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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NYSJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00833

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245425**

2. STATE VENDOR OR MEDICAID NO. (L2) **144343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **THORNE CREST RETIREMENT CENTER**
(L4) **1201 GARFIELD AVENUE**
(L5) **ALBERT LEA, MN** (L6) **56007**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : 08/18/2017 (L19)
Vicky Hamersma HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: (L20)
Kamala Fiske-Downing, Enforcement Specialist 08/18/2017

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245425 August 18, 2017

Mr. Chris Schulz, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

Dear Mr. Schulz:

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

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

Effective July 18, 2017 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2017

Mr. Chris Schulz, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

RE: Project Number S5425028

Dear Mr. Schulz:

On June 19, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 8, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 8, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 8, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 18, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 8, 2017, effective July 18, 2017 and therefore remedies outlined in our letter to you dated June 19, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 18, 2017

Mr. Chris Schulz, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

Re: Reinspection Results - Project Number S5425028

Dear Mr. Schulz:

On July 27, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 8, 2017, with orders received by you on June 26, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NYSJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00833

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2. STATE VENDOR OR MEDICAID NO. (L2) **144343700**

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(L3) **THORNE CREST RETIREMENT CENTER**
(L4) **1201 GARFIELD AVENUE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/08/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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From (a) :
To (b) :

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 06/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/24/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible (L21)

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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 19, 2017

Mr. Chris Schulz, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

RE: Project Number S5425028

Dear Mr. Schulz:

On June 8, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 18, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	06/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On June 5, 6, 7, and 8th 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 167		6/20/17

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

Electronically Signed | 06/26/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING _____ B. WING _____	06/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post notice of availability of the last three years of state agency survey results. This had the potential to affect all 45 current residents, visitors, and staff who wished to review this information. Findings include: During initial tour of the facility on 6/5/17, at 6:15 p.m. a three ring binder labeled, "Survey Results," was observed in both the dayroom and transitional care unit (TCU) sitting area. The survey results contained inside were dated 5/26/16, from the previous full survey; however, there were no additional surveys identified in the binder nor was there anything notifying residents, family and staff that three years of results were available upon request. During interview on 6/7/17, at 1:03 p.m. the director of nursing (DON) stated the previous years surveys are available at the nurses desk and indicated there was a sign at the nurses desk	F 167	It is the policy of this facility to make available the last three years of survey results for residents, families and visitors. Policy was reviewed and updated on 6/20/2017 to reflect that three years of survey results would be available. Sign on wall directs residents, families and visitors to these locations. Completed on 6/20/2017, binders include three years of survey results.	

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 _____	06/08/2017

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 167	Continued From page 2 identifying that availability. However, the DON was unable to locate the sign stating that someone must have removed it from the cupboard door. The DON confirmed there was not a sign nor was any documentation in the binders to notify residents, visitors, or staff that additional survey results were available for examination.	F 167		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		7/18/17

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F 309	Continued From page 3 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and treat a skin lesion for 1 of 3 residents (R21) reviewed for non-pressure related skin conditions. Findings include: Review of the facility face sheet indicated R21 was admitted to the facility 8/12/16. During observation on 6/6/17, at 9:53 a.m. it was noted R21 had an open area/lesion located in the middle of her forehead at the hairline. R21 stated she had this open area for approximately 6 months or more, "I guess I pick it, I should stop that." R21 stated the area had never been examined by a physician. The following day on 6/7/17, at 10:40 a.m. R21 stated staff put some Bacitracin on the area yesterday when she requested. The area at this time was noted to appear red around the edges with a yellow center. Review of the quarterly Minimum Data Set (MDS) assessment dated 3/30/17, indicated R21 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. Review of the admission skin sheet dated 8/12/16, identified 2 small scabs noted on	F 309	It is the policy of this facility to monitor and treat lesions of the skin. For resident 21, a non-pressure skin form with monitoring and ordered skin treatment are in place as of 6/7/2017. Follow up with Nurse Practitioner and treatment change ordered. Area is without signs or symptoms of infection. In-service to educate nurses and CNAs related to reporting, assessing, monitoring, physician and family notification of all skin concerns. In-service held on 6/26/2017. Recently added bath aide position will improve continuity and communication of skin issues to the nurse. Skin Monitoring Report form used to communicate from CNA to nurse skin concerns reviewed by team. Re-education to nurses and CNAs of responsibility to reporting, assessing and monitoring of skin concerns. Skin Monitoring Report form once completed is submitted to DON or designee will audit as received and ongoing with reports made to QAPI committee	

