Continued From page 10 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan had been developed for 1 of 1 resident (R9) who had an impairment in range of motion (ROM) and utilized a splint. Findings included: R9 was admitted to the facility on 12/21/22, with diagnoses (located on the face sheet) dated 10/26/23, including radial nerve lesion (injury to the nerve in the arm that may cause pain, weakness, numbness and tingling) of the upper left arm and muscle weakness. Interview and observation on 10/25/23, at 9:30 a.m. R9 was observed to have a splint on her left hand/arm. R9 stated she wears a splint during the day, to hold her arm in place due to weakness. R9 was unable to lift her arm, more than an inch off the armrest of the chair. R9 indicated she has not been able to use her left arm for at least the past year, due to weakness. R9 also was unable to open her fingers, without using her right hand	F 656	Thorne Crest has and always will ensure that a comprehensive person-centered care plan is developed and implemented for each resident. R9□s Comprehensive Care Plan has been reviewed and updated. See Attachment C-1 All like residents have been reviewed. No other residents were identified during the audit. See Attachment B-3 To ensure that this problem does not recur all residents with splints/assistive devices will be reviewed bi-weekly at PDPM Meeting to determine the need for therapy referral accuracy of the functional ability assessment and splint/assistive devices Care Plan. IDT will review splint/assistive devices Care Plans in line with Care Conference calendar to ensure accuracy.	

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F 656	Continued From page 11 to manually open. R9's occupational therapy (OT) discharge note dated 7/19/23, indicated R9 received OT services to strengthen ROM in the left upper extremity. The note indicated R9 utilizes a left hand splint and had been given instructions, to continue ROM in the left hand/arm. R9's significant change Minimum Data Set (MDS) dated 7/27/23, indicated R9 required extensive assistance with all activities of daily living (ADL's). R9 had been identified as having no impairment in cognition. R9's current care plan dated 10/26/23, indicated R9 required extensive assistance with ADL's including the upper body for dressing, due to weakness and deconditioning. The care plan did not include R9 having impairment in ROM to the right extremity, nor did it include interventions related to the use of a splint or ROM exercises. Interview on 10/26/23 at 1:00 p.m., the MDS coordinator confirmed R9's impairment of the right extremity had not been identified in the plan of care, nor were there interventions included to prevent further decline. Interview on 10/26/23 at 1:30 p.m., the assistant director of nursing (ADON) confirmed the care plan should have identified R9's right hand/arm impairment as well as interventions implemented, to prevent further decline in ROM. A policy was requested, but none provided.	F 656	Care Plans, Comprehensive Person-Centered Policy reviewed. No changes are needed. See Attachment C-2 To ensure compliance, the Director of Nursing/designee has initiated audits to verify accuracy of splint/assistive devices Care Plans weekly x4 weeks, monthly x2 months then quarterly with MDS schedule with results being reported to the QAPI committee.	
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		12/15/23

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F 678	Continued From page 12 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident cardiopulmonary (CPR) life support orders were included in the medical record for 1 of 12 residents (R10) reviewed for advanced directives (AD). Findings include: R10's 10/13/23, admission Minimum Data Set (MDS) assessment identified R10 had diagnoses of coronary artery disease, high blood pressure, kidney disease, anxiety, and depression. Review of R10's current medication orders on 10/24/23 at 10:37 a.m., did not include an AD or physician ordered life-sustaining treatment (POLST). Review of R10's current electronic and paper medical record on 10/24/23 at 10:37 a.m., did not include an AD or POLST. Interview on 10/24/23 at 1:15 p.m., licensed practical nurse (LPN)-A identified if a resident's heart stopped she would look in the residents electronic medical record to find an AD order, LPN-A identified that she was unable to find an AD, or POLST in R10's medical record. LPN-A further identified she was not able to locate a POLST in R10's paper charting in the medical	F 678	Thorne Crest has and always will ensure that our residents cardiopulmonary (CPR) life support orders are included in the Electronic Medical Records upon admission. R10□s POLST has been uploaded in residents Electronic Medical Records. See Attachment D-1 All admissions will have a code status immediately upon admission. A whole house audit was conducted on 10/24/2023. All residents have active code status in Electronic Medical Records See Attachment D-2 The Assistant Director of Nursing provided training and education to the nursing department on the importance of prompt uploading of code status/POLST into Electronic Health Record on 11/1/23 and 11/8/23. Training on scanning items into Medical Health Records completed on 11/8/23. See Attachment A-3 To ensure compliance, the Director of Nursing/designee has initiate audits weekly x4 weeks, monthly x2 months then	

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F 678	Continued From page 13 record. LPN-A identified she would do cardiopulmonary resuscitation (CPR) if she was not able to find an AD order in the medical record. Interview on 10/24/23 at 1:37 p.m., with assistant director of nursing (ADON) identified she was responsible for completing a POLST with residents upon admission. The ADON reported they used to email the POLST to the physician or nurse practitioner, but they have been asked by the provider not to do that anymore. The ADON reported that currently the POLST is placed in a folder for the rounding nurse practitioner or physician to review and sign the next time they are at the facility. The ADON identified the nurse practitioner is at the facility 3 to 4 days a week. The ADON identified that while the POLST is waiting to be signed they will "sometimes" enter the code status into the electronic medical record. however, in this instance they did not do that. ADON was unable to locate R10's POLST in the medical record or in the providers folder at the time of the interview. Interview on 10/24/23 at 2:38 p.m., with ADON identified she found the POLST in the medical records office in a basket of papers on a desk waiting to be scanned into the electronic medical record. ADON identified she would update the medical record immediately. Review of R10's POLST identified it had been completed and signed by the family and nurse practitioner on 10/12/23, 13 days prior to 10/24/23. Interview on 10/25/23 at 4:00 p.m., with administrator agreed with findings and identified that she would expect the medical record to be	F 678	quarterly with MDS schedule with results being reported to the QAPI committee. See Attachment D-3	

