Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 17, 2023

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

RE: CCN: 245425
Cycle Start Date: December 8, 2022

Dear Administrator:

On February 3, 2023, the Minnesota Departments 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 17, 2023

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

Re: Reinspection Results
Event ID: OZQX12

Dear Administrator:

On February 3, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 8, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

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

RE: CCN: 245425
Cycle Start Date: December 8, 2022

Dear Administrator:

On December 8, 2022, 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 March 8, 2023 (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 June 8, 2023 (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:

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 12/08/2022

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 12/5/22 - 12/8/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		1/6/23

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

Electronically Signed | 01/08/2023

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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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on interview and record review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: Based on a review of available documentation and staff interview, the facility failed to maintain, inspect, and test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) sections 8.4, 8.4.9, 8.4.9.1 - 8.4.9.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 12/07/2022 at 11:30 a.m., it was revealed during documentation review that no documents were presented for review to confirm that the once every 36 months - 4 hour continuous run of the emergency generator is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	Thorne Crest has and always will comply with maintaining, inspecting, and testing the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3and 6.4.4.2 and NFPA 110 (2010 edition) sections 8.4.9 through 8.4.9.7. The once every 36 months - 4-hour continuous run of the emergency generator was completed on 1/6/2023. Attachment A To ensure compliance Maintenance Director has added the 4-hour load bank for the emergency generator to the facility HIPPO Maintenance Program every 36 months/3 years. The 4-hour load bank for the emergency generator has been added to our Cummins Equipment Maintenance Agreement to be conducted every 36 months/3 years.	
F 000	INITIAL COMMENTS On 12/5/22 through 12/8/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care	F 000		

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F 000	Continued From page 4 Facilities. The following complaints were found to be SUBSTANTIATED: H54256459C (MN86417), and H5425034C (MN80874) however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaint was found to be UNSUBSTANTIATED: H5425033C (MN79740). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide access to comfortable orthotic seating for 1 of 1 resident (R10) reviewed for reasonable accommodation of	F 558	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	1/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 5 needs. Findings include: R10's admission Minimum Data Set (MDS) assessment dated 11/9/22, indicated R10 was cognitively intact and dependent on staff for all physical mobility, although R10 could participate in bed mobility. The MDS indicated R10 had a primary diagnosis of secondary malignant neoplasm (new and abnormal growth of tissue) of bone resulting from breast cancer and additional significant diagnoses of: multiple sclerosis (a neurological degenerative disease that slowly reduces a person's ability to move over time, also called MS) and quadriplegia (inability to move all four limbs) among other disorders. MDS identified R10 was receiving anti-anxiety and anti-depressant medication on a regular schedule, and was a hospice patient. According to R10's care plan, a focus problem area was entered 11/11/22 indicating "resident has quadriplegia." The goal listed indicated "resident will maintain optimal status and quality of life within limitations imposed by Quadriplegia through review date. Target date: 2/9/23." This problem had two interventions: "give medications as ordered. Monitor/document for side effects and effectiveness; range of motion (active or passive) with am/pm cares daily." A problem area dated 11/11/22 indicated "resident has acute/chronic pain related to breast cancer with mets (metastases-where cancer has moved from a primary site and invaded tissue elsewhere) to bone, MS. This problem had interventions related to monitoring and reporting and providing analgesics, but did not address other methods of providing comfort. Another problem area	F 558	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 assures its residents have the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. R10 expired on 12/20/2022 Like residents will be assessed and if deemed appropriate will follow facility policy for motorized wheelchair.	

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F 558	Continued From page 6 indicated, "I require assistance with my ADLs (activities of daily living) and mobility related to impaired mobility, MS and cancer diagnosis. Created on 11/3/22. Of several goals, one goal indicated, "I will not develop contractures or worsen my current contractures and also, I will travel throughout the facility as I desire." Associated interventions did not address contractures or positioning, but did indicate "Locomotion: I require staff assistance with all locomotion on and off the unit per my Broda chair." According to a hospice document dated 11/3/22 titled, Client Coordination Note Report, "patient has been non ambulatory for years and utilizes motorized wheelchair for mobility. Patient requires assistance from 2 as a Hoyer transfer. This is unchanged from 6 months ago." According to a document titled "assistive device evaluation" effective date 11/7/22, R10 was being assessed by nursing for the use of a Broda chair (this is a type of wheelchair generally used for positioning for persons who cannot safely maintain the position). Although R10 was listed as cognitively intact, the assessment indicated she could not identify the chair control or explain its use, or demonstrate safe use of "recliner." Also, the assessment asked if the resident understood the adverse effects of improper usage and this was marked "no." The assessment asked if "the use of the device restricts the residents movement, transfers, locomotion or access to their own body" and this was marked "no." The assessment indicated the Broda chair was appropriate as R10 needed it "to transfer" (Broda chairs are for positioning and movement, they are not listed as a transfer	F 558	Accommodation of Needs Policy has been reviewed no changes at this time. Thorne Crest will implement the use of motorized wheelchair assessment for all new admissions requesting the use of a motorized wheelchair moving forward, upon request from any resident, and at least quarterly with MDS cycle to assure residents rights are being met. Director of Nursing provided training and education of Motorized Wheelchair policy and procedure to Licensed Nurses on 1/5/2023. To ensure compliance, Director of Nursing or designee has initiated audits on all new admissions requesting the use of a motorized wheelchair and at least quarterly with MDS cycle or as needed, with results being reported to the QAPI committee.	

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F 558	Continued From page 7 device.) The benefits to the resident indicated "able to sit in chair comfortable and transfer." No follow up evaluation was found to see if the intervention of the Broda chair was meeting R10's needs. On 12/5/22, 6:28 p.m. during an observation and interview, R10 was observed in her room, in the dark, in bed. R10 stated she spent most of her time in bed now, and liked the mattress the facility had provided. R10 was observed to be in a room with two beds, but no room-mate. Next to the empty bed, a large Broda chair, almost as long as the bed, was parked. The Broda chair was observed to be a type of seating consisting of poly-vinyl tension straps that are meant to suspend the weight of the user over multiple points. The chair also had a cushion in the seat and side bolsters, and could recline. R10 stated she preferred a power wheel chair she had used prior to admission to the facility. R10 stated she had talked to "someone" in the facility and said she was told the facility was "not licensed for power chairs or something." R10 stated she was spending more time in bed because she did not find the Broda chair very comfortable for sitting. During an interview on 12/6/22, at 12:24 p.m. a nursing assistant (NA)-A stated no resident was allowed to use a motorized wheelchair in the long term care section of the facility. NA-A stated she thought R10 had an electric wheelchair at the facility, but also thought it was in storage because of their policy. NA-A stated R10 had told her the electric wheelchair was more comfortable to sit in. NA-A said R10 would not be able to drive an electric wheelchair because of an inability to use her hands, but NA-A expressed concern about R10 staying in bed and isolated as much as she	F 558		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 8	F 558		

was. NA-A thought the electric wheel chair might make it easier to position R10 and perhaps R10 would get up out of bed more often.

During an interview on 12/6/22, at 12:30 p.m. a licensed practical nurse (LPN)-A stated R10 had been declining in her overall abilities and could no longer use her hands. LPN-A stated R10 would not be able to run an electric wheelchair, but stated she understood R10 was interested in being up in the wheelchair for comfort in positioning instead of the Broda chair. LPN-A stated she was aware the facility had a policy barring the use of electric wheelchairs, but given R10 was interested in using the chair for positioning instead of locomotion, LPN-A thought it should be reconsidered. LPN-A stated an assessment would need to be done, and thought part of the reason the Broda was uncomfortable was it put pressure on R10's cancer site, and LPN-A did not know if the wheelchair would alleviate that concern.

During an interview on 12/6/22, at 12:31 p.m. the director of nursing (DON) stated the policy regarding the use of motorized wheelchairs or scooters had been developed because there were concerns regarding the ability to supervise persons driving them, and safety for others. DON stated the facility had worked with hospice in developing a plan of care for R10 and in getting the Broda chair, but had not sought out a therapy evaluation for seating because "we usually don't if they are in hospice." DON stated they had explained to R10 that they did not allow the use of motorized wheelchairs in the facility and that R10 had said "she was fine, but then she did not want to get up anymore." DON stated she thought R10 was not getting up out of bed because of her

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F 558	Continued From page 9 declining health. During an interview on 12/6/22, at 12:35 p.m. the facility assistant director of nursing (ADON) stated she thought R10 was not getting up because she had had a decline. She stated she understood R10 did not find the Broda chair very comfortable, but did not know R10 was saying she would be more comfortable in the motorized wheelchair. ADON and DON both stated, "unfortunately, it is our policy not to allow motorized wheelchairs." During an interview 12/6/22, at 1:23 p.m. R10 stated she had utilized her motorized wheelchair before coming to the facility and found it more comfortable than the Broda chair provided after admission. R10 stated the motorized wheelchair, "is more comfy because is fitted to me." R10 expressed the wheelchair had been very expensive due to the customized fit and stated, "I think I should be able to use it." R10 stated she had not been able to "drive" the chair for some time, even before coming to the facility, but had been using it for seating and positioning. R10 stated the Broda chair did not provide as much support or comfort and said "I just thought, well, if I can't sit in my chair, I'll just stay in bed." A facility policy titled Accommodation of Needs, last revised in March 2021, indicated "the resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. Due to the size of resident's rooms and for the safety of the individual or other residents we are not able to accommodate Electric Scooters/Wheelchairs."	F 558		

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F 558	Continued From page 10 A policy on positioning for comfort was requested but not provided	F 558		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a level II preadmission screening and resident review (PASARR) for 1 of 1 resident (R11) reviewed with a new mental illness diagnosis. Findings include: R11's face sheet, printed on 12/6/22, indicated R11's original admission date was 10/4/11, diagnosis at time included alcohol dependence and anxiety disorder. Further review of the	F 644	Thorne Crest has and always will ensure that it will coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. Referring all level II	1/19/23

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F 644	Continued From page 11 diagnosis listed on face sheet, indicated R11 was diagnosed with post-traumatic stress disorder (PTSD) on 7/24/12, major depressive disorder, single episode, on 4/4/17; and somatoform disorders on 2/26/18. R11's annual Minimum Data Set (MDS) assessment dated 4/15/22, indicated R11 had intact cognition and received antidepressant medication twice daily. R11's current physician orders printed 12/1/22, included: Duloxetine (an antidepressant medication) 60 milligrams (mg) by mouth two times a day related major depressive disorder, single episode. R11's care plan last reviewed on 11/8/22, included: R11 had behaviors related to (R/T) PTSD, major depressive disorder-single episode, anxiety disorder; may exhibit rejection of evaluations/cares, rudeness, bossing, snipping, being demanding of other residents/staff, acting territorial over community property, tendency to try to manipulate others/situations. Further review of care plan indicated R11 had altered mood patterns/psychosocial well-being, which consisted of feeling down, overeating, had trouble sleeping. R11 had a history of being physically abused by significant other, was withheld food, became sick and frail; received mental health services since 2019. Record review of PASARR screen, completed on 10/18/11, indicated negative level 1 screening, level 2 screening not needed at time. Record review indicated R11 had resided at facility since admission on 10/4/11, was sent to	F 644	residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Level II assessment for R11 was completed on 1/6/2023 by Freeborn County Human Services. All like residents have been reviewed and requests for Level II Assessments will be sent to Freeborn County Human Services for those requiring Level II Assessments. Upon admission, or as needed, the Social Services Director, or designee, will review if any residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Administrator provided training and education to Social Services Director on 1/5/2023 on the importance of reviewing the PASARR on all new admissions to determine the need for a Level II Assessment. Also educated on importance of referring all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. To ensure compliance, Social Services	