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forehead measuring 0.4 by 0.1 centimeters (cm). A picture (undated) in R21's medical record identified the open area was present. A skin Risk Data-Including Braden dated 8/12/16, identified 2 small scabs/abrasion forehead. Review of the skin/wound notes dated from 8/19/16 through 6/7/17, lacked mention of this open area/lesion on the forehead. Review of the treatment sheets from 4/1/17 to 6/7/17, did not identify any treatment to the identified area. A Non-Pressure Skin Condition Report dated 9/21/16, identified the abrasion to forehead as resolved. No further documentation related to the open area was available fore review in the medical record. In a picture [undated] of R21 located in the medical record, it was noted the skin lesion on the forehead was clearly visible. A late entry nurses' note dated 6/7/17 for 6/6/17, at 11:44 a.m. indicated R21 has small area on the top of her forehead that she has been picking at lately. The area was a scab and the area has been present since admission but R 21 has been picking it lately, so it was cleansed and a thin coating of Bacitracin applied to the area. Documentation indicated that staff will have the nurse practitioner (NP) sign telephone order in a.m. for an order to do treatment till healed. No measurements nor description of this area was documented. A review of physician progress notes since admission lacked mention of the scabbed and/or open area/lesion located on the forehead.

The care plan dated 8/25/16, indicated staff were to monitor skin with all cares provided, report any changes in skin to charge nurse for assessment and watch for red areas, open areas, bruising, swelling rashes or any other skin concerns.

During interview on 6/7/17, at 10:41 a.m.

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registered nurse (RN)-B stated R21 had the identified area for quite sometime and "it's just a part of her." RN-B stated they visualize it daily and since it never changes, they haven't done anything about it but explained R21's son was aware of the skin condition. RN-B stated the area should be addressed by the NP. RN-B stated that if Bacitracin was applied to the area yesterday, an NP order was necessary.

During interview on 6/7/18, at 12:31 p.m. licensed practical nurse (LPN)-B stated she thought R21 was applying lotion to the area until R21 approached LPN-B on 6/6/17, and requested LPN-B put something on the area. LPN-B responded by applying Bacitracin to the skin. LPN-B explained that R21 had been admitted with this skin condition, it will almost be healed and then R21 picks at the area and it opens up again.

During interview on 6/8/17, at 10:48 a.m. nursing assistant (NA)-A stated R21 had the notable skin condition/area for quite a while, months at least. NA-A stated R21 picks it and it gets all red.

When interviewed on 6/8/17, at 12:00 p.m. the director of nursing (DON) stated R21's skin condition should have been assessed and a skin monitoring sheet should have been implemented to monitor. The DON also stated it probably should have been addressed by the physician and/or NP.

The facility policy Skin Tears - Abrasions and Minor Breaks, Care of revised 9/2013, indicated a non pressure form should be generated for non pressure areas and family and physician notified.

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F 431	Continued From page 6	F 431		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431		7/18/17

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F 431	Continued From page 7 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff appropriately disposed of and followed facility policy to prevent the potential diversion of 3 of 3 narcotic pain medication (Tramadol and Hydrocodone) tablets dispensed from the AlixaRx (automated dispensing machine) for 3 of 3 residents (R13, R46, R70) reviewed who had narcotic medications but had been administered. This had the potential to affect all 45 residents who resided in the facility. Findings include: During medication cart inspection on 6/7/17, at 10:15 a.m. with trained medication aide (TMA)-A it was noted there were 3 packets of controlled narcotic pain medication in the long term care medication cart that had not been administered. The following was observed: (1) R13 had one tablet of Tramadol dispensed from the AlixaRx machine on 6/5/17, but	F 431	It is the policy of this facility to prevent diversion of narcotics. Policy was reviewed and updated to indicate any unused/refused doses will be destroyed per facility policy to prevent possible diversion. In-service to educate the nurses and TMAs regarding reconciliation of narcotics and destruction of unused/refused doses at change of shift, will occur on 6/26/2017. Daily, Monday-Friday, med cart inspection will occur daily x one month then random checks ongoing with concerns reported to consultant pharmacist and the QAPI committee.	