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F 678	Continued From page 14 updated with the residents or representatives advanced directive wishes upon admission. The facility Advance Directives policy undated, identified the POLST would be completed upon admission and reviewed annually with each resident.	F 678		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate treatment and services were provided to maintain and/or improve hearing and communication for 1 of 1 resident (R3) reviewed for communication-sensory. Findings include: R3 was admitted to facility on 11/15/21. R3's medicare 5-day Minimum Data Set (MDS) assessment dated 9/14/23, indicated R3 had intact cognition, had clear speech, was able to	F 685	Thorne Crest has and always will ensure that all residents receive appropriate treatment and services are provided to maintain and/or improve hearing and communication for communication sensory. R3 has a scheduled appointment with Hearing Associates of Albert Lea on 11/29/23. Whole house audit conducted. No issues noted. See Attachment E-1	12/15/23

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F 685	Continued From page 15 understand others, was understood by others, and had moderate difficulty hearing, no assistive hearing devices. R3's care plan printed on 10/27/23, indicated R3 had alteration/potential alteration in perception related to understanding, hearing moderately impaired, did not wear hearing aids. Goal for R3 would be to communicate needs/wants or needs would be anticipated and met. R3's interventions included for staff to allow time to understand and respond, repeat if necessary, keep communication simple, and speak directly to and facing resident. R3's progress notes in medical record identified on 5/2/23 at 10:50 a.m., a care conference was held with staff, R3, and R3's family. R3's progress notes identified staff would make appt. (appointment) to get hearing aids. During an observation and interview on 10/23/23 at 3:59 p.m., R3 noted to be very hard of hearing, surveyor had to communicate with R3 approximately 6 inches away from her face for R3 to hear surveyor. Surveyor needed to speak slowly and clearly, had to repeat messages several times for R3 to understand, R3 observed occasionally to try to read surveyors lips when speaking. R3 indicated she could not hear well, did not have hearing aids. R3 stated staff aware of her difficulty hearing, unsure if staff were following up on hearing concerns, R3 indicated she would like to have hearing aids if able to. While interviewed on 10/25/23 at 1:39 p.m., nursing assistant (NA)-A indicated awareness of R3 being hard of hearing since time of admission, had no hearing aids since time of admission.	F 685	Hearing/Vision/Dental will be addressed upon Admission and quarterly during Care Conference to determine resident/family preference. Upon resident/family request appointments will be set up with preferred provider by facility staff and documented in Electronic Medical Record. To ensure compliance, the Social Services Director/designee will initiate audits weekly x4 weeks, monthly x2 months then quarterly with MDS schedule with results being reported to the QAPI committee.	

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F 685	Continued From page 16 NA-A reported can communicate with R3 ok, stated had to get up close to R3's face so R3 could read lips. NA-A indicated had to speak slowly and loudly for R3 to hear. During an interview on 10/26/23 at 9:15 p.m., licensed practical nurse (LPN)-A indicated awareness R3 was hard of hearing since time of facility admission and had not changed since that time. LPN-A stated unawareness of R3 having any hearing aids. LPN-A reported when communicating with R3, LPN-A had to be directly in front of R3's face for R3 to read lips. LPN-A stated she had to enunciate more clearly and speak louder due to R3's difficulty hearing. LPN-A indicated was unaware of any hearing evaluations R3 has had since time of admission or any discussions with R3's family members regarding difficulty hearing and need for hearing evaluation since time of R3's admission. LPN-A indicated having a hearing evaluation for R3 would be beneficial as R3 may need hearing aids which could improve R3's hearing and communication. While interviewed on 10/26/23 at 12:53 p.m., the assistant director of nursing (ADON) indicated awareness R3 was hard of hearing and had been hard of hearing since facility admission. The ADON stated R3's hearing had worsened over past 6-9 months,and indicated unawareness R3 had ever had a hearing evaluation since admission. The ADON reported R3 did not have hearing aids. The ADON indicated during care conferences staff discuss with residents and families regarding overall health concerns including vision, hearing, and dental. The ADON reviewed R3's past care conference notes in medical record, stated on 5/2/23 staff discussed	F 685		

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F 685	Continued From page 17 with resident and resident's family scheduling an appt. for hearing aids, indicated staff responsible to schedule appt. for hearing aids. The ADON confirmed R3's medical record and resident appt. book for scheduled hearing appt., identified no record of R3 scheduled for hearing appt. and should have been. The ADON indicated would follow-up to ensure R3 was scheduled for hearing appt. Facility policy for hearing-communication requested but not received.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were implementing fall risk prevention measures for 2 of 3 residents (R18, R31) reviewed for accidents. Findings include: R31's face sheet printed on 10/27/23, indicated R31's diagnoses included traumatic subdural hemorrhage (brain bleed), history of falling, bradycardia (slow heart rate), congestive heart failure (CHF), chronic kidney disease (CKD), and atrial fibrillation (irregular heartbeat).	F 689	Thorne Crest has and always will ensure that all residents with falls will have fall risk prevention measures implemented immediately after a fall. R31 expired on 10/26/2023. R18 Care Plan reviewed and updated with interventions. See Attachment F-1 Whole house audit conducted. All identified residents during the audit had interventions updated and added to Care	12/15/23