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F 644	Continued From page 12 hospital for acute and chronic respiratory failure 4/21, readmitted back to facility on 4/15/21, no PASARR screen completed prior to facility readmission. During an interview, on 12/06/22 at 1:29 p.m., social services (SW)-A indicated when residents are going to be admitted to facility, either she or sending facility will complete PASSARR screening. SW-A stated if resident determined to have mental health concerns, a level 2 PASARR screen would be completed. SW-A indicated to her knowledge, a PASARR screen did not need to be completed again while residing in facility, even if diagnosed with a new mental illness. While interviewed, on 12/06/22 at 2:11 p.m., assistant director of nursing (ADON), indicated was not familiar with PASARR process, stated social worker handled. During an interview, on 12/06/22 at 2:22 p.m., the director of nursing (DON), indicated awareness of PASARR process, stated PASARR should be completed prior to facility admission and anytime there was a new diagnosis of mental illness. DON indicated PASARR was completed typically per SW, ADON or DON could also assist with PASARR process screen if needed. DON stated R11 had been receiving psychiatry services, however lacked communication from previous psychiatry visits regarding new orders and/or diagnosis. DON indicated when residents were diagnosed with a new mental illness and/or intellectual disorder, licensed nursing were to communicate provider orders to ADON or DON, ADON or DON would communicate new diagnosis and need for PASARR screen with SW at daily interdisciplinary team (IDT) meetings,	F 644	Director/designee has initiate audits 3 times a week x 2 weeks, on any changes of newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II assessment, then weekly basis x 4 weeks, and for one month with results being reported to the QAPI committee.	

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F 644	Continued From page 13 health information management (HIM) would update diagnosis list with new diagnosis. The DON confirmed R11 should've had new PASARR screens completed when diagnosed with PTSD on 7/24/12, major depressive disorder, single episode, on 4/4/17, and somatoform disorders on 2/26/18; DON indicated staff needed re-education on PASARR process. Facility policy titled Admission Criteria, revised date 3/19, indicated objectives of admission criteria policy which included provide uniform criteria for admitting residents to the facility, admit residents who can be cared for adequately by the facility. Furthermore, the policy stated all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level 1 PASARR screen for all potential admissions, regardless of payor source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level 2 (evaluation and determination) screening process. 1. The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. 2. The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level 2 evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or	F 644		

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F 644	Continued From page 14 she needs, and whether placement in the facility is appropriate. d. The state PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified.	F 644		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure shaving was completed for 1 of 1 resident (R40) reviewed for ADLs who required extensive staff assistance with cares. Finding include: R40's admission Minimum Data Set (MDS) assessment dated 11/21/22, indicated R40 had severely impaired cognition and required extensive assistance from staff to maintain personal hygiene. R40's care plan, printed on 11/15/22; indicated R40 required staff assist of 1 to maintain personal hygiene, ADL function had deteriorated due to dementia (memory loss), decrease in physical	F 677	Thorne Crest has and always will ensure that any resident unable to carry out activities of daily living (ADL□s) will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R40 has been shaved to resident□s liking. Care plan was reviewed and updated. Whole house audit conducted by Social Services Director Director of Nursing provided training and education on Activities of Daily Living (ADLs), supporting policy and procedure was reviewed with nursing staff on 1/5/2023 to ensure that residents are	1/19/23

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F 677	Continued From page 15 function, and end of life (hospice). Care plan directed staff to ensure appearance was neat and clean daily, staff to perform all facial shaving for R40, offer cues as needed so R40 aware of cares provided. During an observation on 12/06/22 at 8:25 a.m., R40 was observed to have longer facial hair present above lips, to face and chin. While observed on 12/07/22 at 8:34 a.m., R40 continued to have longer facial hair present above lips, to face, and chin. During an interview, on 12/07/22 at 8:35 a.m., nursing assistant (NA)-I indicated awareness of R40's preference to be clean shaven, required staff assistance with shaving cares, occasionally would refuse cares. NA-I verified R40 had longer facial hair present above lips, to chin and face, would offer shaving after breakfast. While interviewed, on 12/07/22 at 8:46 a.m., licensed practical nurse (LPN)-A indicated R40 needed staff assistance with shaving, unsure if he liked to be clean shaven, occasionally would refuse cares. LPN-A stated if residents refuse cares, NA was to notify licensed nurse of refusal, licensed nurse would attempt to perform care refused, if care still refused licensed nurse would document refusal of care in nursing progress note. LPN-A reviewed nursing progress notes from 11/23/22-12/7/22, stated no behaviors or refusal of shaving cares documented for R40 in nursing progress notes. During an interview, on 12/07/22 at 8:55 a.m., family member (FM)-E indicated awareness of R40's preference to be clean shaven daily, and	F 677	supported with ADL□s at that time. To ensure compliance, Social Services Director/designee has initiate audits to ensure all residents are provided ADL□s according to individual resident desires daily (M-F) for 2 weeks, then weekly for 4 weeks, and monthly for one month with results being reported to QAPI.	

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F 677	Continued From page 16 needed staff assistance with all grooming and hygiene cares. FM-E was not aware of R40 being resistive when cares provided. During observation on 12/07/22 at 12:30 p.m., R40 sat calm and relaxed in wheelchair in main living room area watching TV. R40 was noted to continue to have longer facial hair present above lips, to face, and chin. During interview and observation, on 12/07/22 at 12:32 p.m., the director of nursing (DON), indicated staff offered residents shaving cares daily, would not shave residents if refused, would attempt to offer shaving cares x3 before documenting refusal of care. DON stated attempts to offer shaving made by 2 different NAs, if resident shaving cares refused, NA would report refusal of care to licensed nurse, licensed nurse would offer shaving care, if care refused licensed nurse would document refusal in progress note. DON reviewed nursing progress notes from 11/23/22-12/7/22, verified no documentation of refusal of shaving cares. DON observed at time of interview R40's face, confirmed R40 had longer facial hair present above lips, to face and chin. Facility policy titled Activities of Daily Living (ADL), Supporting; revised 3/18, indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		1/19/23

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F 684	Continued From page 17 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to follow their protocol for reporting and monitoring a change of skin condition for 1 of 1 resident (R18) reviewed for a non-pressure skin lesion when the resident had high risk medical diagnoses. Findings include: R18's 5-day admission Minimum Data Set (MDS) assessment dated 11/16/22, indicated R18's cognition was moderately impaired. The MDS indicated R18 was receiving dialysis and had renal disease, diabetes mellitus and with other serious co-morbidities of cardiac and pulmonary involvement. On 12/5/22, at 4:23 p.m. R18 was observed to have a dark purple bruise on the top of his left hand covering approximately half of the surface with some slight redness surrounding the bruise and slight swelling surrounding that. R18 did not know how he had gotten the bruise, but said sometimes he would get his hand stuck between the wheelchair and the door. R18 did not think he had had any lab draw from that hand and could not recall if the injury had occurred in the facility, at dialysis or during transportation to or from dialysis. R18 was not able to state how long he	F 684	Thorne Crest has and always will ensure that our residents are receiving quality 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 does ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A skin assessment was completed on R18 on 12/7/22 and again on 12/14/22. Whole house audit was conducted on 12/7/22 and will be conducted weekly on all resident with skin issues. Any new skin conditions will be reviewed daily (M-F) at morning meeting. Director of Nursing provided training and education to the nursing department on the importance of prompt reporting of skin conditions when found to Licensed Nurse. Quality of Care and Skin Assessment policy and procedure were reviewed with nursing staff on 1/5/2023 to ensure that	

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F 684	Continued From page 18 had had the purple mark on his hand. During an observation on 12/7/22, at 8:00 a.m. the purple area on R18's left hand remained dark purple, but appeared slightly smaller in size; however, the surrounding area was reddened. During an interview on 12/7/22, at 8:06 a.m. a licensed practical nurse (LPN)-B stated the facility practice for monitoring skin condition was to check each resident on bath day for any new lesions. LPN-B stated she had just discovered and measured R18's bruise, and planned to check his chart to see if the injury had already been reported. LPN-A stated R18 had dry skin and would pick and scratch his skin, but he was not able to tell her how the injury had occurred due to his forgetfulness. LPN-B stated R18 was at risk for skin issue due to his condition, and to being a dialysis recipient. LPN-B also stated it was possible R18 might have had lab drawn from his hand, causing the injury, but did not know if any lab had been done recently. During an interview on 12/7/22, at 3:18 p.m. the director of nursing (DON) stated any changes in skin condition, including bruises, were to be reported to nursing who would assess the skin, document assessment, look for a cause of that reported concern, and develop an appropriate intervention. Any "risk management issues" such as falls, injuries, pressure areas or other skin issues were to be reported to the DON for further review. DON stated she had not yet received a report of R18 having a bruise. DON reviewed R18's chart for any documentation and for the possibility of a lab draw on that hand but did not find any.	F 684	residents are always provided Quality Care. Residents skin audits will be conducted by the Assistant Director of Nursing/ designee initiated on 12/7/22. These will be conducted weekly ongoing thereafter with results being reported to QAPI.	