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remained in the medication cart and was not counted during reconciliation;
(2) R46 had one tablet hydrocodone dispensed from the AlixaRx machine on 6/3/17, but remained in the medication cart and was not counted during reconciliation;
(3) R70 had one tablet of hydrocodone dispensed from the AlixaRx machine on 3/8/17,which remained in the medication cart and was not counted during reconciliation.
TMA-A indicated facility practice was for the medication to be dispensed that day for administration and if not given, it was supposed to have been destroyed by that nurse and a witness. She was unsure why those medications remained in the cart. TMA-A agreed without an accurate count or easy reconciliation of narcotic medications, there was a high potential for diversion.

Interview on 6/7/17, at 10:20 a.m. the director of nursing (DON) stated it was her expectation and facility policy that staff were to destroy remaining narcotic medication that was not administered the day it had been dispensed. She agreed there was a strong potential for diversion as those medications had not been reconciled since dispensation from the AlixaRx machine.

Interview with the registered pharmacist (RPh) on 6/8/17, at 11:41 a.m. revealed his expectation was staff were to have disposed of unused or refused doses appropriately in the presence of a witness and medication was reconciled and disposed of per policy.

Review of the June 2015 Controlled Substance Storage policy revealed at each shift change or when keys were transferred, a physical inventory

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F 431	Continued From page 9 of all controlled substances should have been conducted and documented.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441		7/18/17

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F 441	Continued From page 10 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff implemented appropriate infection control technique to prevent cross-contamination of medications and supplies during medication administration observations involving 2 of 3 observed nursing staff (TMA-A, LPN-A).	F 441	It is the policy of this facility to ensure staff implement appropriate infection control techniques to prevent cross-contamination of medications and supplies during medication administration. In-service to educate the nurses and TMAs on proper infection control techniques held on 6/26/2017.	

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F 441	Continued From page 11 Findings include: During medication observation on 6/7/17, at 7:52 a.m. trained medication aide (TMA)-A obtained R14's Advair discus inhaler from the medication cart and placed it into her left front scrub shirt pocket. TMA-A then approached R14 and asked whether she could administer the medication; however, R14 declined at that time. TMA-A returned to the medication cart, removed her medication cart keys and the Advair discus inhaler from her scrub uniform pocket and placed the inhaler back into the cart. Later at 8:01 a.m. during a blood glucose check for R15, TMA-A proceeded to gather the following supplies: a glucometer (measures blood glucose in blood), the container for test strips, alcohol wipes and cotton balls. TMA-A placed all of the supplies into both of her front scrub shirt pockets and proceeded to R15's room. TMA-A performed the glucometer testing, washed her hands, and placed the contaminated glucometer back into her pocket with her keys. The glucometer was a shared use glucometer for insulin dependent diabetic residents. TMA-A then placed the bloody test strip in a paper towel and placed it into her other pocket. She proceeded back out to the medication cart, reached into her pockets and pulled out the contaminated keys and supplies. TMA-A stated she had forgotten the bloody test strip had been in the paper towel and needed to find a sharps container. She then opened the medication cart, pulled out a Sani-wipe disinfecting cloth, wiped the glucometer once and placed it immediately in the medication cart and shut the drawer. She failed to observe whether the glucometer remained wet for the necessary contact time and failed to perform hand hygiene.	F 441	All nurses and TMAs will be audited on med pass infection control techniques, with any concerns noted being corrected at the time of the audit. It will be expected nurse and TMAs show competency of these techniques – to be completed by 7/14/17. Random audits will continue monthly with reports to consultant pharmacist and QAPI committee.	