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F 689	Continued From page 18 R31's quarterly Minimum Data Set (MDS) assessment dated 10/5/23, indicated R31 had intact cognition, displayed verbal behaviors towards others occasionally 1-3 days/7 days, did not reject cares or wander. R31 required extensive assistance from 1 staff for bed mobility, transfers, dressing, toileting, personal hygiene. R31 had impairment to one upper and one lower extremity, did not walk, used a wheelchair for mobility, on hospice. R31's fall risk assessment dated 10/4/23, indicated R31 was at high risk for falls due to intermittent confusion, history of 1-2 falls in past 3 months, unable to walk, had poor vision, required use of assistive devices for gait/balance, was taking psychotropic medications (lorazepam for anxiety) and sedatives (morphine for pain), had predisposing diseases including subdural hemorrhage and history of falls. R31's care plan printed on 10/27/23, indicated R31 at risk for falls due to history of falls, poor balance, unsteady gait related to multiple falls and subdural hematoma. Goal for R31 to not fall and injure self. R31's interventions for falls put in place at time of admission on 7/3/23, included staff to ensure bed in low position, fall mat next to bedside, gripper socks on at bedtime; mobility assist bars on bed to aid in positioning and mobility, ensure appropriate footwear on at all times with a non-skid sole, keep call-light within reach when in room. R31's care plan reviewed did not indicate any new fall interventions since admission. Facility progress note dated 8/5/23 at 6:57 a.m., indicated R31 activated call light in room, staff	F 689	Plans as indicated in the attachment. To ensure that this problem does not recur all residents have baseline fall care plans upon admission in place. Based on assessment, care plan interventions are individualized. See Attachment F-2 Falls Policy reviewed. No changes are needed. See Attachment F-3 To ensure that this problem does not recur all falls will be reviewed at morning IDT meetings daily (M-F) to verify interventions are appropriate. Any fall incident will be audited for immediate interventions and fall risk care plans will be reviewed per care plan schedule for appropriateness of current interventions. Assistant Director of Nursing provided education to Licensed Nurses on importance of implementing a fall risk intervention immediately after every fall. List of potential interventions provided to all Licensed Nurses via email and placed in Nurse report binder at HCW desk. Fall policy was reviewed with Licensed Nurses. See Attachment A-3 To ensure compliance, the Director of Nursing/designee will initiate audits to verify all fall incidents have interventions added to fall risk care plans weekly x4 weeks, monthly x2 months then quarterly with MDS schedule with results being reported to the QAPI committee.	

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F 689	Continued From page 19 responded to unwitnessed fall, R31 sitting upright on floor in front of recliner with legs extended in front of him, R31 stated he wanted to get back into bed, slid off end of recliner, sat on floor. R31 sustained skin tear below left elbow. Facility progress note of post-fall evaluation from 8/5/23 incident completed on 8/5/23 at 7:22 a.m., indicated root cause of fall due to R31 self-transferring. Progress note did not indicate intervention to prevent further falls. Facility progress note dated 10/15/2023 at 12:00 p.m., indicated R31 had unwitnessed fall in room, R31 found sitting on floor in front of recliner chair, R31 reported was adjusting self in recliner chair and slid from chair onto floor. R31 sustained no injuries from fall. Progress note did not indicate intervention to prevent further falls. Facility progress note dated 10/16/2023 at 5:11 p.m., indicated R31 had unwitnessed fall from bed, landed on floor mat on floor beside bed, no injuries from fall. Root cause of fall due to restlessness and confusion, lorazepam provided for comfort, R31 assisted per staff to recliner in dayroom to be monitored more closely. Progress note did not indicate intervention to prevent further falls. Facility progress note dated 10/17/2023 at 2:27 a.m., indicated R31 had unwitnessed fall in room, call-light on at time, staff found R31 on floor with back against the bed, R31's legs stretched out in front of him. R31 unable to report cause of fall, stated repeatedly to staff to put him back in bed. R31 assisted per staff to recliner in dayroom to be monitored more closely. Progress note did not indicate intervention to prevent further falls.	F 689		

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F 689	Continued From page 20 Facility progress note dated 10/17/2023 at 5:53 p.m., indicated R31 had unwitnessed fall in room, R31 found per staff on floor next to bedside on hands and knees, forehead leaning against side of bed. R31 observed to have redness and minimal swelling to forehead. Staff assisted R31 into recliner in dayroom for closer monitoring. Progress note did not indicate intervention to prevent further falls. During an observation and interview on 10/23/23 at 7:18 p.m., R31 noted in room, lying in center of bed on backside, appeared calm, was sleeping. R31's bed visualized positioned lower to floor, fall mat folded up and placed against wall, call-light within reach, family at bedside. Family member (FM)-D indicated R31 was admitted to facility following a fall and sustaining a head injury this past summer, stated R31 was on hospice and progressively declining medically. FM-D stated R31 had some falls since facility admission, had 4 falls in last 2 weeks, had not sustained any major injuries since admission. FM-D indicated staff always contacted family to update on R31's falls, reported unawareness of what facility was doing to prevent falls for R31, stated unaware of plans for further fall prevention measures when R31 had fallen. While interviewed on 10/25/23 at 1:27 p.m., nursing assistant (NA)-A indicated awareness of R31 having fallen since facility admission, stated R31 required 1 staff to assist with transfers and toileting, indicated R31 did not ambulate, was impulsive and often tried to self-transfer. NA-A indicated awareness of fall interventions for R31 and included ensuring fall mat next to bedside when R31 was lying in bed and R31 needed	F 689		