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F 684	Continued From page 19 A facility policy titled Pressure Ulcers/Skin Breakdown-clinical protocol, last revised April 2018, indicated "the physician will help identify factors contributing or predisposing residents to skin breakdown" and the physician will order pertinent wound treatments. The protocol did not provide direction on monitoring and reporting of skin condition by nurses.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R24) reviewed for contractures and limited ROM. In addition, the facilty to provide ambulation service to maintain function for 1 of 2 residents (R18)	F 688	Thorne Crest has and always will ensure that all residents are provided services to maintain and prevent loss of range of motion or mobility. R24 (ROM) Updated care plan to include assisted ROM twice daily. Tracking for	1/19/23

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F 688	Continued From page 20 reviewed for a walking program. Findings include: R24's quarterly Minimum Data Set (MDS) assessment dated 9/22/22, identified R23 had severely impaired cognition, had impairment to both lower extremities (LEs), had no impairment to both upper extremities (UEs); required extensive assist of 2 staff with activities of daily living (ADL) including bed mobility, transfers, dressing, toileting; extensive assist of 1 staff with eating and personal hygiene. R24 used a wheelchair for mobility and required 1 staff assist for locomotion. The MDS further indicated R24 was on hospice, received scheduled and as needed (PRN) pain medication for pain, had not received restorative nursing services. R24's face sheet, printed on 12/7/22, identified diagnosis list to include Parkinson's disease (brain disorder causing uncontrollable body movements), dementia (brain disorder causing memory loss), dystonia (involuntary muscle contraction causing repetitive twisting movements), corticobasal degeneration (brain and nerve disorder causing difficulty in moving one or both sides of body), abnormal reflex, and weakness. R24's order summary report, printed 12/2/22, indicated R24 received acetaminophen 500mg three times daily for pain, bengay vanishing scent gel 2.5%- applied to neck and upper shoulders topically twice daily for discomfort, morphine sulfate 5mg one time daily for pain. R24's order summary report, signed per physician on 8/5/22, indicated physician noting	F 688	task was added to POC. R18 (Ambulation) Care Plan was reviewed, no changes to current plan. Updated tracking in POC. All like residents requiring assistance with ambulation and/or at risk for contractures have been reviewed and added to nursing rehab list. Wellness Director has developed an exercise program which includes ROM, muscle atrophy, posture, contractures, and gait performance. Director of Nursing provided training and education on 1/5/2023 to the nursing department on the importance of following resident individual nursing rehab programs. Wellness Director will be providing additional in-depth training with nursing staff. To ensure compliance, Director of Nursing or designee will initiate audits to ensure appropriate care and services are implemented to maintain abilities and reduce the risk for contractures occurring and/or prevent contractures from worsening. Audits will be conducted daily (M-F) for 2 weeks, weekly 4 weeks, and then monthly x1 month thereafter for three months thereafter with results reported to QAPI.	

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F 688	Continued From page 21 slight contractures for resident, no recommendations provided for contractures. Hospice service provider residential communication form indicated upper contractures very tight on 11/30/22, upper extremities very rigid on 9/20/22, continues to have contractures bilateral upper extremities (BUEs)- right arm is able to be extended with time on 7/1/22. Hospice admission note, dated 11/16/21, indicated R24's left upper extremity (LUE) contracted and very rigid. R24's care plan, last revised on 9/30/22, indicated pain due disease, to receive pain medications as ordered and nonpharmacologic interventions including massage, heat, cold, position change; to establish and coordinate plan of care (POC) and services between long-term care (LTC) and hospice team. During an observation and interview, on 12/05/22 at 4:26 p.m., R24's LUE was observed bent and slightly rigid at elbow, was crossed over chest to right side, lying on top of pillow, fingers curled inwards toward palm of hand. R24 was able to extend left 2nd finger, rest of fingers remained curled inwards toward palm of hand and appeared slightly rigid. R24 denied pain at time of observation. Family member (FM)-D was present during observation and interview, stated awareness of LUE contracture, had been progressively worsening, not aware of any therapy exercises or interventions in place to prevent further decline of contracture, would like R24 to have therapy exercises and equipment in place, as "beneficial" to prevent further contractures.	F 688		

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F 688	Continued From page 22 While interviewed, on 12/07/22 at 7:25 a.m., nursing assistant (NA)-H indicated awareness of contracture to R24's LUE. NA-H stated R24's LUE had always been bent and rigid at elbow, elbow too painful to extend. NA-H indicated R24 was not receiving any type of exercise therapy or had any interventions in place to prevent further contracture of LUE that she was aware of, stated R24 was on hospice, goal was comfort cares. During an interview, on 12/07/22 at 7:26 a.m., licensed practical nurse (LPN)-A indicated awareness of contracture to R24's LUE, had no changes in contracture to LUE since admission to facility on 3/30/22. LPN-A stated R24 had not received any type of exercise therapy or had any interventions in place to prevent further contracture to LUE that she was aware of, R24 admitted to facility already on hospice care, no recommendations provided from hospice for therapy exercises, goal was for comfort cares. During an observation and interview, on 12/07/22 at 7:45 a.m., assistant director of nursing (ADON) indicated awareness of contracture to R24's left upper extremity, had no changes since admission to facility. ADON stated she thought R24 had been receiving restorative nursing services for exercise therapy to prevent further contractures, checked R24's orders and care plan, verified R24 had not been receiving any restorative nursing services or had interventions in place for contracture since admission to facility. ADON assessed R24's LUE, confirmed contracture at left elbow and 3rd-5th digits of left hand. ADON indicated it was her expectation that with staff awareness of R24's LUE contracture, even if R24 was on hospice, R24 should've received	F 688		

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F 688	Continued From page 23 restorative nursing services including exercise therapy and assistive devices for prevention of worsening contracture and comfort from pain due to contracture of LUE. Facility policy titled Resident Mobility and Range of Motion, revised date 7/17, indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 1. As part of the resident's comprehensive assessment, the nurse will identify the resident's current range of motion of his or her joints, limitations in movement, opportunities for improvement, and previous treatment and service. 2. Conditions that place the resident at risk for complications related ROM and mobility including: pain, muscle wasting and atrophy, gait and balance issues, contractures. 3. During the resident assessment, the nurse will identify the underlying factors that contribute to his or her range of motion or mobility problems including: immobilization, neurological conditions, conditions in which movement may lead to pain and/or conditions that limit or immobilize movement of limbs or digits. 4. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. 5. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Walking Program	F 688		

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F 688	Continued From page 24 R18's 5-day admission Minimum Data Set (MDS) assessment dated 11/16/22, indicated R18's cognition was moderately impaired. R18 required extensive assist of two persons to transfer, but could walk independently with supervision in his room. The MDS indicated walking in the hallway happened only 1 or 2 times during a 7 day look back period and R18 required the assistance of one person for that activity. The MDS did not indicate any rejection of care during that time period. The MDS indicated R18 had generalized muscle weakness and difficulty walking with unsteadiness of gait. The MDS further indicated R18 had diagnoses including renal disease, diabetes mellitus and obesity along with other serious co-morbidities of cardiac and pulmonary involvement. According to a R18's care plan focus problem area entered on 9/30/22, "resident is at high risk for falls related to deconditioning." The associated interventions indicated staff were to anticipate and meet the resident's needs, have physical therapy (PT) evaluate and treat as ordered or as needed, but no further interventions were listed related to resolution of R18's deconditioning. Another problem area indicated "I require assistance with my ADLs (activities of daily living) and mobility related to recent hospitalization for UTI and deconditioning, created 9/23/22." Interventions for mobility indicated, "I require staff assistance of 2 to transfer with use of my walker. Offer me cues and set up assistance as needed," and "I require assistance of 2 with my roll walker for all ambulation." The care plan did not indicate how often staff were to offer ambulation, but interventions included, "OT (occupational therapy) and PT as ordered."	F 688		

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F 688	Continued From page 25 According to a document titled Therapy Recommendations and dated 10/25/22, PT had recommended R18 be walked to the bathroom or in his room with 1 assist and a 2 wheeled walker. Additionally, R18 should walk in the hall daily with one assist as tolerated. According to a review of nursing assistant documentation of "walking to bathroom/in room and in halls as tolerates" with two opportunities per day over 30 days, "not applicable" was charted 29 times. Resident refused was charted 5 times and resident not available charted three times. Out of 60 opportunities, ambulation was charted only 12 times. During an interview and observation on 12/5/22, at 4:24 p.m. R18 was sitting in a wheel-chair in his room and did not attempt to move himself about the room. R18 stated he did not get walked, nor did he get exercise, but stated his wife said he should go to therapy. R18 stated he would like it if he would be walked on a regular basis or if he could return to therapy for further exercise. During an interview on 12/7/22, at 1:02 p.m. a nursing assistant (NA)-B stated R18 was on their walking list and can walk with one assistant to the bathroom and in the halls. NA-B stated she had walked with R18 a few times, but said, "he refuses a lot." NA-B did not think R18 clearly understood explanations or consequences. During an interview on 12/8/22, at 8:45 a.m. the director of nursing (DON) reviewed the documentation in R18's chart and stated she could see R18 did refuse at times, but said	F 688		

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F 688	Continued From page 26 documentation of "not applicable" was not appropriate. DON stated residents had the right to refuse their plan of care, but documentation should clearly indicated if the person was refusing or if staff were not providing the care for whatever reason. DON stated an expectation for staff to attempt ambulation as care planned and document and report refusals. DON stated a concern of R18 becoming more deconditioned and stated, "I think we need to figure out if we need a change in plans, to see if R18 needs to go back to therapy." During an interview 12/8/22, at 8:55 a.m. a physical therapy aide (PTA)-A stated an expectation for staff to follow therapy recommendations after a resident had been discharged from therapy services. PTA-A stated the therapy department should receive communication if a resident refuses their exercise program or is not able to do it. PTA-A stated she had not received any communication from staff as to whether R18 was compliant with his advised program or not. PTA-A stated R18 had developed more strength when he was attending therapy sessions because they strongly encouraged participation in exercise, but they had determined he was more appropriate for a maintenance program. PTA-A stated concerns that R18 could develop pressure sores, joint contractures and/or a continued decline in his condition if he was not participating in the maintenance program as outlined. A policy titled Resident Mobility and Range of Motion, last revised July 2017, indicated "residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction	F 688		

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F 688	Continued From page 27 in mobility is unavoidable." The policy indicated the care plan would be developed by the interdisciplinary team based on the comprehensive assessment, and would be revised as needed. The care plan would include specific interventions and exercises to maintain or prevent an avoidable decline in mobility. The policy indicated "documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs."	F 688		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired food were identified and removed from 1 of 3 stand-up	F 812	Thorne Crest has and always will ensure that all food is stored, prepared, distributed, and served in accordance with	1/19/23

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F 812	Continued From page 28 kitchen refrigerators, walk-in refrigerator, and walk-in freezer. This had the potential to affect all 42 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 12/5/22 at 1:10 p.m., with dietary aide (DA)-A, observed food items in stand-up refrigerator, walk-in refrigerator, and walk-in freezer that were not dated or marked and/or were expired. The DA-A indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators and freezers should be gone through daily to check for expired or damaged food. The DA-A indicated if any food or drink were not dated when opened, it should be removed immediately, all left over food should be used within 3 days from opening days, discarded after 3 days. The following items were observed during tour: Stand-up refrigerator across from dish sink: 1. sliced black olives in facility container; approx. ¾ full; open date of 11/18/22, no expiration date or use by date listed. Walk-in refrigerator labeled 1: 1.sun-dried tomatoes in facility zip-lock plastic bag; approx. ¼ full, observed to be mushy, molded together, foul odor present when bag opened; open date of 9/10/22, no expiration date or use by date listed. Walk-in freezer labeled 2: 1. seasoned marinara in facility container; full, opened date of 6/30/22, no expiration or use by	F 812	professional standards for food service safety. The policy on Food Storage was reviewed, no changes made. Dietary Director provided training and education to dietary staff on proper labeling/dating of food items completed by 12/26/2022. Attachment B To ensure compliance, the Dietary Director initiated audits on 12/26/22 to ensure all foods are properly labeled/dated and that all foods are monitored for expiration dates and discarded daily (M-F) for 2 weeks, and 3 times week for 2 weeks, and monthly for three months thereafter with results being reported to QAPI. Attachment C	

