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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YMLL

Facility ID: 00833

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/31/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 09/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245425

September 8, 2015

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

Dear Mr. Schulz:

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

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

Effective August 13, 2015 the above facility is certified for:
52 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 8, 2015

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

RE: Project Number S5425026

Dear Mr. Schulz:

On August 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 23, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 31, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 4, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 23, 2015, effective August 13, 2015 and therefore remedies outlined in our letter to you dated August 3, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245425	A. Building B. Wing	8/31/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	08/13/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	08/13/2015	ID Prefix F0309 Reg. # 483.25 LSC	08/13/2015
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	08/13/2015	ID Prefix F0456 Reg. # 483.70(c)(2) LSC	08/13/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	KS/kfd	09/07/2015	03048	08/31/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/23/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245425	A. Building 01 - MAIN BUILDING 01 B. Wing	9/4/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	08/13/2015	ID Prefix Reg. # NFPA 101 LSC K0144	08/13/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	09/07/2015	25822	09/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/21/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YMLL
Facility ID: 00833

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 08/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 3, 2015

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

RE: Project Number S5425026

Dear Mr. Schulz:

On July 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> <u>Opportunity to Correct</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Electronic Plan of Correction</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 1, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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

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 ______	07/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		8/13/15

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

Electronically Signed — 08/12/2015

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 ______	07/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a plan of care related to activities of daily living (ADL) assistance for 1 of 3 residents (R9) reviewed for ADL's. Findings include: R9's care plan lacked interventions for ADL's. R9's diagnoses included dementia and blindness in both eyes. R9 was observed on 7/20/15, at 2:00 p.m. to have long chin hair as well as long, dirty and jagged fingernails. R9 was also observed on 7/22/15, at 1:00 p.m. and 7/23/15, at 9:16 a.m. sitting in the day room. Chin hair was still present and nails continued to be long, jagged and dirty. The quarterly Minimum Data Set (MDS) dated 4/27/15, identified R9 as having a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairments, needing extensive assistance of one person with personal hygiene and dressing and physical assistance in part of bathing. The Care Area Assessment (CAA) dated 7/29/14, identified that ADL's would be addressed in the care plan. Review of the care plan dated 6/29/12, did not identify ADL assistance needed and no interventions were evident. During interview with the director of nursing on 7/23/15, at 10:33 a.m. she verified the care plan did not identify the deficit in ADL's and that ADL's should be addressed on the residents plan of care (R9).	F 279	It is the policy of the facility to develop a comprehensive plan of care for all residents, which would include ADL¿s. For resident R9 resident¿s care plan was reviewed and updated revisions to ADL¿s on 7/23/15 to include grooming and nail care. All care plans were audited for comprehensive ADL care plan which was completed by the IDT and completed on 8/12/2015. IDT met on 8/6/15 to review comprehensive care planning policy. It was decided that beginning 8/10/15, IDT would add reviewing/monitoring care plans of residents due for care conference, during our weekly behavioral meeting. IDT will be responsible to assure the comprehensive plan of care is developed for each resident. Care plans will be updated at time of review and also occur on an on-going basis as indicated. IDT will report the number of care plans reviewed and number of changes, to the QA committee monthly.	