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F 689	Continued From page 21 frequent supervision by staff due to his impulsiveness and history of self-transfers. During an interview on 10/26/23 at 8:35 a.m., licensed practical nurse (LPN)-A indicated awareness R31 at risk for falls and has had a couple of falls since admission. LPN-A indicated process for when a resident fell was for licensed nurse to complete an initial assessment on resident, licensed nurse contacted physician and resident representative to update on fall incident, licensed nurse informed assistant director of nursing (ADON), DON, and administrator of resident fall. LPN-A indicated a fall intervention should be put into place for a resident immediately every time a fall occurred, stated the DON followed up on the new fall intervention put into place to determine appropriateness, reported the DON followed up on new fall intervention typically next day after fall incident occurred. While interviewed on 10/26/23 at 8:51 a.m., the ADON indicated when a resident falls, a fall incident report was to be completed per staff, stated staff were aware to implement a new fall intervention for residents after each fall occurrence. The ADON reported the previous DON would evaluate the appropriateness and make changes if needed to a resident's new fall intervention implemented on the next day following the fall and update the resident's care plan, stated the interim DON was now responsible for and aware of process. The ADON reviewed R31's fall incident reports, fall incident evaluation reports, nursing fall progress notes, and care plan. The ADON verified R31 had 5 fall incidents since facility admission on 7/3/23, stated initial fall interventions were in place at time of R31's admission, confirmed no	F 689		

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F 689	Continued From page 22 new fall interventions had been implemented since time and should have been. R18's annual MDS assessment dated 9/7/23, identified moderately impaired cognition. R18 had diagnoses of non-traumatic brain dysfunction, anemia, irregular heartbeat, orthostatic hypotension, kidney failure, dementia, depression, and psychotic disorder. R18 was able to transfer independently. R18's current fall care plan printed 10/24/23, last updated on 9/12/22, identified R18 was at moderate risk for falls, staff should anticipate and meet needs, be sure residents call light is within reach and encourage resident to use call light for assistance as needed, and staff should follow fall protocol. Staff should provide assistance with transfers, and dressing. R18's fall report in progress note dated 10/10/23 at 7:30 a.m., identified R18 had been found on her bathroom floor with legs extended out in front of her, R18 reported she self-transferred to use the bathroom without her wheelchair. Nurse reported that she reminded R18 to user her wheelchair. No injury was identified, R18 reported left knee pain. Nursing will continue to monitor. R18's care plan was not updated with any new interventions to help reduce risks for falls following the 10/10/23, fall. R18's nursing progress note dated 10/12/23 at 10:47 a.m., identified R18 had been sleepy, staff had gone in several times to try to get her up but she commented she is just tired but feels okay. R18's nursing progress note dated 10/15/23 at 7:15 a.m., identified R18 had been found on the	F 689		

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F 689	Continued From page 23 floor in her room sitting on the floor in front of her recliner with legs out in front of her next to her wheelchair. R18 reported she had tried to get into her wheelchair, but the breaks were not on and the wheelchair moved away from her. Nursing identified that R18's wheelchair breaks were not on and R18 did not have any footwear on. Assessment was completed and no injuries were observed. Nurse reported she would notify family and print a fall report for the nurse practitioner. R18's fall details report dated 10/15/23, identified R18 had been attempting to use the bathroom at the time of the fall. The report identified that the reason for the fall was improper footwear, did not have her wheelchair, and had self-transferred. The report identified no observed injury, report identified that R18 had recent changes in mobility status. R18's medical record lacked any evidence that the care plan had been updated with any new interventions to help reduce the risk of R18 sustaining another fall. R18's progress note dated 10/16/23, identified nurse practitioner had been updated on fall from 10/15/23 with no injury. R18's progress note dated 10/17/23, identified R18 has "numerous" bruises on forearms and skin tears on her legs including a bruise on her right great toe from her fall last week. Progress note identified a scratch on left shin. R18's progress note dated 10/18/23, identified dialysis had reported R18 did not finish her dialysis run and would be returning to the facility early. Progress note identified nursing would	F 689		

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F 689	Continued From page 24 monitor R18 when she returns. R18's progress note dated 10/22/23 at 1:10 p,m., identified over last few days resident has reported elevated pain levels throughout whole body and has been lethargic, is sleeping more than usual, is weaker and has needed more assistance. R18 needs more encouragement to wake up for meals. "will update provider on patient and new symptoms". R18's nursing progress note dated 10/22/23 at 8:19 p.m., identified R18 had been lethargic for most of the shift, R18 did not complain of pain. It took time for R18 to wake up to take her pills. R18 complained of legs, nurse noticed edema present. nurse encouraged resident to elevate legs. nurse will update the physician on his next visit to the facility. R18's medical record had no indication that the nurse practitioner or physician had been updated regarding R18's changes in condition. R18's fall report progress note dated 10/23/23 at 4:34 a.m., identified nursing had found R18 at 3:45 a.m., laying on left side, R18 reported she was trying to get different clothes. Nurse reports R18 had underwear over her pants, blood was on the floor next to R18's head. R18 had a 1.5 cm laceration and a lump on left side of forehead. R18 reported her head hurt, nurse applied cold compress and covered laceration with 2 steri-strips. Nurse practitioner was notified. Interview on 10/24/23 at 3:18 p.m., ADON identified when a resident falls, print the report and place it in a folder for the physician to review the next time they are at the facility for rounds. If	F 689		