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F 812	Continued From page 29 date listed 2. facility steel pan filled with frozen chicken thighs; at least 10 chicken thighs sitting over plastic liner covering steel pan; moderate amount of frozen blood on plastic liner and bottom of steel pan, chicken thighs observed to have been freezer burned, prep date listed 11/17/22, use by date of 11/22/22. When interviewed, on 12/8/22 at 10:52 a.m., cook (C)-A indicated all dietary staff had monthly facility in-service meetings regarding proper food handling, and yearly state food handling course. Facility policy titled Food Storage, dated 2021, consisted of; sufficient storage facilities will be provided to keep food safe, food will be stored by methods designated to prevent contamination or cross contamination; date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS food should be consumed, sold, or discarded; plastic containers with tight-fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk foods or opened packages; all containers or storage bags must be legible and accurately labeled and dated; leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated; leftover food must be used within 7 days or discarded per the 2017 Federal Food Code; all foods will be checked to assure that foods will be consumed by their safe use by dates or discarded.	F 812		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		1/19/23

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F 881	Continued From page 30 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any residents who had infections requiring antibiotic use. Findings include: During interview on 12/7/22, 1:12 p.m., the facility's infection preventionist (IP)-A indicated the nurses complete monitoring of symptoms if resident has a possible infection and report that information to the providers. The providers are required to use criteria per their own employer to identify potential infections, order testing and to review the cultures and results to ensure resident is taking proper antibiotic. The IP indicated the facility currently is not using McGeer's or Loeb's criteria. The IP-A indicated she has access to culture results but has not been looking at them on a routine basis or tracking culture results to ensure proper antibiotics are prescribed. A log titled infection and antibiotic tracking included resident name, date of onset, symptoms present, diagnosis, labs and type, and name of	F 881	Thorne Crest has and always will ensure that an Antibiotic Stewardship Program is implemented to include a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. All antibiotic orders and associated lab/culture findings will be reviewed as part of morning clinical meeting daily (M-F). The facility will utilize the Point Click Care infection module to track all confirmed and suspected infections. Director of Nursing provided education to Infection Preventionist, and Licensed Nurses on Point Click Care infection module and surveillance tracking. To ensure compliance, Director of Nursing and/or Infection Preventionist will audit Point Click Care Infection Module daily (M-F) times 2 weeks, three days a week times 2 weeks, monthly thereafter results being reported to QAPI.	

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F 881	Continued From page 31 the antibiotic used and date resolved. Review of the logs included: (all had resident name and room number) --June 2022 there was one entry: Date of onset was 6/17/22, symptoms present, temperature and per family request, diagnosis urinary tract infection (UTI), labs urinalysis (UA) antibiotic Bactrim, date resolved was blank. --July 2022 there were 4 entries: Date of onset 7/6/22, symptoms was blank, diagnosis pneumonia labs and type, antibiotic was blank and date resolved "res". Date of onset 7/8/22, symptoms present was blank, diagnosis UTI, labs UA, antibiotic Cefidinir, date resolved "res". Date of onset 7/13/22 symptoms present was blank, diagnosis rule out pneumonia or exacerbation of chronic obstructive pulmonary disease (COPD), labs was blank, antibiotic Azithromycin for 5 days, date resolved "res". Date of onset 7/31/22, symptoms present was blank, diagnosis UTI, labs was blank, antibiotic ciprofloxacin for 5 days, date resolved "res". --August 2022 there were 2 entries: Date of onset 8/3/22, symptoms present was blank, diagnosis UTI, labs was blank, antibiotic Macrobid twice a day for 14 doses, date resolved 8/10 or 8/11. Date of onset 8/31/22, symptoms present blank, diagnosis pneumonia, labs was blank, antibiotics inhalers used and no antibiotic prescribed, date resolved "resolved". --September 2022 there was 5 entries: date of onset 9/6/22, symptoms present was blank, diagnosis was COVID-19, labs was blank, antibiotic Cefdinar, date resolved 9/21/22. Date of onset 9/6/22, symptoms present was UTI,	F 881		

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F 881	Continued From page 32 diagnosis UTI, labs was blank, antibiotic Cefdinir for 5 days, date resolved was blank. Date of onset 9/14/22, symptoms present fever, swelling, diagnosis infection of jaw, labs was blank, antibiotic amoxicillin for 10 days with date resolved 9/14/22. Date of onset 9/19/22, symptoms present was UTI, diagnosis was blank, labs was blank, antibiotic Bactrim with date resolved as 9/18/22. Date of onset 9/26/22, symptoms UTI (admitted to the facility with this), antibiotics SMZT 400-80 mg on Monday, Wednesday and Friday daily, date resolved indefinite. Date of onset 3/11/22, symptoms was infection following procedure, diagnosis had antibiotic of Doxycycline 100 mg twice a day, date resolved indefinite. --October 2022 there were 5 entries: date of onset 3/11/22, symptoms infection following procedure, diagnosis had doxycycline 100 mg twice a day, labs was blank, antibiotics blank and date resolved was indefinite. Date of onset 10/3/22, symptoms UTI - culture indicated, diagnosis had levofloxacin before breakfast once a daily for 3 days, labs was blank, antibiotics blank, and date resolved 10/6/22. Date of onset 10/4/22, symptoms mouth infection/tooth, diagnosis was Augmentin 500 mg tablets, 1 tab three times a day for 7 days written in, antibiotics and date resolved was blank. Date of onset 10/5/22, symptoms present wound on right lower leg, diagnosis had cefdinir 300 mg tablet, labs had twice a day for 7 days, antibiotics had presumptive/preventative written and date resolved was blank. Date of onset 10/17/22 symptoms present UTI, culture indicated, diagnosis was Bactrim DS, labs had twice a day for 7 days, antibiotics and date resolved was blank. Date of onset 9/26/22, symptoms present	F 881		

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 12/08/2022

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 881	Continued From page 33 was Wegener's granulomatosisis with renal involvement, diagnosis was Bactrim 400-80, labs was Monday, Wednesday and Friday, antibiotics was blank and date resolved was indefinite. --November 2022 a new form was used that included onset of symptoms, symptoms, which was split into 7 categories including flu like, cold/URI, pneumonia, UTI, gastroenteritis, skin infection and EENT (Eyes, ears, nose and throat), labs, doctor visit, treatment and date resolved. There were 10 entries. Diagnosis was written into symptoms columns, labs and doctor visit had antibiotic and dosage written in columns and date resolved was present. A policy and procedure titled Antibiotic stewardship, dated 12/2016, included: When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued. A policy titled "Antibiotic Stewardship - Staff and Clinician Training and Roles" dated 12/2016 included: The director of nursing (DON)/infection preventionist will monitor individual resident antibiotic regimens, including: Reviewing clinical documentation supporting antibiotic orders; and compliance with start/stop dates and or days of therapy.	F 881		
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		1/19/23

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 12/08/2022

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 888	Continued From page 34 §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.	F 888		

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F 888	Continued From page 35 §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized	F 888		

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F 888	Continued From page 36 clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or	F 888		

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F 888	Continued From page 37 those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that three of 94 staff (nursing assistant (NA)-E and Dietary aide (DA)-D, DA-E) were fully vaccinated for COVID-19 or were provided a medical or religious exemption. This resulted in a 97.9 % vaccination rate for the facility which created the potential for the spread of the COVID-19 virus. In addition, the facility did not implement a contingency plan for 3 of 3 exempted staff (licensed practical nurse (LPN)-E, NA-F, DA-C) or not fully vaccinated staff. Findings include: Review of the facility's Healthcare Personnel COVID-19 Tracking Worksheet dated 12/6/22, indicated the following: -Nursing assistant (NA)-E received the first dose of Moderna vaccine on 8/31/22, and had not received a second dose. -DA-D received the first dose of Moderna vaccine on 8/3/22, and had not received a second dose. -DA-E received her first dose of Pfizer vaccine on 7/21/22, and had not received a second dose. -LPN-E was not vaccinated and had a religious exemption -NA-F was not vaccinated and had a religious exemption -DA-C was not vaccinated and had a religious exemption During an interview on 12/7/22, at 1:08 p.m. the	F 888	Thorne Crest has and always will ensure that it has an established, and it maintains, an infection prevention and control program (IPCP) Policy provided during survey was incorrect policy. Current policies were reviewed, no changes needed. Attachment: D & E DA-D is no longer working at the facility. Her last day of employment was 12/24/2022. NA-E, DA-E, LPN-E, NA-F, and DA-C have been trained and educated to the current facility/company policies on COVID-19 Vaccination Requirements and COVID-19 Mandatory Testing. Infection Preventionist provided training and education on 1/6/2023 on required use of facemasks, eye protection, testing, /and vaccination requirements. Policies reviewed were COVID-19 Vaccination Requirements and COVID-19 Mandatory Testing. To ensure compliance, Infection Preventionist initiated audits COVID-19 vaccine compliance for vaccinations and mitigation of COVID-19 for non-vaccinated employees, appropriate use of facemasks and eye protection and	

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F 888	Continued From page 38 infection preventionist (IP) indicated they have 3 staff members who have not completed their second COVID-19 vaccine yet. The IP indicated reminders have been sent to the above employees, but to her knowledge they have not completed them. The IP indicated if they don't complete their 2nd vaccine they will be pulled from the schedule in the future. Review of recent 2022 schedules included: -NA-E worked 10/3, 10/4, 10/5, 10/7, 10/12, 10/13, 10/15, 10/16, 10/18, 10/19, 10/21, 10/27, 10/28, 10/29, 10/30, 11/4, 11/9, 11/10, 11/11, 11/12, 11/13, 11/14, 11/18, 11/23, 11/24, 11/26, 11/27, 11/28, 11/29, 12/2, 12/5. -DA-D worked 8/20, 8/21, 9/1, 9/3, 9/4, 9/5, 9/18, 10/1, 10/2, 10/15, 10/16, 10/29, 10/30, 11/12, 11/13, 11/29, 11/20, 11/26, 11/27 -DA-E worked 8/20, 8/21, 8/27, 8/28, 9/3, 9/4, 9/5, 9/18, 10/1, 10/2, 10/22, 10/23, 10/29, 10/30 During interview on 12/7/22, at 1:30 p.m., IP indicated all staff are currently required to wear masks and goggles when in outbreak which the facility is currently in. The IP indicated the facility no longer does testing of any employee unless they have signs and symptoms of COVID-19. The IP indicated there is no distinguishing between vaccinated or non-vaccinated employees anymore for testing or for PPE. When asked what they are doing to mitigate the risks for non-vaccinated employees, the IP again indicated they are no longer distinguishing between vaccinated and non-vaccinated employees. During interview on 12/8/22, at 7:26 a.m., the dietary manager (DM)-A indicated both employees (DA-E and DA-D) still work at the facility but mainly weekends. When asked if staff	F 888	educate all staff on the requirements of use. Audits will be conducted 3 times weekly times 2 weeks, weekly times 2 weeks and monthly thereafter with results being reported to QAPI.	