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 2 of 2 residents (R9, R70) reviewed for non pressure related skin issues. Findings include: R9's plan of care was not followed regarding bruising. R9's diagnoses included dementia, blindness both eyes and chronic microcytic anemia. The care plan dated 6/29/12, identified an alteration to skin integrity. Interventions included facility protocol for routine skin care and SWAT (skin wound assessment tool) PRN (as needed), report reddened, open, irritated, swollen areas to nurse immediately. During initial interview and observation on 7/20/15, at 2:00 p.m. R9 was noted to have purple and red bruises up the left arm and a purple bruise to the right wrist. On 7/22/15, at 7:17 p.m. bruising remained on right wrist and up left arm. Observation on 7/23/15, at 8 a.m. R9 was in bed with hospital gown on. Bruising was noted to left forearm from elbow to wrist as well as on right wrist. Bruises were dark purple in color. R9 was unable to state where the bruises came from.	F 282	It is the policy of this facility to follow the plan of care related to bruising. R9 bruising was assessed with documentation completed on 7/23/15. Continued monitoring of bruising will occur until resolved. R70 bruising was assessed with documentation completed on 7/23/15. Continued monitoring of bruising will occur until resolved. Policy for assessment and monitoring of non-pressure related skin issues including bruises was reviewed by DON and revised on 8/5/15, which includes a Skin Monitoring Report form that will be used by CNAs to report skin concerns to the charge nurse. This form will then get forwarded to the DON or designee to audit that proper documentation and follow up occur on an on-going basis. Education provided to Licensed Nurses on 8/6/15 and CNAs on 8/11/15 related to the updated policy that includes the Skin Monitoring Report form for communication, assessment and monitoring of non-pressure related skin issues, including bruises. Non-pressure related skin issues such as bruising, will be reviewed as the Skin	8/13/15

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F 282	Continued From page 3 Review of the medical record did not identify any of the bruising to R9's left arm or right wrist. During an interview with registered nurse B (RN-B) on 7/23/15 at 10:57 a.m. she stated there should be documentation regarding the bruising. She stated she was not aware of the bruising and they had not been reported to her. During an interview with the director of nursing on 7/23/15, at 10:33 a.m. she verified that the care plan had not been followed regarding reporting of skin conditions. Review of the care plan last revised 6/26/15, identified R70 was on anticoagulant therapy (Coumadin) related to diagnosis of atrial fibrillation. The interventions included: "Daily skin inspection. Report abnormalities to the nurse." During observation and interview on 7/20/15, at 3:45 p.m. R70 was observed seated in her room in her recliner. R70 was observed to have a large purple bruise on her left forearm, a fading purplish bruise on the lower aspect of her right thumb extending to the wrist, and a fading purplish bruise across the top of the right hand. R70 stated she bruises easily due to being prescribed Coumadin (an anticoagulant medication). Review of the physician order dated 7/22/15 indicated to continue same Coumadin dose of 1.5 milligrams (mg) daily every Sunday and 1 mg daily all other days. Review of the Green Hall Bath Schedule indicated R70 received a bath once a week on Friday evening. The skin/wound progress note	F 282	Monitoring Report forms are received by the DON or designee and audits will occur through this process on an on-going basis. Concerns will be addressed with staff education and findings will be reported the QA committee monthly.	

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F 282	Continued From page 4 dated 7/17/15 at 20:00 (8:00 p.m.) indicated: "Skin check completed after bath. No red or open areas present. Scattered bruising on arms." The treatment administration record dated July 2015 did not include monitoring of bruises for R70. When interviewed on 7/23/15, at 11:49 a.m. nursing assistant (NA)-C stated when a new skin issue such as a bruise or skin tear is identified with a resident she would notify the charge nurse immediately. When interviewed on 7/23/15, at 12:18 p.m. registered nurse (RN)-B stated when a new skin issue is identified for a resident such as a bruise, laceration, or skin tear, the area should be evaluated, treated if necessary, and measured. RN-B further stated a Wound/Skin sheet should be initiated and the area should be measured at least weekly; monitoring of the area is also added to the treatment administration record. At 12:28 p.m., RN-B observed the bruising to R70's left forearm and right hand. When observing R70's arms a new purple bruise was also noted to R70's right elbow. RN-B confirmed the bruising should be reported and monitored though was unsure if this had been completed. After reviewing R70's medical record, treatment administration record, and wound/skin sheets, RN-B confirmed the bruising was not identified, evaluated or monitored and should have been as stated in the care plan. Review of the progress notes dated 7/23/15 at 13:34 (1:34 p.m.) included the following measurements of bruises: Bruise 1 - Right thumb/hand measures 5 cm (centimeters) x (by) 6 cm, bruise 2 - right top of hand 5 cm x 5 cm,	F 282		

