DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 30, 2024

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

RE: CCN: 245425
Cycle Start Date: November 20, 2024

Dear Administrator:

On December 27, 2024, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 30, 2024

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

Re: Reinspection Results
Event ID: SH5512

Dear Administrator:

On December 27, 2024 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 November 20, 2024. 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 5, 2024

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

RE: CCN: 245425
Cycle Start Date: November 20, 2024

Dear Administrator:

On November 20, 2024, 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, Regional Operations Supervisor
Mankato District Office
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 February 20, 2025 (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 May 20, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

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 11/20/2024

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 11/18/24-11/20-24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/18/24-11/20/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54251365C (MN00107811), H54251382C (MN00108209) and H54471023C (MN00107955). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 12/13/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING _____ B. WING _____	C 11/20/2024

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 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 ensure 1 of 1 resident (R31) had adequate hydration and hydration within reach. Findings include: R31's Minimum Data Set (MDS) assessment dated 9/26/24, indicated R31 had a Brief Interview for Mental Status (BIMS) score of 3, indicated severe cognitive impairment . R31 was independent with eating and drinking with limited assistance. R31 required extensive assistance for mobility, transfers, and toileting. R31 did not have difficulty swallowing or require specialty diet. R31 had a diagnosis of Parkinson's. R31's care plan dated 10/8/24, indicated staff will bring R31 refreshments in the afternoon. R31 could make basic needs known. R31 could reposition himself in bed. R31 could drink water without assistance if within reach. R31's physician order dated 10/1/24, indicated diet: regular diet, regular texture, thin consistency. During observations on 11/18/24 at 11:07 a.m., R31's bed was located closest to the door and head of bed was next to the bathroom door. R31	F 558	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: "Resident #31□s room has been rearranged to accommodate easier access to the bathroom. How the facility will identify other residents having the potential to be affected by the same deficient practice: "All Residents have been identified as having the potential of not having fresh water or not having access to their bathroom. "All rooms that been checked, rearranged as needed and addressed on the care plan. All residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: "All residents□ rooms have been viewed	12/20/24

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 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558	Continued From page 2 did not have a bedside table. R31's water pitcher was observed across the room under the television on a table; R31 was in his bed across the room from the water pitcher. Water pitcher was located on the lower left corner of the table; when lifted it felt about half full. During interview and observation on 11/18/24 at 11:39 a.m., R31 stated his mouth was dry and he was thirsty. R31's mouth was dry and his tongue was sticking to inside of mouth. During observation on 11/9/24 at 8:13 a.m., R31's water pitcher was observed in the same position on the table under the television and when lifted felt about half full. R31 was seated in the activity room with staff prompting him to eat. R31 was able to feed and drink on his own. During interview on 11/19/24 at 8:16 a.m., nursing assistant (NA)-A, stated R31 can feed and drink for himself. NA-A verified R31's water pitcher was across the room from his bed on a table under his television. NA-A stated R31 could not reach his water pitcher while he was in bed. NA-A stated the water pitcher should be on a bedside table and she didn't know why R31 did not have a bedside table. NA-A stated it was the responsibility of staff on each shift to ensure R31 has water within reach. Upon exiting room, NA-A did not move water pitcher within reach of R31. During observation on 11/19/24 at 8:39 a.m., R31 had a bedside table next to the head of his bed and his water pitcher had been moved to the bedside table. Water pitcher was within reach. Bathroom door was closed. During interview and observation on 11/19/24 at	F 558	to see that they have space for a table for water and have enough space to move about in their room safely. "Education will be completed on or before December 17, 2024, by DON/designee. Education will include keeping the room organized for residents in a shared resident room so both residents can move in ease. "Each resident will receive a water pitcher according to our policy. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: "Education huddles will be completed by December 17, 2024, for staff to include ensuring water pitchers are within reach of each resident. Tray tables or tabletops will be available to place the pitchers within reach. "Personalized information regarding residents□ requests will be added to the care plan and the Kardex. "The HUC/designee will audit 10 residents weekly x4 weeks, and then bi-weekly for 3 months to ensure that water pitchers are within reach. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected:	