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F 888	Continued From page 39 were wearing an N-95 mask or completing COVID-19 testing, DM-A indicated no. When asked what they are doing to mitigate risk factors, DM-A indicated she didn't know. DM-A indicated she had spoken with DA-E who stated she would get an appointment for her second covid shot. DM-A was not able to reach DA-D. During interview on 12/8/22, at 11:10 a.m., the director of nursing (DON) indicated staff are not required to wear N-95 masks unless they are in outbreak status with residents who are positive for COVID-19. Review of testing log indicated the facility has been in outbreak status since 10/3/22. Testing logs included: LPN-E was tested 10/6 and 10/8, 10/31 and 11/3 NA-E was tested 10/10/22 DA-C, DA-D and DA-E were not tested NA-F was tested 10/14, 10/31 and 11/4 Review of the facility policy titled COVID-19 Vaccination Requirements, dated 2/25/22, included: - The facility shall ensure all newly hired employees, licensed practitioners, students, trainees, volunteers and contracted staff are fully vaccinated against COVID-19 at the time of hire, or receive their first dose of the COVID-19 vaccination prior to assignment involving exposure to clients and/or infectious materials. Alternatively, individuals may request a medical or religious exemption. Those not fully vaccinated, awaiting their second vaccine dose, will be required to follow the PPE (personal protective equipment) guidelines and testing requirements of unvaccinated individuals granted medical or religious exemptions.	F 888		

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F 888	Continued From page 40 -Unvaccinated Individuals Granted Medical or Reglious Exemptions: -Any employee exempted from COVID-19 vaccination under the mandatory vaccination policy, if approved to continue working at the community, is required to wear personal protection wear while on ABHM campus, which includes an N-95 mask, and protective eyewear (if required). The employee may be assigned to a unit or area other than normal work assignment at the discretion of the DON and IP. -The facility will conduct routine surveillance testing for all unvaccinated individuals who have been granted medical or religious exemptions, according to the latest update from the state and federal governments. -The infection preventionist or designee will will contact each employee who does not meet the definition of fully vaccinated to determine: -If eligible staff have received one-dose of the two-dose series and has an appointment for the second dose. - The infection preventionist or designee will educate all employees who are not fully vaccinated (employee received one dose of a two-dose series or less than two weeks since the last dose of a primary COVID-19 vaccine and employees with a valid exemption) additional precautions and measures to mitigate the spread of COVID-19 for all staff that are not fully vaccinated: -Personal protective equipment -Transmission-Based Precautions -Hand Hygiene -Physical distancing -Cleaning and Disinfection -Screening -Testing per facility COVID-19 testing policy and procedure.	F 888		

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F 888	Continued From page 41 A policy titled "CMS-COVID-19 Mandatory Testing" last revised 9/29/22 included: -A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in any residents triggers an outbreak investigation. -Routine Testing of asymptomatic staff is no longer recommended but may be performed at the discretion of the facility	F 888		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245425	A. BUILDING: _____ B. WING _____	12/8/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 2 of 3 residents (R37, R18) whose Medicare A coverage ended, and the residents remained in the facility. Findings include: R37's Centers for Medicare and Medicaid Services (CMS)-10123 was signed by R37 on 10/27/22 and identified the last effective date of coverage of current services was 10/29/22. This document lacked the reason for discontinuation of Medicare A benefits, although R37 remained in the facility. R37s medical record lacked any evidence a SNFABN 10055 had been provided to inform R37 of the estimated cost per day, or an explanation of the extended care services or items to be furnished, reduced, or terminated.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245425	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/8/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1

R18's Centers for Medicare and Medicaid Services (CMS)-10123 was signed by R18 on 10/24/22 and identified the last effective date of coverage of current services was 10/26/22. This document lacked the reason for discontinuation of Medicare A benefits, although R18 remained in the facility. R18s medical record lacked any evidence a SNFABN 10055 had been provided to inform R18 of the estimated cost per day, or an explanation of the extended care services or items to be furnished, reduced, or terminated.

During interview on 12/06/22, at 10:13 a.m., the director of nursing (DON) indicated her understanding is if a resident is discharged from Part A Medicare, the Notice of Medicare Non-Coverage (NOMNC) was given and if discharged from Part B medicare, the other form (Advanced Beneficiary Notice CMS-10055) was given.

During interview on 12/6/22 at 2:30 p.m., the DON indicated the wrong form was given and has been corrected.

A policy and procedure titled Notice of Covered and Non-Covered Services, last revised 10/2022, included:
- Notice of Medicare Non-Coverage (NOMNC) form 10123 is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization. See also 42 CFR 405.1200 and 422.624.
- The NOMNC is not given if the beneficiary exhausts the Skilled Nursing Facility (SNF) benefits coverage (100 days), thus exhausting their Medicare Part A SNF benefit.

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 _____	**12/07/2022**

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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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 12/07/2022. 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 | 01/08/2023

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.

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 _____	**12/07/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THORNE CREST RETIREMENT CENTER is a 1-story building with no basement. The building was constructed in 1953 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 52 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2. This deficient finding could have an isolated impact on the residents	K 353	Thorne Crest has and always will comply with the inspection and maintenance of the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25(2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2.	1/6/23

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K 353	Continued From page 3 within the facility. Findings include: On 12/07/2022 at 11:30 AM, it was revealed by observation, that sprinkler head(s) located in 44B exhibited signs of being foreign substance laden or paint. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	The sprinkler head(s) located in44B has been cleaned of foreign substance immediately. All other sprinkler heads in the facility were checked immediately and none were found to have foreign substance on them. To ensure compliance, Maintenance Director initiated audits to assure that all sprinkler heads are free of foreign substance daily (M-F) for 2 weeks, then weekly for 4 weeks and for one month thereafter with results being reported to QAPI.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		1/6/23

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K 918	Continued From page 4 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, inspect, and test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3 and 6.4.4.2 and NFPA 110 (2010 edition) sections 8.4.9 through 8.4.9.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/07/2022 at 11:30 AM, it was revealed during documentation review that no documents were presented for review to confirm that the once every 36 months - 4 hour continuous run of the emergency generator is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Thorne Crest has and always will comply with maintaining, inspecting, and testing the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3and 6.4.4.2 and NFPA 110 (2010 edition) sections 8.4.9 through 8.4.9.7. The once every 36 months - 4-hour continuous run of the emergency generator was completed on 1/6/2023. Attachment: A	

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K 920	Continued From page 5	K 920		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D) and UL 1363. These deficient findings could have a patterned impact on the residents within the facility.	K 920	Thorne Crest has and always will comply with Life Safety Codes in regard to the use of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70 (2011 edition), National Electrical Code, sections 400-8, 590.3(D). Appliance connected to power strip in ADON office has been relocated and	1/6/23

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K 920	Continued From page 6 Findings include: 1. On 12/07/2022 at 11:30 AM, it was revealed by observation that in the Assistant Director of Nursing Office, a high current device (refrigerator) was connected to a power strip. 2. On 12/07/2022 at 11:30 AM, it was revealed by observation that in the Charting Office, power-strips were daisy-chained together. 3. On 12/07/2022 at 11:30 AM, it was revealed by observation that in the Activities Room, power-strips were daisy-chained together. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	plugged into outlet in office. Power strip has been removed. To ensure compliance, Maintenance Director initiated audits to assure that all power strips are being utilized correctly daily (M-F) for 2 weeks, then weekly for 4 weeks and for one month thereafter with results being reported to QAPI.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: OZQX11

Dear Administrator:

The above facility was surveyed on December 5, 2022 through December 8, 2022 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

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

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 12/08/2022

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

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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: On 12/5/22 through 12/8/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H54256459C (MN86417) and H5425034C (MN80874) however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5425033C (MN79740). 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic	2 302		1/19/23

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2 302	Continued From page 3 topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to fully integrate their Alzheimer's/dementia training plan with their orientation program for staff which resulted in the incomplete training of 3 of 8 staff (nursing assistant (NA)-C, NA-D and NA-G) reviewed. Findings include: According to the facility policy and written communication to residents titled Dementia Training Disclosure dated 6/12/17, "[facility] provides required dementia training to all direct care staff (licensed nursing, non-licensed nursing, activity staff, marketing, pastoral staff), support staff (dietary staff, housekeeping, medical records, maintenance, transportation) who are providing services to people with dementia. Direct care staff are required to complete 8 hours of initial training, and 2 hours per year of ongoing training. Support staff are required to complete 4 hours of initial training, and 2 hours per year of ongoing training." The policy indicated "training will be completed at orientation and annually at a minimum." According to an interview on 12/8/22, 1:20 p.m. registered nurse (RN)-I, doing staff development, stated she was not familiar with the policy, but stated the facility was doing Alzheimer's/dementia training through a program on the computer called Healthcare Academy. RN-I was unsure	2 302	Corrected	

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2 302	Continued From page 4 which courses might have met the requirements set out by the facility policy, and did not know how to find the course contents. RN-I did not know how many hours of training would be needed to meet requirements, and stated she thought newly hired staff had about thirty days to complete their initial training. According to an interview on 12/8/22, 1:41 p.m. the facility administrator and RN-I provided a course list for orientation which showed a one hour Healthcare Academy class titled Understanding Dementia, and the administrator stated that course should be completed "immediately" during orientation. RN-I and the administrator pointed out the listed course on a printed list. At the top of the list was the following, "priority assignments must be completed before working independently on the floor;" however, the Understanding Dementia course was not marked as a priority course. The Understanding Dementia course was listed as needing to be completed within seven days of hire, but did not indicated if it needed to be done prior to working with any dementia residents. The administrator stated all dementia training should be completed during a new hire's orientation period, but was not able to state how many hours of training or which courses would comprise that training. The "orientation period" was not defined. A review of the Healthcare Academy courses related to Alzheimer's/dementia training found the following courses met all of the facility and state requirements for dementia training: -Alzheimer's Disease-one contact hour -Alzheimer's Dementia: Creating Routines-one contact hour -Behaviors: Medications and Interventions-one contact hour	2 302		

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2 302	Continued From page 5 An alternative course, CMS Hand in Hand: A training Series for Nursing homes, also met the requirements if all modules were completed-five contact hours A review of the sampled staff showed the following individuals' transcript results for Alzheimer's/dementia training since their hire date in the past year: -A nursing assistant (NA)-C, hired in 12/2021, completed only Alzheimer's Dementia: Creating Routines. NA-C had not completed Alzheimer's Disease or Behaviors: Medications and Interventions in 12 months since hire. -NA-D, hired in 4/2022, completed only Alzheimer's Dementia: Creating Routines, and then the first module of the CMS Hand in Hand training (which would have been similar to Alzheimer's disease), but had not completed Behaviors: Medications and Interventions in the 8 months since hire. -NA-G, hired in 5/2022, completed only Alzheimer's Dementia: Creating Routines, but had not completed Alzheimer's Disease or Behaviors: Medications and Interventions in the 7 months since hire. SUGGESTED METHODS OF CORRECTION: The administrator, director of nursing (DON) or designee could review the facility policy for Alzheimer's/dementia training for accuracy, and update as needed. The administrator, DON and staff development nurse could review all course work and develop a clear plan for Alzheimer's/dementia training during orientation, including time lines for completion and any follow-up training to be subsequently completed. The staff development nurse could devise a tracking/audit plan to ensure all course work has been completed to meet facility expectations.	2 302		