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F 282	Continued From page 5 bruise 3 - right elbow 5.5 cm x 3.8 cm, bruise 4 - left forearm 9 cm x 4 cm.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and monitor bruising for 2 of 3 residents (R9, R70) reviewed for non-pressure related skin issues. Findings include: During observation and interview on 7/20/15, at 2:00 p.m. R9 was observed seated in her room in her wheelchair. R9 was observed to have purple and red bruises located on the left forearm up to the elbow. She also had a large purple bruise on her right wrist. Review of the quarterly Minimum Data Set (MDS) assessment dated 4/27/15, indicated R9 required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene, and limited assistance with locomotion on/off the unit. The Brief Interview for Mental Status (BIMS) scored 4 indicating severe cognitive impairment.	F 309	It is the policy of this facility to identify and monitor bruising. (Same POC as for the F282 above)	8/13/15

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F 309	Continued From page 6 Review of the medical record did not identify any of the bruising noted on R9's left arm and right wrist. The care plan dated 6/29/12, identified an alteration to skin integrity. Interventions included facility protocol for routine skin care and SWAT (skin wound assessment tool) PRN (as needed), report reddened, open, irritated, swollen areas to nurse immediately. Review of the Green Hall Bath Schedule indicated R9 received a bath once a week on Wednesday days. No skin/wound note was found for 7/22/15 after bath. The treatment administration record dated July 2015 did not include monitoring of bruises for R9. When interviewed on 7/23/15, at 10:28 a.m. licensed practical nurse B (LPN-B) verified that R9 had received her bath on 7/22/15. She was unaware of any bruising. When interviewed on 7/23/15, at 10:35 a.m. trained medication aide A (TMA-A) stated she had given R9 a bath yesterday. She stated she had noticed the bruises on R9's arms and told the nurse. When interviewed on 7/23/15, at 10:57 a.m. registered nurse (RN)-B stated when a new skin issue is identified for a resident such as a bruise, laceration, or skin tear, the area should be evaluated, treated if necessary, and measured. RN-B further stated a Wound/Skin sheet should be initiated and the area should be measured at least weekly; monitoring of the area is also added to the treatment administration record. At 12:00 p.m., RN-B observed the bruising to R9's left forearm and right hand. RN-B confirmed the bruising should be reported and monitored and	F 309		

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F 309	Continued From page 7 stated this had not been completed. After reviewing R9's medical record, treatment administration record, and wound/skin sheets, RN-B confirmed the bruising was not identified, evaluated or monitored and should have been. Review of the progress notes dated 7/23/15, at 12:43 p.m. included the following measurements of bruises: Bruise right forearm measures 5.7 x 3 cm (centimeters) purple yellow, right lower arm has several bruises scattered up arm. Measurements 3 x 2 cm, 4.5 x 4 cm, 2 x 1 cm and 1 x 1 cm dark purple to light purple. During observation and interview on 7/20/15, at 3:45 p.m. R70 was observed seated in her room in her recliner. R8 was observed to have a large purple bruise on her left forearm, a fading purplish bruise on the lower aspect of her right thumb extending to the wrist, and a fading purplish bruise across the top of the right hand. R70 stated she bruises easily due to being prescribed Coumadin (an anticoagulant medication). Review of the 30-day Minimum Data Set (MDS) assessment dated 6/24/15 indicated R70 required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and locomotion on/off the unit. The BIMS score was 15/15, indicating intact cognition. Review of the care plan last revised 6/26/15, identified R70 was on anticoagulant therapy (Coumadin) related to diagnosis of atrial fibrillation. The interventions included: "Daily skin inspection. Report abnormalities to the nurse."	F 309		

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F 309	Continued From page 8	F 309		

Review of the physician order dated 7/22/15 indicated to continue same Coumadin dose of 1.5 milligrams (mg) daily every Sunday and 1 mg daily all other days.