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F 689	Continued From page 25 the nurse "feels it is necessary" to update the physician, then she would call the on-call doctor. Interview on 10/24/23 at 4:32 p.m., director of nursing (DON) identified her expectation is that nursing would review each fall at morning stand up and care plan should be updated with new interventions to help reduce risk for falls. DON agreed that R18's care plan should have been updated following each fall and her changes in condition that could have placed R18 at greater risk for falls. The facility Fall Risk Assessment policy undated, provided by facility identified that nursing along with physician would assess for possible causes within 24 hours of the fall. Based on those assessments the residents care plan would be updated with interventions to reduce the risk for repeated falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		12/15/23

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F 690	Continued From page 26 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow physician's orders to ensure appropriate management and routine care was provided for 1 of 1 resident (R31) reviewed for urinary catheter. Findings include: R31's face sheet printed on 10/27/23, included diagnoses of traumatic subdural hemorrhage (brain bleed), malignant neoplasm of right kidney (cancerous tumor of kidney), kidney and ureter disorder, malignant neoplasm of prostate (cancerous tumor of prostate), congestive heart failure (CHF), and chronic kidney disease (CKD). R31's quarterly Minimum Data Set (MDS) assessment dated 10/5/23, indicated R31 had	F 690	Thorne Crest has and always will ensure that all residents continent of bladder and bowel on admission receives services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. The facility has and always will follow physician's orders to ensure appropriate management and routine care for urinary catheters. R31 expired on 10/26/2023. Whole house audit conducted. No changes are needed. No other residents were identified during the audit. See Attachment G-1	

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F 690	Continued From page 27 intact cognition, had minimal difficulty hearing, had adequate vision, had clear speech and was able to understand others and was understood by others. R31 occasionally displayed verbal behaviors towards others 1-3 days/7 days, did not reject cares. R31 required extensive assistance from 1 staff for bed mobility, transfers, dressing, toileting, personal hygiene, had an indwelling catheter for urination and was continent of bowel. R31 had impairment to one upper and one lower extremity, did not walk, used a wheelchair for mobility, and was on hospice care. R31's physician order report printed on 10/27/23, included to change Foley catheter monthly, 16 Fr, in the evening starting on 28th and ending on the 28th every month. R31's treatment administration record (TAR) indicated to change catheter monthly, 16 Fr, in the evening starting on the 28th and ending on the 28th every month. Review of catheter changes from 8/1/23 - 10/26/23, indicated catheter last changed on 8/28/23. R31's care plan printed on 10/27/23, indicated R31 had an indwelling Foley catheter due to prostate cancer and on hospice care. R31's interventions for staff included to position catheter bag and tubing below the level of the bladder and away from the entrance room door, check tubing for kinks each shift and as needed (PRN), monitor for signs and symptoms (s/s) of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter, monitor/record/report to medical doctor (MD) for s/s of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,	F 690	Catheter Care Policy reviewed. No changes are needed. See Attachment G-2 To ensure all residents in similar situations are protected the facility will follow protocol according to the Catheter Care Policy. Catheter change is scheduled in the Electronic Medical Record. Assistant Director of Nursing provided education to Licensed Nurses on the importance of following physicians orders and documentation in MAR. Catheter Care Policy reviewed will Licensed Nurses. See Attachment A-3 To ensure compliance, the Director of Nursing/designee will initiate audits to verify catheters are being changed per physician orders weekly x4 weeks, monthly x2 months then quarterly with MDS schedule with results being reported to the QAPI committee.	

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F 690	Continued From page 28 increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Care plan did not indicated need for catheter changes or identify when catheter changes were to be completed. During an observation and interview on 10/23/23 at 7:01 p.m., R31 was noted in room, lying in center of bed on backside, appeared calm, was sleeping. R31's catheter bag attached to bedside, covered by bedding, catheter tubing patent, free of kinks, urine in amber in color with occasional sediments. R31's family member (FM)-D indicated this past summer R31 was hospitalized due to a fall and sustaining a head injury, stated during hospitalization R31 had progressively declined medically, was placed onto hospice care, and was admitted to facility in July '23. FM-D reported R31 had a Foley catheter initially placed during hospitalization and continued need for catheter while residing in facility, stated unawareness of catheter changes for R31. While interviewed on 10/25/23 at 1:33 p.m., nursing assistant (NA)-A indicated awareness of R31's Foley catheter, stated had catheter since facility admission. NA-A reported no catheter concerns for R31, stated if had any concerns related to resident catheter would notify licensed nurse right away. During an interview on 10/26/23 at 8:53 a.m., licensed practical nurse (LPN)-A reported awareness of R31 having Foley catheter, stated R31 had a catheter in place upon 7/3/23 facility admission due to urinary retention caused by prostate issues. LPN-A stated R31's Foley	F 690		