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2 302	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 302		
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, facility failed to follow their protocol for reporting and monitoring a change of skin condition for 1 of 1 resident (R18) reviewed for a non-pressure skin lesion when the resident had high risk medical diagnoses. Findings include: R18's 5-day admission Minimum Data Set (MDS) assessment dated 11/16/22, indicated R18's cognition was moderately impaired. The MDS indicated R18 was receiving dialysis and had renal disease, diabetes mellitus and with other serious co-morbidities of cardiac and pulmonary	2 830	Corrected	1/19/23

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2 830	Continued From page 7 involvement. On 12/5/22, at 4:23 p.m. R18 was observed to have a dark purple bruise on the top of his left hand covering approximately half of the surface with some slight redness surrounding the bruise and slight swelling surrounding that. R18 did not know how he had gotten the bruise, but said sometimes he would get his hand stuck between the wheelchair and the door. R18 did not think he had had any lab draw from that hand and could not recall if the injury had occurred in the facility, at dialysis or during transportation to or from dialysis. R18 was not able to state how long he had had the purple mark on his hand. During an observation on 12/7/22, at 8:00 a.m. the purple area on R18's left hand remained dark purple, but appeared slightly smaller in size; however, the surrounding area was reddened. During an interview on 12/7/22, at 8:06 a.m. a licensed practical nurse (LPN)-B stated the facility practice for monitoring skin condition was to check each resident on bath day for any new lesions. LPN-B stated she had just discovered and measured R18's bruise, and planned to check his chart to see if the injury had already been reported. LPN-A stated R18 had dry skin and would pick and scratch his skin, but he was not able to tell her how the injury had occurred due to his forgetfulness. LPN-B stated R18 was at risk for skin issue due to his condition, and to being a dialysis recipient. LPN-B also stated it was possible R18 might have had lab drawn from his hand, causing the injury, but did not know if any lab had been done recently. During an interview on 12/7/22, at 3:18 p.m. the director of nursing (DON) stated any changes in	2 830		

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2 830	Continued From page 8 skin condition, including bruises, were to be reported to nursing who would assess the skin, document assessment, look for a cause of that reported concern, and develop an appropriate intervention. Any "risk management issues" such as falls, injuries, pressure areas or other skin issues were to be reported to the DON for further review. DON stated she had not yet received a report of R18 having a bruise. DON reviewed R18's chart for any documentation and for the possibility of a lab draw on that hand but did not find any. A facility policy titled Pressure Ulcers/Skin Breakdown-clinical protocol, last revised April 2018, indicated "the physician will help identify factors contributing or predisposing residents to skin breakdown" and the physician will order pertinent wound treatments. The protocol did not provide direction on monitoring and reporting of skin condition by nurses. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies to ensure a plan for regular monitoring, reporting and care of non-pressure related skin problems is included, and educate all nursing staff on the importance of prompt reporting of skin conditions when found. DON or designee could do audits to ensure skin conditions are promptly and accurately reported to nursing and monitoring put in place as appropriate. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		1/19/23

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2 895	Continued From page 9 Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R24) reviewed for contractures and limited ROM. In addition, the facility to provide ambulation service to maintain function for 1 of 2 residents (R18) reviewed for a walking program. Findings include: R24's quarterly Minimum Data Set (MDS) assessment dated 9/22/22, identified R23 had severely impaired cognition, had impairment to both lower extremities (LEs), had no impairment to both upper extremities (UEs); required extensive assist of 2 staff with activities of daily living (ADL) including bed mobility, transfers, dressing, toileting; extensive assist of 1 staff with eating and personal hygiene. R24 used a wheelchair for mobility and required 1 staff assist for locomotion. The MDS further indicated R24	2 895	Corrected	

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2 895	Continued From page 10 was on hospice, received scheduled and as needed (PRN) pain medication for pain, had not received restorative nursing services. R24's face sheet, printed on 12/7/22, identified diagnosis list to include Parkinson's disease (brain disorder causing uncontrollable body movements), dementia (brain disorder causing memory loss), dystonia (involuntary muscle contraction causing repetitive twisting movements), corticobasal degeneration (brain and nerve disorder causing difficulty in moving one or both sides of body), abnormal reflex, and weakness. R24's order summary report, printed 12/2/22, indicated R24 received acetaminophen 500mg three times daily for pain, bengay vanishing scent gel 2.5%- applied to neck and upper shoulders topically twice daily for discomfort, morphine sulfate 5mg one time daily for pain. R24's order summary report, signed per physician on 8/5/22, indicated physician noting slight contractures for resident, no recommendations provided for contractures. Hospice service provider residential communication form indicated upper contractures very tight on 11/30/22, upper extremities very rigid on 9/20/22, continues to have contractures bilateral upper extremities (BUEs)- right arm is able to be extended with time on 7/1/22. Hospice admission note, dated 11/16/21, indicated R24's left upper extremity (LUE) contracted and very rigid. R24's care plan, last revised on 9/30/22, indicated pain due disease, to receive pain medications as	2 895		

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2 895	Continued From page 11 ordered and nonpharmacologic interventions including massage, heat, cold, position change; to establish and coordinate plan of care (POC) and services between long-term care (LTC) and hospice team. During an observation and interview, on 12/05/22 at 4:26 p.m., R24's LUE was observed bent and slightly rigid at elbow, was crossed over chest to right side, lying on top of pillow, fingers curled inwards toward palm of hand. R24 was able to extend left 2nd finger, rest of fingers remained curled inwards toward palm of hand and appeared slightly rigid. R24 denied pain at time of observation. Family member (FM)-D was present during observation and interview, stated awareness of LUE contracture, had been progressively worsening, not aware of any therapy exercises or interventions in place to prevent further decline of contracture, would like R24 to have therapy exercises and equipment in place, as "beneficial" to prevent further contractures. While interviewed, on 12/07/22 at 7:25 a.m., nursing assistant (NA)-H indicated awareness of contracture to R24's LUE. NA-H stated R24's LUE had always been bent and rigid at elbow, elbow too painful to extend. NA-H indicated R24 was not receiving any type of exercise therapy or had any interventions in place to prevent further contracture of LUE that she was aware of, stated R24 was on hospice, goal was comfort cares. During an interview, on 12/07/22 at 7:26 a.m., licensed practical nurse (LPN)-A indicated awareness of contracture to R24's LUE, had no changes in contracture to LUE since admission to facility on 3/30/22. LPN-A stated R24 had not received any type of exercise therapy or had any	2 895		

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2 895	Continued From page 12 interventions in place to prevent further contracture to LUE that she was aware of, R24 admitted to facility already on hospice care, no recommendations provided from hospice for therapy exercises, goal was for comfort cares. During an observation and interview, on 12/07/22 at 7:45 a.m., assistant director of nursing (ADON) indicated awareness of contracture to R24's left upper extremity, had no changes since admission to facility. ADON stated she thought R24 had been receiving restorative nursing services for exercise therapy to prevent further contractures, checked R24's orders and care plan, verified R24 had not been receiving any restorative nursing services or had interventions in place for contracture since admission to facility. ADON assessed R24's LUE, confirmed contracture at left elbow and 3rd-5th digits of left hand. ADON indicated it was her expectation that with staff awareness of R24's LUE contracture, even if R24 was on hospice, R24 should've received restorative nursing services including exercise therapy and assistive devices for prevention of worsening contracture and comfort from pain due to contracture of LUE. Facility policy titled Resident Mobility and Range of Motion, revised date 7/17, indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 1. As part of the resident's comprehensive assessment, the nurse will identify the resident's current range of motion of his or her joints, limitations in movement, opportunities for improvement, and previous treatment and service. 2. Conditions that place the resident at risk	2 895		

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2 895	Continued From page 13 for complications related ROM and mobility including: pain, muscle wasting and atrophy, gait and balance issues, contractures. 3. During the resident assessment, the nurse will identify the underlying factors that contribute to his or her range of motion or mobility problems including: immobilization, neurological conditions, conditions in which movement may lead to pain and/or conditions that limit or immobilize movement of limbs or digits. 4. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. 5. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Walking program R18's 5-day admission Minimum Data Set (MDS) assessment dated 11/16/22, indicated R18's cognition was moderately impaired. R18 required extensive assist of two persons to transfer, but could walk independently with supervision in his room. The MDS indicated walking in the hallway happened only 1 or 2 times during a 7 day look back period and R18 required the assistance of one person for that activity. The MDS did not indicate any rejection of care during that time period. The MDS indicated R18 had generalized muscle weakness and difficulty walking with unsteadiness of gait. The MDS further indicated R18 had diagnoses including renal disease, diabetes mellitus and obesity along with other serious co-morbidities of cardiac and pulmonary involvement. According to a R18's care plan focus problem	2 895		

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2 895	Continued From page 14 area entered on 9/30/22, "resident is at high risk for falls related to deconditioning." The associated interventions indicated staff were to anticipate and meet the resident's needs, have physical therapy (PT) evaluate and treat as ordered or as needed, but no further interventions were listed related to resolution of R18's deconditioning. Another problem area indicated "I require assistance with my ADLs (activities of daily living) and mobility related to recent hospitalization for UTI and deconditioning, created 9/23/22." Interventions for mobility indicated, "I require staff assistance of 2 to transfer with use of my walker. Offer me cues and set up assistance as needed," and "I require assistance of 2 with my roll walker for all ambulation." The care plan did not indicate how often staff were to offer ambulation, but interventions included, "OT (occupational therapy) and PT as ordered." According to a document titled Therapy Recommendations and dated 10/25/22, PT had recommended R18 be walked to the bathroom or in his room with 1 assist and a 2 wheeled walker. Additionally, R18 should walk in the hall daily with one assist as tolerated. According to a review of nursing assistant documentation of "walking to bathroom/in room and in halls as tolerates" with two opportunities per day over 30 days, "not applicable" was charted 29 times. Resident refused was charted 5 times and resident not available charted three times. Out of 60 opportunities, ambulation was charted only 12 times. During an interview and observation on 12/5/22, at 4:24 p.m. R18 was sitting in a wheel-chair in his room and did not attempt to move himself	2 895		