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F 441	Continued From page 12 Review of the package instructions for the Sani-wipe indicated it needed a wet contact time of 2 minutes for disinfection. On 6/7/17, at 8:10 a.m. TMA-A was observed placing a resident's eye drops in her right pocket where the bloody lancet had been transported and/or stored. During medication administration observation involving licensed practical nurse (LPN)-A on 6/7/17, at 8:27 a.m. revealed she entered the room of R15 with insulin syringes in her hand. She proceeded into the bathroom to perform handwashing and placed the syringes into her left front scrub shirt pocket. After handwashing, she removed the syringes and performed the medication administration. Later at 8:30 a.m., TMA-A once again removed R14's Advair inhaler from the medication cart, placed it into her pocket and proceeded to the resident's room. TMA-A administered the medication to R14, placed the medication back into her pocket, performed hand hygiene and left the room. Once back at the medication cart, she removed the Advair and the medication cart keys from the same pocket. At this time, her personal jacket was also noted to be draped over the medication cart ledge. During interview and medication cart review on 6/7/17, at 10:15 a.m. with TMA-A regarding the above mentioned infection control breaches revealed she had not realized she had cross-contaminated medication and supplies by placing them into her scrub pockets. She then agreed she should not be placing the above	F 441		

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mentioned items into her pockets as it was a source of cross-contamination. TMA-A confirmed she was unsure how long the Sani-cloth product had to remain in wet contact with the glucometer for effective disinfection. There were numerous nail clippers observed with particles of dirt and debris inside a cup located inside the medication cart. When questioned what they were used for, TMA-A stated she would give the nail clippers to the aides to trim the residents nails and toenails. These items were noted to be visibly dirty and TMA-A indicated she wiped them with an alcohol wipe and was unsure what staff were required to do for disinfection. TMA-A was unsure whether facility policy allowed staff to place contaminated items back into the medication cart. She stated "After I thought about it, the internal pieces of a fingernail clipper had not been appropriately disinfected and should not have been placed inside the medication cart with medications."

Interview with the director of nursing (DON) on 6/7/17, at 10:20 a.m. revealed TMA-A had recently had training and competency in glucometer disinfection. She confirmed it was a shared resident glucometer and it was her expectation all nursing staff were to have cleaned and disinfected all resident care items appropriately. It was also her expectation that staff follow infection control (IC) policies including the following: No medications were to be placed inside staff pockets, glucometers were to be appropriately disinfected and used lancets were not to be placed inside a staff pockets but were to be placed inside the sharps container immediately after use. She agreed staff needed re-education on appropriate IC technique to prevent cross-contamination.

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F 441	Continued From page 14 Interview on 6/7/17, at 1:41 p.m. with LPN-A revealed she agreed she should not have placed the insulin syringes in her scrub pocket and contaminated the syringes. Review of the facility's April 2007 Storage of Medications policy revealed nursing staff shall be responsible for maintaining medication storage in a clean and sanitary manner. Review of the facility's July 2014 Infection Control policy revealed staff were to have maintained a safe and sanitary environment for everyone in the facility. Its objective was to prevent and control infections. All personnel were to be trained on policies and procedures relating to IC practices. Review of the facility's May 2014 Assure Brilliance policy revealed Step 4 of disinfection of the glucometer was to let the meter dry per wipe manufacturer's instructions.	F 441		

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey on June 06, 2017, 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/09/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Thorne Crest Retirement Center is a 1-story building, with no basement. The facility was built in 1973 and was determined to be of Type II(111) construction. The facility is fully sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 42 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 916 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System	K 916		7/18/17

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K 916	Continued From page 2 Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the fire alram sysytem in accordance with NFPA 99, Health Care facilities Code.This deficient practice could affect 42 of the 42 residents. Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) FINDINGS INCLUDE: During the facility tour between the hours of 09:30 AM and 12:30 PM on 06/06/2017, observation revealed that a remote electric system annunciator panel for the emergency generator could not be located. This deficient practice was verified by the Facility Maintenance Director.	K 916	A remote annunciator will be installed in a centralized location readily observed by operating personnel.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 19, 2017