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F 690	Continued From page 29 catheter was to be changed monthly, was not aware of any concerns with R31's catheter or concerns for infection related to catheter use. LPN-A reviewed R31's physician orders in medical record, stated provider orders indicated for staff to complete catheter changes for R31 monthly, on the 28th day of each month and as needed (PRN). LPN-A reported upon review of R31's treatment administration record (TAR), R31 had a catheter change on 7/29/23, 8/2/23, and 8/28/23, stated last documentation of catheter change being completed was on 8/28/23. LPN-A verified catheter change scheduled for 9/28/23 lacked documentation of being completed, and stated was unaware staff had not complete on 9/28/23. LPN-A indicated staff had not communicated any follow-up was needed with catheter change for R31. LPN-A reported no way of staff knowing that a resident care had been missed, stated in electronic medical record (EMR) system nothing triggers to notify staff that residents cares were missed or not documented. LPN-A indicated it was up to staff to communicate with each other if resident cares were still needing to be completed during shift change and staff member should have communicated on 9/28/23 R31's catheter change was needing to be completed. While interviewed on 10/26/23 at 9:02 a.m., the assistant director of nursing (ADON) indicated awareness of R31 having a Foley catheter, stated R31's Foley catheter was to be changed monthly. Upon review of R31's TAR in EMR, the ADON verified last documentation of catheter change being completed was on 8/28/23. The ADON confirmed R31's catheter change scheduled for 9/28/23 lacked documentation per staff of catheter change being completed. The ADON	F 690		

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F 690	Continued From page 30 stated was unaware staff had not completed R31's catheter change per provider orders. The ADON indicated it was her expectation for staff to follow all physician orders for resident cares. LPN-A stated if staff were unable to complete resident cares for any reason staff needed to document in progress note what care had not been completed and reason why, and staff were to communicate with on-coming staff at next shift change what resident care wasn't completed and need for on-coming staff follow-up with completion of resident care. The ADON further indicated if concerns with completion of resident cares arise, it was her expectation staff would notify her as well. The facility Catheter Care, Urinary policy revised date 8/22, indicated Documentation- the following information should be documented in the resident's medical record: 1. The date and time that catheter care was given 2. The name and titles of the individual(s) giving the catheter care 8. If the resident refused the procedure, the reason(s) why and the interventions taken Reporting 1. Notify the supervisor if the resident refuses the procedure 2. Report other information in accordance with facility policy and professional standards of practice	F 690		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699		12/15/23

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F 699	Continued From page 31 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 resident (R23), who had post-traumatic stress disorder (PTSD), reviewed for behavioral-emotional. Findings include: R23 was admitted to facility on 5/223, face sheet printed on 10/27/23 indicated diagnoses to include affective mood disorder (disruption of emotional mood), anxiety, major depressive disorder (mood disorder), chronic post-traumatic disorder ((PTSD)- mental disorder caused by a terrifying event), sleep disorder, and hepatitis C (liver disease). R23's quarterly Minimum Data Set (MDS) assessment dated 8/16/23, indicated R23 had intact cognition, required partial/moderate assistance by 1 staff member with all activities of daily living (ADLs). R23's MDS assessment did not identify symptoms of depression, behaviors, or medication use for mood management. R23's physician orders printed on 10/27/23, indicated R23 was taking buspirone (an anxiolytic medication) for anxiety, clonazepam (sedative medication) for sleep disorder, escitalopram (mood medication) for anxiety, lorazepam	F 699	Thorne Crest has and always will ensure that all residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. It is the facilities intent to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for individuals who have had post-traumatic stress disorder (PTSD). R23 Comprehensive Care Plan has been reviewed and revised. See Attachment H-1 Whole house audit conducted. No other residents were identified during the audit. See Attachment H-2 Trauma Informed Care Policy reviewed. No changes are needed. See Attachment H-3 To ensure all residents in similar situations are protected the facility will complete a Trauma Informed Care Assessment Day of Admission, Change of Condition, Quarterly, and Annually in line with MDS	

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	245425	A. BUILDING _____ B. WING _____	C 10/26/2023

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

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F 699	Continued From page 32 (sedative medication) for anxiety, and mirtazapine (antidepressant medication) for mood disorder. Facility trauma informed care assessment had been completed for R23 on 5/10/23, assessment indicated R23 had been through life threatening/traumatic events. R23's care plan printed on 10/27/23, failed to identify PTSD/trauma as a focus area. As a result, the care plan lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to PTSD. During an observation and interview on 10/23/23 at 4:23 p.m., R23 indicated feeling depressed recently due to progressive medical decline. R23 reported being on hospice care, stated was frustrated he can't do the things he used to. At time of interview, R23 denied any suicidal ideation/harmful thoughts to self and others. R23 reported was working with provider on medication readjustment for mood, indicated mood stable at time. During visit, R23 visualized to occasionally smile, make jokes, was very talkative and open to discussion of past life experiences. R23 reported being through a lot in his life, at age 4 R23 indicated while playing with neighbor friend and making a fort R23's neighbor friend accidentally cut left 5th finger off with a hedge sheer (large scissor type clippers used to cut/trim bushes). R23 stated he had been in the war, R23 was stationed on a combat support ship that carried fuel and bombs. During the war, R23 reported ship crashed into another ship while sailing the ocean, part of cargo wing was hit, watched helplessly as a member of their squad was washed away into the ocean, reported nightmares	F 699	schedule. The New Trauma Informed Care Assessment includes a score to determine if resident lands on the risk scale of 14 or higher. A Care Plan will be implemented with person centered interventions for all residents landing on the risk scale of 14 or higher. All interventions on the Care Plan will be added to the task list for Nursing Staff awareness. To ensure compliance, the Social Services Director/designee will initiate audits to verify Trauma Informed Care Plans are accurate weekly x4 weeks, monthly x2 months then quarterly with MDS schedule with results being reported to the QAPI committee.	