Review of the Green Hall Bath Schedule indicated R70 received a bath once a week on Friday evening. The skin/wound progress note dated 7/17/15 at 20:00 (8:00 p.m.) indicated: "Skin check completed after bath. No red or open areas present. Scattered bruising on arms." The treatment administration record dated July 2015 did not include monitoring of bruises for R70.

When interviewed on 7/23/15, at 11:49 a.m. nursing assistant (NA)-C stated when a new skin issue such as a bruise or skin tear is identified with a resident she would notify the charge nurse immediately.

When interviewed on 7/23/15, at 12:18 p.m. registered nurse (RN)-B stated when a new skin issue is identified for a resident such as a bruise, laceration, or skin tear, the area should be evaluated, treated if necessary, and measured. RN-B further stated a Wound/Skin sheet should be initiated and the area should be measured at least weekly; monitoring of the area is also added to the treatment administration record. At 12:28 p.m., RN-B observed the bruising to R70's left forearm and right hand. R70 stated the staff knew about the bruising and stated she bruises easily due to her Coumadin use. When observing R70's arms a new purple bruise was also noted to R70's right elbow. RN-B confirmed the bruising should be reported and monitored though was unsure whether this had been completed. After reviewing R70's medical record,

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F 309	Continued From page 9 treatment administration record, and wound/skin sheets, RN-B confirmed the bruising was not identified, evaluated or monitored and should have been. Review of the progress notes dated 7/23/15 at 13:34 (1:34 p.m.) included the following measurements of bruises: Bruise 1 - Right thumb/hand measures 5 cm (centimeters) x (by) 6 cm, bruise 2 - right top of hand 5 cm x 5 cm, bruise 3 - right elbow 5.5 cm x 3.8 cm, bruise 4 - left forearm 9 cm x 4 cm.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 the facility failed to provide grooming and personal hygiene for 1 of 3 residents (R9) reviewed who was unable to perform activities of daily living (ADL's). Findings include: R9 was unable to perform ADL's independently and did not receive assistance with shaving and nail care. R9's diagnosis included dementia and blindness both eyes. During observation and interview on 7/20/15, at	F 312	It is the policy of this facility to provide necessary services for grooming and person hygiene. R9 grooming and hygiene was completed on 7/23/15. Audit was done to ensure all residents had or received an electric razor on 8/4/15. Policy for nail care and shaving was reviewed by DON on 8/5/15. Education to Licensed Nurses on 8/6/15 and CNAs on 8/11/15 related to grooming and hygiene, specifically nail care and shaving. Skin Monitoring Form was	8/13/15

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F 312	Continued From page 10 2:00 p.m. R9 was observed seated in her room in her wheelchair. R9 was observed to have several long hair on her chin. R9's fingernails were noted to be long, jagged and have a black substance underneath the nails. Review of the quarterly Minimum Data Set (MD'S) assessment dated 4/27/15, indicated R9 required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene, and limited assistance with locomotion on/off the unit. The Brief Interview for Mental Status (BIMS) scored 4 indicating severe cognitive impairment. Review of the Green Hall Bath Schedule indicated R9 received a bath once a week on Wednesday days. No skin/wound note was found for 7/22/15, after bath. When interviewed on 7/23/15, at 10:28 a.m. licensed practical nurse B (LPN-B) verified that R9 had received her bath on 7/22/15. When interviewed on 7/23/15, at 10:35 a.m. trained medication aide A (TMA-A) stated she had given R9 a bath yesterday. She stated she had not trimmed nor cleaned her fingernails. She stated she had not shaved her as R9 didn't have her own razor. TMA-A verified that R9's nails were very dirty and should have been cleaned. When interviewed on 7/23/15, at 10:57 a.m. the director of nursing (DON) stated that shaving should be done with daily cares as needed and nails should be done a least weekly with bath and also as needed. She also stated that ADL's should be addressed on the care plan and verified it was not.	F 312	developed for communication of skin related issues from CNA to nurse which also includes checking facial hair and nails with bathing. This form is then forwarded to DON for review for auditing purposes and on-going monitoring. Concerns will be addressed with staff education and reported to the QA committee monthly.	