Mr. Chris Schulz, Administrator
Thorne Crest Retirement Center
1201 Garfield Avenue
Albert Lea, MN 56007

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5425028

Dear Mr. Schulz:

The above facility was surveyed on June 5, 2017 through June 8, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at Kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00833	A. BUILDING: _____ B. WING _____	06/08/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 5, 6, 7, and 8th, 2017, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and treat a skin lesion for 1 of 3 residents (R21) reviewed for non-pressure related skin conditions. Findings include: Review of the facility face sheet indicated R21 was admitted to the facility 8/12/16. During observation on 6/6/17, at 9:53 a.m. it was noted R21 had an open area/lesion located in the middle of her forehead at the hairline. R21 stated she had this open area for approximately 6	2 830	corrected	7/18/17

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2 830	Continued From page 3	2 830		

months or more, "I guess I pick it, I should stop that." R21 stated the area had never been examined by a physician. The following day on 6/7/17, at 10:40 a.m. R21 stated staff put some Bacitracin on the area yesterday when she requested. The area at this time was noted to appear red around the edges with a yellow center.

Review of the quarterly Minimum Data Set (MDS) assessment dated 3/30/17, indicated R21 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition.

Review of the admission skin sheet dated 8/12/16, identified 2 small scabs noted on forehead measuring 0.4 by 0.1 centimeters (cm). A picture (undated) in R21's medical record identified the open area was present. A skin Risk Data-Including Braden dated 8/12/16, identified 2 small scabs/abrasion forehead. Review of the skin/wound notes dated from 8/19/16 through 6/7/17, lacked mention of this open area/lesion on the forehead. Review of the treatment sheets from 4/1/17 to 6/7/17, did not identify any treatment to the identified area. A Non-Pressure Skin Condition Report dated 9/21/16, identified the abrasion to forehead as resolved. No further documentation related to the open area was available fore review in the medical record. In a picture [undated] of R21 located in the medical record, it was noted the skin lesion on the forehead was clearly visible. A late entry nurses' note dated 6/7/17 for 6/6/17, at 11:44 a.m. indicated R21 has small area on the top of her forehead that she has been picking at lately. The area was a scab and the area has been present since admission but R 21 has been picking it lately, so it was cleansed and a thin coating of Bacitracin applied to the area. Documentation

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2 830	Continued From page 4 indicated that staff will have the nurse practitioner (NP) sign telephone order in a.m. for an order to do treatment till healed. No measurements nor description of this area was documented. A review of physician progress notes since admission lacked mention of the scabbed and/or open area/lesion located on the forehead. The care plan dated 8/25/16, indicated staff were to monitor skin with all cares provided, report any changes in skin to charge nurse for assessment and watch for red areas, open areas, bruising, swelling rashes or any other skin concerns. During interview on 6/7/17, at 10:41 a.m. registered nurse (RN)-B stated R21 had the identified area for quite sometime and "it's just a part of her." RN-B stated they visualize it daily and since it never changes, they haven't done anything about it but explained R21's son was aware of the skin condition. RN-B stated the area should be addressed by the NP. RN-B stated that if Bacitracin was applied to the area yesterday, an NP order was necessary. During interview on 6/7/18, at 12:31 p.m. licensed practical nurse (LPN)-B stated she thought R21 was applying lotion to the area until R21 approached LPN-B on 6/6/17, and requested LPN-B put something on the area. LPN-B responded by applying Bacitracin to the skin. LPN-B explained that R21 had been admitted with this skin condition, it will almost be healed and then R21 picks at the area and it opens up again. During interview on 6/8/17, at 10:48 a.m. nursing assistant (NA)-A stated R21 had the notable skin condition/area for quite a while, months at least. NA-A stated R21 picks it and it gets all red.	2 830		

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2 830	Continued From page 5 When interviewed on 6/8/17, at 12:00 p.m. the director of nursing (DON) stated R21's skin condition should have been assessed and a skin monitoring sheet should have been implemented to monitor. The DON also stated it probably should have been addressed by the physician and/or NP. The facility policy Skin Tears - Abrasions and Minor Breaks, Care of revised 9/2013, indicated a non pressure form should be generated for non pressure areas and family and physician notified. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and record	21375	corrected	7/18/17

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21375	Continued From page 6	21375		

review, the facility failed to ensure staff implemented appropriate infection control technique to prevent cross-contamination of medications and supplies during medication administration observations involving 2 of 3 observed nursing staff (TMA-A, LPN-A).