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F 699	Continued From page 33 on occasion when trying to sleep as visions of what R23 endured during time of war comes flooding back. R23 indicated trying to numb the pain with alcohol, drank so much over time and developed Hepatitis C, stated he tried interferon therapy injections for 6 months to try to treat his hepatitis C, indicated the interferon therapy took a toll on his body, interferon therapy failed, continued to live with hepatitis C disease. R23 stated he continued to have times PTSD was difficult to manage, indicated facility staff aware of his PTSD, stated facility staff had never offered any resources to address his PTSD. While interviewed on 10/25/23 at 1:41 p.m., nursing assistant (NA)-A indicated R23 had always appeared down, depressed since facility admission. NA-A stated he didn't get much company to visit him, indicated R23 enjoyed having visitors and conversing. NA-A reported was unaware if R23 had a history of being through any traumatic life events, stated R23 never conversed about his past life events with her, indicated was unaware of any precautions or triggers to avoid that may affect R23's mood/behaviors, stated she had never seen anything in R23's care plan regarding triggers to avoid for alteration in mood/behaviors and staff had not informed her of anything new. During an interview on 10/26/23 at 1:13 p.m., the assistant director of nursing (ADON) was assisting on floor as licensed nursing staff. ADON reported awareness of R23's history of PTSD and triggers to avoid. The ADON indicated an initial trauma assessment was completed for R23 at time of facility admission, reported loud noises were a trigger to avoid with R23. The ADON indicated if there was for example a fire	F 699		

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F 699	Continued From page 34 drill at facility, staff would notify R23 of impending fire drill and loud noise to follow, staff would suggest he use his headphones he had during fire drill to drown out loud noise. The ADON reported staff should be aware of R23's PTSD history and triggers to avoid, stated staff needed to review R23's care plan for interventions/management of PTSD condition. The ADON stated she was responsible for care plan focus areas, goals, and intervention development. Upon review of R23's care plan, the ADON confirmed trauma/PTSD was not care planned for and should have been for staff awareness, avoidance of triggers, implementation of appropriate interventions, and provision of additional resources if needed. The facility Trauma Informed Care and Culturally Competent Care policy revised 8/22, indicated purpose to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice, to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Resident Care Planning 1. Develop individualized care plans that address past trauma in collaboration with resident and family, as appropriate 2. Identify and decrease exposure to triggers that may re-traumatize the resident 3. Recognize the relationship between past trauma and current health conditions (e.g. anxiety and depression) Resident-Care Strategies a. Safety b. Trust and Transparency c. Peer Support d. Collaboration	F 699		

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F 699	Continued From page 35 e. Empowerment, voice, and choice f. Respect for cultural, historical, and gender differences	F 699		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);	F 851		12/15/23

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F 851	Continued From page 36 (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately record weekend staffing data for fiscal year quarter 3 2023 (April 1-June 30) on the payroll-based journal (PBJ) Staffing Data Report. This deficient practice had the potential to affect all 33 residents residing in the facility. Findings include: The PBJ staffing data report for fiscal year quarter 3 2023 (April 1-June 30), printed on	F 851	Thorne Crest has and always will ensure that staffing data is accurately recorded each fiscal quarter on the payroll-based journal (PBJ) Staffing Data Report. Reporting Direct Care Staffing Information (Payroll-Based Journal) Policy reviewed. No changes are needed. See Attachment J-1 Reporting Direct Care Staffing Information (Payroll-Based Journal) Policy was	

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F 851	Continued From page 37 10/20/23, indicated excessively low weekend staffing triggered, requiring further investigation during survey. Record review for weekend of 4/1/23 (Sat) and 4/2/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. nursing assistant (NA)- 4 until 10 a.m., then 3 licensed nurse (LN)- 2 Evening shift 2 p.m.-10 p.m. NA- at least 4 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 3 LN-1 Record review for weekend of 4/8/23 (Sat) and 4/9/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2 Evening shift 2 p.m.-10 p.m., NA- at least 4 LN- 2 Night shift 10 p.m.- 6 a.m., NA- 2-3 LN-1 Record review for weekend of 4/15/23 (Sat) and 4/16/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- at least 4 LN- 2 Evening shift 2 p.m.-10 p.m. NA- at least 4 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 3 LN-1 Record review for weekend of 4/22/23 (Sat) and 4/23/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2	F 851	reviewed with HR Director. To ensure that this problem does not recur ABHM has contracted with Simple PBJ to Analyze our data prior to submission. Summary report is provided to facility quarterly. A daily review of punches will be completed to verify the facility has appropriate hours daily. To ensure compliance, the Administrator or Human Relations Director will initiate audits to verify accurate PBJ reporting monthly x3 months then quarterly prior to PBJ reports are submitted with the results being reported to the QAPI committee.	