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2 895	Continued From page 15 about the room. R18 stated he did not get walked, nor did he get exercise, but stated his wife said he should go to therapy. R18 stated he would like it if he would be walked on a regular basis or if he could return to therapy for further exercise. During an interview on 12/7/22, at 1:02 p.m. a nursing assistant (NA)-B stated R18 was on their walking list and can walk with one assistant to the bathroom and in the halls. NA-B stated she had walked with R18 a few times, but said, "he refuses a lot." NA-B did not think R18 clearly understood explanations or consequences. During an interview on 12/8/22, at 8:45 a.m. the director of nursing (DON) reviewed the documentation in R18's chart and stated she could see R18 did refuse at times, but said documentation of "not applicable" was not appropriate. DON stated residents had the right to refuse their plan of care, but documentation should clearly indicated if the person was refusing or if staff were not providing the care for whatever reason. DON stated an expectation for staff to attempt ambulation as care planned and document and report refusals. DON stated a concern of R18 becoming more deconditioned and stated, "I think we need to figure out if we need a change in plans, to see if R18 needs to go back to therapy." During an interview 12/8/22, at 8:55 a.m. a physical therapy aide (PTA)-A stated an expectation for staff to follow therapy recommendations after a resident had been discharged from therapy services. PTA-A stated the therapy department should receive communication if a resident refuses their exercise program or is not able to do it. PTA-A stated she	2 895		

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2 895	Continued From page 16 had not received any communication from staff as to whether R18 was compliant with his advised program or not. PTA-A stated R18 had developed more strength when he was attending therapy sessions because they strongly encouraged participation in exercise, but they had determined he was more appropriate for a maintenance program. PTA-A stated concerns that R18 could develop pressure sores, joint contractures and/or a continued decline in his condition if he was not participating in the maintenance program as outlined. A policy titled Resident Mobility and Range of Motion, last revised July 2017, indicated "residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable." The policy indicated the care plan would be developed by the interdisciplinary team based on the comprehensive assessment, and would be revised as needed. The care plan would include specific interventions and exercises to maintain or prevent an avoidable decline in mobility. The policy indicated "documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents requiring assistance with ambulation and/or at risk for contractures to assure they are receiving the necessary treatment/services to maintain abilities and prevent contractures from occurring and/or prevent contractures from worsening. The director of nursing or designee could conduct measurable audits for a specific amount of time	2 895		

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2 895	Continued From page 17 of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented to maintain abilities and reduce the risk for contractures occurring and/or prevent contractures from worsening. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure shaving was completed for 1 of 1 resident (R40) reviewed for ADLs who required extensive staff assistance with cares. Finding include: R40's admission Minimum Data Set (MDS) assessment dated 11/21/22, indicated R40 had severely impaired cognition and required extensive assistance from staff to maintain	2 920	Corrected	1/19/23

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2 920	Continued From page 18 personal hygiene. R40's care plan, printed on 11/15/22; indicated R40 required staff assist of 1 to maintain personal hygiene, ADL function had deteriorated due to dementia (memory loss), decrease in physical function, and end of life (hospice). Care plan directed staff to ensure appearance was neat and clean daily, staff to perform all facial shaving for R40, offer cues as needed so R40 aware of cares provided. During an observation on 12/06/22 at 8:25 a.m., R40 was observed to have longer facial hair present above lips, to face and chin. While observed on 12/07/22 at 8:34 a.m., R40 continued to have longer facial hair present above lips, to face, and chin. During an interview, on 12/07/22 at 8:35 a.m., nursing assistant (NA)-I indicated awareness of R40's preference to be clean shaven, required staff assistance with shaving cares, occasionally would refuse cares. NA-I verified R40 had longer facial hair present above lips, to chin and face, would offer shaving after breakfast. While interviewed, on 12/07/22 at 8:46 a.m., licensed practical nurse (LPN)-A indicated R40 needed staff assistance with shaving, unsure if he liked to be clean shaven, occasionally would refuse cares. LPN-A stated if residents refuse cares, NA was to notify licensed nurse of refusal, licensed nurse would attempt to perform care refused, if care still refused licensed nurse would document refusal of care in nursing progress note. LPN-A reviewed nursing progress notes from 11/23/22-12/7/22, stated no behaviors or refusal of shaving cares documented for R40 in	2 920		

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2 920	Continued From page 19 nursing progress notes. During an interview, on 12/07/22 at 8:55 a.m., family member (FM)-E indicated awareness of R40's preference to be clean shaven daily, and needed staff assistance with all grooming and hygiene cares. FM-E was not aware of R40 being resistive when cares provided. During observation on 12/07/22 at 12:30 p.m., R40 sat calm and relaxed in wheelchair in main living room area watching TV. R40 was noted to continue to have longer facial hair present above lips, to face, and chin. During interview and observation, on 12/07/22 at 12:32 p.m., the director of nursing (DON), indicated staff offered residents shaving cares daily, would not shave residents if refused, would attempt to offer shaving cares x3 before documenting refusal of care. DON stated attempts to offer shaving made by 2 different NAs, if resident shaving cares refused, NA would report refusal of care to licensed nurse, licensed nurse would offer shaving care, if care refused licensed nurse would document refusal in progress note. DON reviewed nursing progress notes from 11/23/22-12/7/22, verified no documentation of refusal of shaving cares. DON observed at time of interview R40's face, confirmed R40 had longer facial hair present above lips, to face and chin. Facility policy titled Activities of Daily Living (ADL), Supporting; revised 3/18, indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.	2 920		

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2 920	Continued From page 20 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain grooming needs. The director of nursing or designee could implement audit tools to monitor compliance. Audit results could be reported to the QAPI committee for further recommendations related to ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired food were identified and removed from 1 of 3 stand-up kitchen refrigerators, walk-in refrigerator, and walk-in freezer. This had the potential to affect all 42 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on	21080	Corrected	1/19/23

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21080	Continued From page 21 12/5/22 at 1:10 p.m., with dietary aide (DA)-A, observed food items in stand-up refrigerator, walk-in refrigerator, and walk-in freezer that were not dated or marked and/or were expired. The DA-A indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators and freezers should be gone through daily to check for expired or damaged food. The DA-A indicated if any food or drink were not dated when opened, it should be removed immediately, all left over food should be used within 3 days from opening days, discarded after 3 days. The following items were observed during tour: Stand-up refrigerator across from dish sink: 1. sliced black olives in facility container; approx. ¾ full; open date of 11/18/22, no expiration date or use by date listed. Walk-in refrigerator labeled 1: 1.sun-dried tomatoes in facility zip-lock plastic bag; approx. ¼ full, observed to be mushy, molded together, foul odor present when bag opened; open date of 9/10/22, no expiration date or use by date listed. Walk-in freezer labeled 2: 1. seasoned marinara in facility container; full, opened date of 6/30/22, no expiration or use by date listed 2. facility steel pan filled with frozen chicken thighs; at least 10 chicken thighs sitting over plastic liner covering steel pan; moderate amount of frozen blood on plastic liner and bottom of steel pan, chicken thighs observed to have been freezer burned, prep date listed 11/17/22, use by date of 11/22/22.	21080		

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21080	Continued From page 22 When interviewed, on 12/8/22 at 10:52 a.m., cook (C)-A indicated all dietary staff had monthly facility in-service meetings regarding proper food handling, and yearly state food handling course. Facility policy titled Food Storage, dated 2021, consisted of; sufficient storage facilities will be provided to keep food safe, food will be stored by methods designated to prevent contamination or cross contamination; date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS food should be consumed, sold, or discarded; plastic containers with tight-fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk foods or opened packages; all containers or storage bags must be legible and accurately labeled and dated; leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated; leftover food must be used within 7 days or discarded per the 2017 Federal Food Code; all foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate sanitation and food storage occurs of food items. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance.	21080		

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21080	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21080		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that three of 94 staff	21390	Corrected	1/19/23

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21390	Continued From page 24 (nursing assistant (NA)-E and Dietary aide (DA)-D, DA-E) were fully vaccinated for COVID-19 or were provided a medical or religious exemption. This resulted in a 97.9 % vaccination rate for the facility which created the potential for the spread of the COVID-19 virus. In addition, the facility did not implement a contingency plan for 3 of 3 exempted staff (licensed practical nurse (LPN)-E, NA-F, DA-C) or not fully vaccinated staff. Findings include: Review of the facility's Healthcare Personnel COVID-19 Tracking Worksheet dated 12/6/22, indicated the following: -Nursing assistant (NA)-E received the first dose of Moderna vaccine on 8/31/22, and had not received a second dose. -DA-D received the first dose of Moderna vaccine on 8/3/22, and had not received a second dose. -DA-E received her first dose of Pfizer vaccine on 7/21/22, and had not received a second dose. -LPN-E was not vaccinated and had a religious exemption -NA-F was not vaccinated and had a religious exemption -DA-C was not vaccinated and had a religious exemption During an interview on 12/7/22, at 1:08 p.m. the infection preventionist (IP) indicated they have 3 staff members who have not completed their second COVID-19 vaccine yet. The IP indicated reminders have been sent to the above employees, but to her knowledge they have not completed them. The IP indicated if they don't complete their 2nd vaccine they will be pulled from the schedule in the future.	21390		

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21390	Continued From page 25 Review of recent 2022 schedules included: -NA-E worked 10/3, 10/4, 10/5, 10/7, 10/12, 10/13, 10/15, 10/16, 10/18, 10/19, 10/21, 10/27, 10/28, 10/29, 10/30, 11/4, 11/9, 11/10, 11/11, 11/12, 11/13, 11/14, 11/18, 11/23, 11/24, 11/26, 11/27, 11/28, 11/29, 12/2, 12/5. -DA-D worked 8/20, 8/21, 9/1, 9/3, 9/4, 9/5, 9/18, 10/1, 10/2, 10/15, 10/16, 10/29, 10/30, 11/12, 11/13, 11/29, 11/20, 11/26, 11/27 -DA-E worked 8/20, 8/21, 8/27, 8/28, 9/3, 9/4, 9/5, 9/18, 10/1, 10/2, 10/22, 10/23, 10/29, 10/30 During interview on 12/7/22, at 1:30 p.m., IP indicated all staff are currently required to wear masks and goggles when in outbreak which the facility is currently in. The IP indicated the facility no longer does testing of any employee unless they have signs and symptoms of COVID-19. The IP indicated there is no distinguishing between vaccinated or non-vaccinated employees anymore for testing or for PPE. When asked what they are doing to mitigate the risks for non-vaccinated employees, the IP again indicated they are no longer distinguishing between vaccinated and non-vaccinated employees. During interview on 12/8/22, at 7:26 a.m., the dietary manager (DM)-A indicated both employees (DA-E and DA-D) still work at the facility but mainly weekends. When asked if staff were wearing an N-95 mask or completing COVID-19 testing, DM-A indicated no. When asked what they are doing to mitigate risk factors, DM-A indicated she didn't know. DM-A indicated she had spoken with DA-E who stated she would get an appointment for her second covid shot. DM-A was not able to reach DA-D. During interview on 12/8/22, at 11:10 a.m., the director of nursing (DON) indicated staff are not	21390		