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F 558	Continued From page 3 10:00 a.m., R31 stated his mouth is always dry. R31 stated if his water pitcher was closer, he would drink water. Surveyor reminded R31 a water pitcher was on the bedside table and R31 stated he will drink when he wakes up. R31's mouth was dry and his tongue appeared to be sticking to inside of mouth. During interview on 11/19/24 at 1:35 p.m., NA-B states she will refill the water pitcher if a resident asks for water. NA-B stated she was unsure if there is a policy about when to refill water pitchers. During interview on 11/19/24 at 1:37 p.m., NA-C stated staff refilled water pitchers on the night shift, day shift will check the water pitchers if they can; will refill if resident asks for more water. NA-C stated she does not believe there is a policy about refilling water. During interview on 11/19/24 at 1:45 p.m., licensed practical nurse (LPN)-A, stated each resident should have fresh water within reach every day. LPN-A stated she doesn't know if there is an actual policy about how often to refill water pitchers. During observation on 11/19/24 at 3:42 p.m., R31 was laying in bed. The bedside table was located at the foot of his bed, out of reach. The bathroom door was open, there was not enough room for the bathroom door to be open and the bedside table to be within reach. During interview on 11/19/24 at 4:42 p.m., director of nursing (DON) stated each resident should have fresh water within reach, should be changed each shift. DON stated within reach means they	F 558	"The DON will share results of weekly audits at QAPI to revaluate the need to continue the need for the audit. "If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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F 558	Continued From page 4 can reach the water pitcher from wherever they are seated. DON verified the facility had a policy about refilling water pitchers. A facility policy dated 2024, titled "Serving Drinking Water" indicated water pitchers should be placed within easy reach of the resident.	F 558		

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 _____	**11/19/2024**

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 11/19/2024. At the time of this survey, THORNE CREST RETIREMENT CENTER 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	K 000		

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

Electronically Signed | 12/13/2024

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
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K 000	Continued From page 1 IS NOT REQUIRED. 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.	K 000		

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K 000	Continued From page 2 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. The facility has a capacity of 52 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		12/20/24

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

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2, 11.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by review of available documentation that no documentation was presented for review to confirm that the Ansul type system had been inspected since 02/06/2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Ansul type system was inspected by Nardine on 12/2/2024. The prevented maintenance on the Ansul system is scheduled 2 times a year. The Maintenance Director is responsible for monitoring that the facility is in compliance. The audit will be completed 2X a year. The Maintenance Director will bring the information from the audit to the QAPI meeting two times a year for the next 2 years. QAPI will provide recommendations with the findings from the audits	
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		12/20/24

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	245425	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2024**

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 345	Continued From page 4 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.1.1, 14.2.2, Table 14.4.5.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by review of available documentation that the fire alarm sensitivity report presented for review was not dated, did not identify the vendor that completed the testing, and was inconclusive in results and presentation of findings. The pass (P) / fail (F) column on the form was filled in with " X "'s - as such not providing info as to whether device(s) passed or failed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	The fire alarm sensitivity report has been updated to include date, vendor identification and the results of the fire drill inspection form now includes the results and findings. The Maintenance Director is responsible for monitoring that facility is in compliance. The audit will be completed for the next year to show compliance. The Maintenance Director will bring the information from the audit to the QAPI meeting monthly for the next 6 months. QAPI will provide recommendations with the findings from the audits.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per	K 374		12/20/24

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K 374	Continued From page 5 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by observation that the fire / smoke barrier door assembly adjacent to RM 31 exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	The smoke barrier door near room 31 has been corrected with a door sweep. The door is now in compliance. All smoke barrier doors will be audit monthly to assure proper closing. The Maintenance Director is responsible for monitoring that the facility is in compliance. Audits will be completed for the next year to show compliance. Findings will be presented to QAPI for recommendations with the findings from the audits for the next year.	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		12/20/24

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K 712	Continued From page 6 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7, 4.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that fire drill documentation presented for review exhibited date patterning as to when fire drills were conducted for all shifts / all four quarters for the past twelve months. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	The facility has set up a yearly calendar showing fire drills at random times to eliminate patterns. This plan will begin in December. The maintenance Director is responsible for completing audits to ensure the facility is in compliance. Audits happen monthly and will be reported to QAPI for recommendations from the audits for the next 6 months.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		12/20/24

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K 761	Continued From page 7 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual smoke / fire door inspections had been completed . An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	The facility now has written records of inspection and testing of fire doors. Maintenance men who oversee the testing possess knowledge and training of experience and can show ability of this understanding. The maintenance Director is responsible for completing audits to ensure the facility is in compliance. Audits happen monthly and will be reported to QAPI for recommendations from the audits for the next 6 months.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is	K 914		12/20/24

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K 914	Continued From page 8 performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct annual electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual electrical outlet inspection / testing had been completed . An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	All residents' rooms have had electrical outlet inspections/testing. Yearly audits will be completed to show the completion of the inspections. The maintenance Director is responsible for completing audits to ensure the facility is in compliance. Audits happen yearly and will be reported to QAPI for recommendations from the audits for the next 2 years.	
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	K 918		12/20/24

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K 918	Continued From page 9 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 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 test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. This deficient finding could have a widespread impact on the residents within the facility.	K 918	On December 10, 2024, The vendor was at the facility to inspect and to assure that the generator is operating according to regulations. The generator was offloaded and run within code. Documentation forms were reviewed and updated. Audits to continue weekly for the next 3 months. The maintenance Director is responsible for completing audits to ensure the facility is in compliance. Audits happen weekly	