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F 851	Continued From page 38	F 851		

Evening shift 2 p.m.-10 p.m. NA- 4 until 8 p.m., then 3 on 4/22/23, 4 on 4/23/23 LN- 2
Night shift 10 p.m.- 6 a.m., NA- 3
LN-1

Record review for weekend of 4/29/23 (Sat) and 4/30/23 (Sun) indicated sufficient staffing across all shifts.
Day shift 6 a.m.-2 p.m. NA- 4; on 4/30/23 had 4 until 10 a.m. then 3 NA from 10 a.m.-2 p.m.
LN- 2
Evening shift 2 p.m.-10 p.m.,NA- at least 4
LN- 2
Night shift 10 p.m.- 6 a.m., NA- 3
LN-1

Record review for weekend of 5/6/23 (Sat) and 5/7/23 (Sun) indicated sufficient staffing across all shifts.
Day shift 6 a.m.-2 p.m. NA- 4
LN- 2
Evening shift 2 p.m.-10 p.m. NA- 4, 5/7/23 had 3 LN- 2
Night shift 10 p.m.- 6 a.m. NA- 2 -5/6/23, 3- 5/7/23 LN-1

Record review for weekend of 5/13/23 (Sat) and 5/14/23 (Sun) indicated sufficient staffing across all shifts.
Day shift 6 a.m.-2 p.m. NA- 4 LN- 2
Evening shift 2 p.m.-10 p.m. NA- 3 LN- 2
Night shift 10 p.m.- 6 a.m. NA- 3 LN-1

Record review for weekend of 5/20/23 (Sat) and 5/21/23 (Sun) indicated sufficient staffing across all shifts.
Day shift 6 a.m.-2 p.m NA- 4- 5/20/23, 4 until 12 p.m., then 3 12-2 p.m.- 5/21/23 LN- 2
Evening shift 2 p.m.-10 p.m., NA- at least 3

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F 851	Continued From page 39 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 3 LN-1 Record review for weekend of 5/27/23 (Sat) and 5/28/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2 Evening shift 2 p.m.-10 p.m. NA- 3- 5/27/23, 4- 5/28/23 LN- 2 Night shift 10 p.m.- 6 a.m. .NA- 3 LN-1 Record review for weekend of 6/3/23 (Sat) and 6/4/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2 Evening shift 2 p.m.-10 p.m. NA- 3- 6/3/23, 4- 6/4/23 LN- 2 Night shift 10 p.m.- 6 a.m. .NA- 2 LN-1 Record review for weekend of 6/10/23 (Sat) and 6/11/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2 until 12:30 p.m., then 1 from 12:30 p.m.-2 p.m.- 6/10/23 2 -6/11/23 Evening shift 2 p.m.-10 p.m. NA- 4- 6/10/23, 3- 6/11/23 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 2 LN- 1 Record review for weekend of 6/17/23 (Sat) and 6/18/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4	F 851		

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F 851	Continued From page 40 LN- 2 Evening shift 2 p.m.-10 p.m. NA- 3-4 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 2-3 LN- 1 Record review for weekend of 6/24/23 (Sat) and 6/25/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2 Evening shift 2 p.m.-10 p.m. NA- 4 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 3 LN- 1 Record review for weekend of 7/1/23 (Sat) and 7/2/23 (Sun) indicated sufficient staffing across all shifts. Day shift 6 a.m.-2 p.m. NA- 4 LN- 2 Evening shift 2 p.m.-10 p.m. NA- 3 LN- 2 Night shift 10 p.m.- 6 a.m. NA- 2 LN- 1 During an interview on 10/26/23 at 3:35 p.m., the administrator indicating staffing was dependent upon facility census- approximately 40 residents or less; as well as resident acuity of care needs. The administrator indicated typically tries to schedule 4 NAs on day shift/evening shift and 3 NAs on overnights. For LN tries to schedule 2 on day/evening shift, 1 LN on overnights. The administrator reviewed PBJ report for fiscal year quarter 3 2023 (April 1-June 30), stated based on resident census/acuity, facility was appropriately staffed during those months. Administrator indicated a lot of those weekends had additional	F 851		

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F 851	Continued From page 41 NAs for parts of shift, overnights typically had 3 NAs, occasionally went down to 2 NAs on overnights in June due to vacations. The administrator did indicate awareness with corporate making an error when submitting PBJ staffing data during quarter 3, stated corporate management did not accurately report agency staff used in staffing for quarter 3, and caused low staffing data. The administrator indicated since error, corporate had hired an outside agency system to monitor employees entering PBJ staffing data, and corporate management would be notified of any errors or spot checks needed prior to submitting data to ensure data accuracy.	F 851		

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	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/24/2023. At the time of this survey, THORNE CREST RETIREMENT CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/24/2023

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

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THORNE CREST RETIREMENT CENTER	**1201 GARFIELD AVENUE** **ALBERT LEA, MN 56007**

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

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 _____	**10/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 52 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to investigate a known issue a signal testing issue of the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 26.6.1.10.1, 26.6.3.1.10.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/24/2023 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that the documentation presented for review identified that during the 08/20/2023	K 345	Thorne Crest has and always will comply with investigating a known issue a signal testing issue of the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.13, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 26.6.1.10.1, 26.6.3.1.10.2. The alarm panel was tested by Tech One our provider to verify operating correctly on 11/24/2023. See Attachment. To ensure compliance Maintenance Director will audit fire drills to verify the signal from the fire alarm panel is reaching the signal monitoring vendor.	12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 3 Fire Drill conducted at 1810 HRS, the signal from the fire alarm panel did not reach the signal monitoring vendor. There was not follow-up documentation presented for review to confirm the matter had been investigated or resolved. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345		