Findings include:

During medication observation on 6/7/17, at 7:52 a.m. trained medication aide (TMA)-A obtained R14's Advair discus inhaler from the medication cart and placed it into her left front scrub shirt pocket. TMA-A then approached R14 and asked whether she could administer the medication; however, R14 declined at that time. TMA-A returned to the medication cart, removed her medication cart keys and the Advair discus inhaler from her scrub uniform pocket and placed the inhaler back into the cart.

Later at 8:01 a.m. during a blood glucose check for R15, TMA-A proceeded to gather the following supplies: a glucometer (measures blood glucose in blood), the container for test strips, alcohol wipes and cotton balls. TMA-A placed all of the supplies into both of her front scrub shirt pockets and proceeded to R15's room. TMA-A performed the glucometer testing, washed her hands, and placed the contaminated glucometer back into her pocket with her keys. The glucometer was a shared use glucometer for insulin dependent diabetic residents. TMA-A then placed the bloody test strip in a paper towel and placed it into her other pocket. She proceeded back out to the medication cart, reached into her pockets and pulled out the contaminated keys and supplies. TMA-A stated she had forgotten the bloody test strip had been in the paper towel and needed to find a sharps container. She then opened the

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21375	Continued From page 7	21375		

medication cart, pulled out a Sani-wipe disinfecting cloth, wiped the glucometer once and placed it immediately in the medication cart and shut the drawer. She failed to observe whether the glucometer remained wet for the necessary contact time and failed to perform hand hygiene.

Review of the package instructions for the Sani-wipe indicated it needed a wet contact time of 2 minutes for disinfection.

On 6/7/17, at 8:10 a.m. TMA-A was observed placing a resident's eye drops in her right pocket where the bloody lancet had been transported and/or stored.

During medication administration observation involving licensed practical nurse (LPN)-A on 6/7/17, at 8:27 a.m. revealed she entered the room of R15 with insulin syringes in her hand. She proceeded into the bathroom to perform handwashing and placed the syringes into her left front scrub shirt pocket. After handwashing, she removed the syringes and performed the medication administration.

Later at 8:30 a.m., TMA-A once again removed R14's Advair inhaler from the medication cart, placed it into her pocket and proceeded to the resident's room. TMA-A administered the medication to R14, placed the medication back into her pocket, performed hand hygiene and left the room. Once back at the medication cart, she removed the Advair and the medication cart keys from the same pocket. At this time, her personal jacket was also noted to be draped over the medication cart ledge.

During interview and medication cart review on 6/7/17, at 10:15 a.m. with TMA-A regarding the

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21375	Continued From page 8	21375		

above mentioned infection control breaches revealed she had not realized she had cross-contaminated medication and supplies by placing them into her scrub pockets. She then agreed she should not be placing the above mentioned items into her pockets as it was a source of cross-contamination. TMA-A confirmed she was unsure how long the Sani-cloth product had to remain in wet contact with the glucometer for effective disinfection. There were numerous nail clippers observed with particles of dirt and debris inside a cup located inside the medication cart. When questioned what they were used for, TMA-A stated she would give the nail clippers to the aides to trim the residents nails and toenails. These items were noted to be visibly dirty and TMA-A indicated she wiped them with an alcohol wipe and was unsure what staff were required to do for disinfection. TMA-A was unsure whether facility policy allowed staff to place contaminated items back into the medication cart. She stated "After I thought about it, the internal pieces of a fingernail clipper had not been appropriately disinfected and should not have been placed inside the medication cart with medications."