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21390	Continued From page 26 required to wear N-95 masks unless they are in outbreak status with residents who are positive for COVID-19. Review of testing log indicated the facility has been in outbreak status since 10/3/22. Testing logs included: LPN-E was tested 10/6 and 10/8, 10/31 and 11/3 NA-E was tested 10/10/22 DA-C, DA-D and DA-E were not tested NA-F was tested 10/14, 10/31 and 11/4 Review of the facility policy titled COVID-19 Vaccination Requirements, dated 2/25/22, included: - The facility shall ensure all newly hired employees, licensed practitioners, students, trainees, volunteers and contracted staff are fully vaccinated against COVID-19 at the time of hire, or receive their first dose of the COVID-19 vaccination prior to assignment involving exposure to clients and/or infectious materials. Alternatively, individuals may request a medical or religious exemption. Those not fully vaccinated, awaiting their second vaccine dose, will be required to follow the PPE (personal protective equipment) guidelines and testing requirements of unvaccinated individuals granted medical or religious exemptions. -Unvaccinated Individuals Granted Medical or Reglious Exemptions: -Any employee exempted from COVID-19 vaccination under the mandatory vaccination policy, if approved to continue working at the community, is required to wear personal protection wear while on ABHM campus, which includes an N-95 mask, and protective eyewear (if required). The employee may be assigned to a unit or area other than normal work assignment at the discretion of the DON and IP.	21390		

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21390	Continued From page 27 -The facility will conduct routine surveillance testing for all unvaccinated individuals who have been granted medical or religious exemptions, according to the latest update from the state and federal governments. -The infection preventionist or designee will will contact each employee who does not meet the definition of fully vaccinated to determine: -If eligible staff have received one-dose of the two-dose series and has an appointment for the second dose. - The infection preventionist or designee will educate all employees who are not fully vaccinated (employee received one dose of a two-dose series or less than two weeks since the last dose of a primary COVID-19 vaccine and employees with a valid exemption) additional precautions and measures to mitigate the spread of COVID-19 for all staff that are not fully vaccinated: -Personal protective equipment -Transmission-Based Precautions -Hand Hygiene -Physical distancing -Cleaning and Disinfection -Screening -Testing per facility COVID-19 testing policy and procedure. A policy titled "CMS-COVID-19 Mandatory Testing" last revised 9/29/22 included: -A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in any residents triggers an outbreak investigation. -Routine Testing of asymptomatic staff is no longer recommended but may be performed at the discretion of the facility SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	21390		

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21390	Continued From page 28 audit COVID-19 vaccine compliance for vaccinations and mitigation of COVID-19 for non-vaccinated employees. The DON or designee could audit the appropriate use of facemask and eye protection, and mitigation and educate all staff on the requirements of use. The DON or designee could report findings of the audits to the quality assurance committee for follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		1/19/23

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21426	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to ensure appropriate screening for tuberculosis (TB) was conducted for 1 of 6 residents (R33) reviewed for TB. Findings include: R33's admission date was 7/7/22. R33's received a Mantoux test (TST) on 7/7/22, which was recorded as negative. There was no second step completed. A progress note dated 7/21/22, at 9:18 p.m. under behavioral note included R33 refused to receive Mantoux by this writer stating he already had one and doesn't need another one. During interview on 12/08/22, at 7:37 a.m., infection preventionist (IP) indicated the first that she was aware the second Mantoux was not completed is when she pulled his information upon request. The IP indicated the documentation was completed on the medication administration record (MAR) versus immunization area of the electronic documentation so she did not notice it but did confirm the second step Mantoux was not completed and no alternatives such as chest x-ray or Quantiferon (simple blood test that aids in the detection of Mycobacterium tuberculosis, the bacteria which causes TB) test were offered. The facility's policy and procedure titled Tuberculosis, Screening Residents, dated 8/2019, indicated screening of all new admission or readmissions for tuberculosis infection and disease is in compliance with state regulations.	21426	Corrected	

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21426	Continued From page 30 Suggested Method of Correction: The DON (director of nursing) or designee could review/revise facility policies to ensure they contain all components for tuberculosis identification and control. The DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21426		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide access to comfortable orthotic seating for 1 of 1 resident (R10) reviewed for reasonable accommodation of needs. Findings include: R10's admission Minimum Data Set (MDS) assessment dated 11/9/22, indicated R10 was cognitively intact and dependent on staff for all	21810	Corrected	1/19/23

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21810	Continued From page 31 physical mobility, although R10 could participate in bed mobility. The MDS indicated R10 had a primary diagnosis of secondary malignant neoplasm (new and abnormal growth of tissue) of bone resulting from breast cancer and additional significant diagnoses of: multiple sclerosis (a neurological degenerative disease that slowly reduces a person's ability to move over time, also called MS) and quadriplegia (inability to move all four limbs) among other disorders. MDS identified R10 was receiving anti-anxiety and anti-depressant medication on a regular schedule, and was a hospice patient. According to R10's care plan, a focus problem area was entered 11/11/22 indicating "resident has quadriplegia." The goal listed indicated "resident will maintain optimal status and quality of life within limitations imposed by Quadriplegia through review date. Target date: 2/9/23." This problem had two interventions: "give medications as ordered. Monitor/document for side effects and effectiveness; range of motion (active or passive) with am/pm cares daily." A problem area dated 11/11/22 indicated "resident has acute/chronic pain related to breast cancer with mets (metastases-where cancer has moved from a primary site and invaded tissue elsewhere) to bone, MS. This problem had interventions related to monitoring and reporting and providing analgesics, but did not address other methods of providing comfort. Another problem area indicated, "I require assistance with my ADLs (activities of daily living) and mobility related to impaired mobility, MS and cancer diagnosis. Created on 11/3/22. Of several goals, one goal indicated, "I will not develop contractures or worsen my current contractures and also, I will travel throughout the facility as I desire." Associated interventions did not address	21810		

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	00833	A. BUILDING: _____ B. WING _____	C 12/08/2022

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21810	Continued From page 32 contractures or positioning, but did indicate "Locomotion: I require staff assistance with all locomotion on and off the unit per my Broda chair." According to a hospice document dated 11/3/22 titled, Client Coordination Note Report, "patient has been non ambulatory for years and utilizes motorized wheelchair for mobility. Patient requires assistance from 2 as a Hoyer transfer. This is unchanged from 6 months ago." According to a document titled "assistive device evaluation" effective date 11/7/22, R10 was being assessed by nursing for the use of a Broda chair (this is a type of wheelchair generally used for positioning for persons who cannot safely maintain the position). Although R10 was listed as cognitively intact, the assessment indicated she could not identify the chair control or explain its use, or demonstrate safe use of "recliner." Also, the assessment asked if the resident understood the adverse effects of improper usage and this was marked "no." The assessment asked if "the use of the device restricts the residents movement, transfers, locomotion or access to their own body" and this was marked "no." The assessment indicated the Broda chair was appropriate as R10 needed it "to transfer" (Broda chairs are for positioning and movement, they are not listed as a transfer device.) The benefits to the resident indicated "able to sit in chair comfortable and transfer." No follow up evaluation was found to see if the intervention of the Broda chair was meeting R10's needs. On 12/5/22, 6:28 p.m. during an observation and interview, R10 was observed in her room, in the dark, in bed. R10 stated she spent most of her	21810		

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21810	Continued From page 33 time in bed now, and liked the mattress the facility had provided. R10 was observed to be in a room with two beds, but no room-mate. Next to the empty bed, a large Broda chair, almost as long as the bed, was parked. The Broda chair was observed to be a type of seating consisting of poly-vinyl tension straps that are meant to suspend the weight of the user over multiple points. The chair also had a cushion in the seat and side bolsters, and could recline. R10 stated she preferred a power wheel chair she had used prior to admission to the facility. R10 stated she had talked to "someone" in the facility and said she was told the facility was "not licensed for power chairs or something." R10 stated she was spending more time in bed because she did not find the Broda chair very comfortable for sitting. During an interview on 12/6/22, at 12:24 p.m. a nursing assistant (NA)-A stated no resident was allowed to use a motorized wheelchair in the long term care section of the facility. NA-A stated she thought R10 had an electric wheelchair at the facility, but also thought it was in storage because of their policy. NA-A stated R10 had told her the electric wheelchair was more comfortable to sit in. NA-A said R10 would not be able to drive an electric wheelchair because of an inability to use her hands, but NA-A expressed concern about R10 staying in bed and isolated as much as she was. NA-A thought the electric wheel chair might make it easier to position R10 and perhaps R10 would get up out of bed more often. During an interview on 12/6/22, at 12:30 p.m. a licensed practical nurse (LPN)-A stated R10 had been declining in her overall abilities and could no longer use her hands. LPN-A stated R10 would not be able to run an electric wheelchair, but stated she understood R10 was interested in	21810		

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21810	Continued From page 34 being up in the wheelchair for comfort in positioning instead of the Broda chair. LPN-A stated she was aware the facility had a policy barring the use of electric wheelchairs, but given R10 was interested in using the chair for positioning instead of locomotion, LPN-A thought it should be reconsidered. LPN-A stated an assessment would need to be done, and thought part of the reason the Broda was uncomfortable was it put pressure on R10's cancer site, and LPN-A did not know if the wheelchair would alleviate that concern. During an interview on 12/6/22, at 12:31 p.m. the director of nursing (DON) stated the policy regarding the use of motorized wheelchairs or scooters had been developed because there were concerns regarding the ability to supervise persons driving them, and safety for others. DON stated the facility had worked with hospice in developing a plan of care for R10 and in getting the Broda chair, but had not sought out a therapy evaluation for seating because "we usually don't if they are in hospice." DON stated they had explained to R10 that they did not allow the use of motorized wheelchairs in the facility and that R10 had said "she was fine, but then she did not want to get up anymore." DON stated she thought R10 was not getting up out of bed because of her declining health. During an interview on 12/6/22, at 12:35 p.m. the facility assistant director of nursing (ADON) stated she thought R10 was not getting up because she had had a decline. She stated she understood R10 did not find the Broda chair very comfortable, but did not know R10 was saying she would be more comfortable in the motorized wheelchair. ADON and DON both stated, "unfortunately, it is our policy not to allow	21810		

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21810	Continued From page 35 motorized wheelchairs." During an interview 12/6/22, at 1:23 p.m. R10 stated she had utilized her motorized wheelchair before coming to the facility and found it more comfortable than the Broda chair provided after admission. R10 stated the motorized wheelchair, "is more comfy because is fitted to me." R10 expressed the wheelchair had been very expensive due to the customized fit and stated, "I think I should be able to use it." R10 stated she had not been able to "drive" the chair for some time, even before coming to the facility, but had been using it for seating and positioning. R10 stated the Broda chair did not provide as much support or comfort and said "I just thought, well, if I can't sit in my chair, I'll just stay in bed." A facility policy titled Accommodation of Needs, last revised in March 2021, indicated "the resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. Due to the size of resident's rooms and for the safety of the individual or other residents we are not able to accommodate Electric Scooters/Wheelchairs." A policy on positioning for comfort was requested but not provided SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure coordination of positioning assessment by therapy to determine the best positioning device for support and comfort for residents as needed. The DON or designee could develop a plan for follow-up evaluations and audit for compliance. DON or designee could review facility policy on the use of motorized devices to	21810		

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21810	Continued From page 36 determine when or if exceptions could be made to the policy, and what would need to be put in place to best allow for resident choice while still providing safety for other residents. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21810		