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K 918	Continued From page 10 Findings include: On 11/19/2024 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that documentation presented for review identified that the generator was last weekly inspected and monthly operationally tested - July 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	and will be reported to QAPI for recommendations from the findings of the audits for the next 6 months.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: SH5511

Dear Administrator:

The above facility was surveyed on November 18, 2024 through November 20, 2024 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, Regional Operations Supervisor
Mankato District Office
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

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	00833	A. BUILDING: _____ B. WING _____	C 11/20/2024

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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 11/18/24-11/20/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was 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 these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H54251365C (MN00107811), H54251382C (MN00108209) and H54471023C (MN00107955) no licensing orders were issued. 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 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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		
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 ensure 1 of 1 resident (R31) had adequate hydration and hydration within reach. Findings include: R31's Minimum Data Set (MDS) assessment dated 9/26/24, indicated R31 had a Brief Interview for Mental Status (BIMS) score of 3, indicated severe cognitive impairment . R31 was independent with eating and drinking with limited assistance. R31 required extensive assistance for mobility, transfers, and toileting. R31 did not have	21810	Corrected.	12/20/24

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

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21810	Continued From page 3 difficulty swallowing or require specialty diet. R31 had a diagnosis of Parkinson's. R31's care plan dated 10/8/24, indicated staff will bring R31 refreshments in the afternoon. R31 could make basic needs known. R31 could reposition himself in bed. R31 could drink water without assistance if within reach. R31's physician order dated 10/1/24, indicated diet: regular diet, regular texture, thin consistency. During observations on 11/18/24 at 11:07 a.m., R31's bed was located closest to the door and head of bed was next to the bathroom door. R31 did not have a bedside table. R31's water pitcher was observed across the room under the television on a table; R31 was in his bed across the room from the water pitcher. Water pitcher was located on the lower left corner of the table; when lifted it felt about half full. During interview and observation on 11/18/24 at 11:39 a.m., R31 stated his mouth was dry and he was thirsty. R31's mouth was dry and his tongue was sticking to inside of mouth. During observation on 11/9/24 at 8:13 a.m., R31's water pitcher was observed in the same position on the table under the television and when lifted felt about half full. R31 was seated in the activity room with staff prompting him to eat. R31 was able to feed and drink on his own. During interview on 11/19/24 at 8:16 a.m., nursing assistant (NA)-A, stated R31 can feed and drink for himself. NA-A verified R31's water pitcher was across the room from his bed on a table under his television. NA-A stated R31 could not reach his water pitcher while he was in bed. NA-A stated	21810		

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 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21810	Continued From page 4 the water pitcher should be on a bedside table and she didn't know why R31 did not have a bedside table. NA-A stated it was the responsibility of staff on each shift to ensure R31 has water within reach. Upon exiting room, NA-A did not move water pitcher within reach of R31. During observation on 11/19/24 at 8:39 a.m., R31 had a bedside table next to the head of his bed and his water pitcher had been moved to the bedside table. Water pitcher was within reach. Bathroom door was closed. During interview and observation on 11/19/24 at 10:00 a.m., R31 stated his mouth is always dry. R31 stated if his water pitcher was closer, he would drink water. Surveyor reminded R31 a water pitcher was on the bedside table and R31 stated he will drink when he wakes up. R31's mouth was dry and his tongue appeared to be sticking to inside of mouth. During interview on 11/19/24 at 1:35 p.m., NA-B states she will refill the water pitcher if a resident asks for water. NA-B stated she was unsure if there is a policy about when to refill water pitchers. During interview on 11/19/24 at 1:37 p.m., NA-C stated staff refilled water pitchers on the night shift, day shift will check the water pitchers if they can; will refill if resident asks for more water. NA-C stated she does not believe there is a policy about refilling water. During interview on 11/19/24 at 1:45 p.m., licensed practical nurse (LPN)-A, stated each resident should have fresh water within reach every day. LPN-A stated she doesn't know if there is an actual policy about how often to refill water	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21810	Continued From page 5 pitchers. During observation on 11/19/24 at 3:42 p.m., R31 was laying in bed. The bedside table was located at the foot of his bed, out of reach. The bathroom door was open, there was not enough room for the bathroom door to be open and the bedside table to be within reach. During interview on 11/19/24 at 4:42 p.m., director of nursing (DON) stated each resident should have fresh water within reach, should be changed each shift. DON stated within reach means they can reach the water pitcher from wherever they are seated. DON verified the facility had a policy about refilling water pitchers. A facility policy dated 2024, titled "Serving Drinking Water" indicated water pitchers should be placed within easy reach of the resident. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have means to hydration and within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		