Interview with the director of nursing (DON) on 6/7/17, at 10:20 a.m. revealed TMA-A had recently had training and competency in glucometer disinfection. She confirmed it was a shared resident glucometer and it was her expectation all nursing staff were to have cleaned and disinfected all resident care items appropriately. It was also her expectation that staff follow infection control (IC) policies including the following: No medications were to be placed inside staff pockets, glucometers were to be appropriately disinfected and used lancets were not to be placed inside a staff pockets but were to be placed inside the sharps container

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	00833	A. BUILDING: _____ B. WING _____	06/08/2017

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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21375	Continued From page 9 immediately after use. She agreed staff needed re-education on appropriate IC technique to prevent cross-contamination. Interview on 6/7/17, at 1:41 p.m. with LPN-A revealed she agreed she should not have placed the insulin syringes in her scrub pocket and contaminated the syringes. Review of the facility's April 2007 Storage of Medications policy revealed nursing staff shall be responsible for maintaining medication storage in a clean and sanitary manner. Review of the facility's July 2014 Infection Control policy revealed staff were to have maintained a safe and sanitary environment for everyone in the facility. Its objective was to prevent and control infections. All personnel were to be trained on policies and procedures relating to IC practices. Review of the facility's May 2014 Assure Brilliance policy revealed Step 4 of disinfection of the glucometer was to let the meter dry per wipe manufacturer's instructions. SUGGESTED METHOD OF CORRECTION: The DON or designee could re-educate the staff on appropriate infection control practices during medication passes. The DON or designee could verify staff have received the infection-control education, and also perform additional audits to verify staff compliance with the training. TIME FRAME FOR CORRECTION: Twenty One (21) Days	21375		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction	21630		7/18/17

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21630	Continued From page 10 Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff appropriately disposed of and followed facility policy to prevent the potential diversion of 3 of 3 narcotic pain medication (Tramadol and Hydrocodone) tablets dispensed from the AlixaRx (automated dispensing machine) for 3 of 3 residents (R13, R46, R70) reviewed who had narcotic medications but had been administered. This had the potential to affect all 45 residents who resided in the facility.	21630	corrected	

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21630	Continued From page 11 Findings include: During medication cart inspection on 6/7/17, at 10:15 a.m. with trained medication aide (TMA)-A it was noted there were 3 packets of controlled narcotic pain medication in the long term care medication cart that had not been administered. The following was observed: (1) R13 had one tablet of Tramadol dispensed from the AlixaRx machine on 6/5/17, but remained in the medication cart and was not counted during reconciliation; (2) R46 had one tablet hydrocodone dispensed from the AlixaRx machine on 6/3/17, but remained in the medication cart and was not counted during reconciliation; (3) R70 had one tablet of hydrocodone dispensed from the AlixaRx machine on 3/8/17,which remained in the medication cart and was not counted during reconciliation. TMA-A indicated facility practice was for the medication to be dispensed that day for administration and if not given, it was supposed to have been destroyed by that nurse and a witness. She was unsure why those medications remained in the cart. TMA-A agreed without an accurate count or easy reconciliation of narcotic medications, there was a high potential for diversion. Interview on 6/7/17, at 10:20 a.m. the director of nursing (DON) stated it was her expectation and facility policy that staff were to destroy remaining narcotic medication that was not administered the day it had been dispensed. She agreed there was a strong potential for diversion as those medications had not been reconciled since dispensation from the AlixaRx machine.	21630		

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21630	Continued From page 12 Interview with the registered pharmacist (RPh) on 6/8/17, at 11:41 a.m. revealed his expectation was staff were to have disposed of unused or refused doses appropriately in the presence of a witness and medication was reconciled and disposed of per policy. Review of the June 2015 Controlled Substance Storage policy revealed at each shift change or when keys were transferred, a physical inventory of all controlled substances should have been conducted and documented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures to destroy unused narcotic medications. The DON or diesignee could educate licensed staff on these policy and procedures. The DON or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME FRAME FOR CORRECTION: Twenty One (21) Days	21630		