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F 312	Continued From page 11 Review of the facility policy revised 2010: Care of Fingernails/Toenails: General Guidelines 1. Nail care includes daily cleaning and regular trimming. .	F 312		
F 456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in freezer was maintained with a minimal amount of ice build-up to ensure it's safe operating condition. This had the potential to affect the foods integrity which is served to all 41 residents who eat at the facility and the safety of staff who access this freezer on a daily basis. Findings include: During the initial kitchen tour on 7/20/2015 at 9:15 a.m. with cook (C)-A, the walk-in freezer was observed to have an area of approximately 4-5 inches by ½ inch thickness along both sides of the doorway and along the floor. C-A verified the ice buildup on the floor and on both sides of the doorway. C-A stated they chip the ice away if it	F 456	Per regulation 483.70 (c) (2) essential equipment, safe operating condition Thorne Crest maintenance placed more plastic curtains in freezer to prevent ice build-up. Maintenance will also perform a weekly audit of freezer to maintain and remove ice build up that could affect the integrity of the food and safety of our staff. These audits will start August 13th 2015 and will be ongoing for the next two (2) months.	8/13/15

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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 456	Continued From page 12	F 456		

builds up too much.

On 7/22/15, at 3:03 p.m. Registered Dietician (RD)-A verified being unaware of any ice buildup in the walk-in freezer. RD-A verified there was ice buildup on the top of the ceiling of the walk-in freezer as well as 4-5 inches and ½ inch thickness ice buildup along the doorway and bottom. RD-A stated, "We've had refrigeration (reference to repair person) come. They did replace the seal." The facility contracts with a refrigeration company called Fountain Refrigeration. A record of service provided and dated 1/12/15, indicated that a door trim on the walk-in freezer was installed. No other records of service were provided related to the freezer. RD-A verified that it was an accident hazard by having ice buildup along either side of the doorway an on the floor. RD-A stated, "It's not good to have ice chunks by the door. We will have them (Fountain Refrigeration) come back."

On 7/22/15, at 4:57 p.m. RD-A stated that if a piece of equipment was not functioning properly then staff would first report to RD-A who would then contact maintenance. RD-A stated, "I would have expected staff to notify me of the ice buildup in the freezer."

On 7/23/15, at 10:51 a.m. RD-A stated that the walk-in freezer was cleaned weekly. RD-A stated, "That would include monitoring of ice in the walk-in freezer. Typically, when equipment concerns are identified, it comes to me first. Staff would alert me and then I would notify maintenance." RD-A stated that maintenance was notified yesterday (7/22/15) (this was done after surveyor inquired about ice buildup). RD-A verified that those processes (notification of ice

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 ______	07/23/2015

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

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F 456	Continued From page 13 buildup in walk-in freezer from staff) weren't done. RD-A stated, "I would have expected staff to notify me of the ice buildup in the freezer." On 7/23/15, at 10:59 a.m. RD-A stated that Fountain Refrigeration had been notified of the ice buildup in the walk-in freezer. On 7/23/15, at 12:41 p.m. RD-A stated that Fountain Refrigeration commented on the ice buildup in the walk-in freezer. RD-A stated at this time of the year there is more humidity in the air and so it would be expected to have frost buildup on the ceiling. RD-A stated that Fountain Refrigeration had advised that the curtains in the walk-in freezer should overlap at the doorway to prevent warm air from entering and to keep cold air from escaping; it is also good to keep the door shut as much as possible. RD-A stated that another curtain will be put in the freezer so that the curtains will then overlap to help prevent condensation buildup in the walk-in freezer. A copy of the facility's Cleaning Schedule for the A.M. Cook was provided which directed the staff to sweep the walk-in freezer once a week before delivery; it also directed staff to organize the walk-in freezer after delivery. It showed that the last time the walk-in freezer was swept was on 7/22/15 and the last time it was organized was on 7/21/15. The facilities Cleaning Instructions: Cleaning Freezers Cleaning Policy [2008] states, "For walk-in freezers, mop floors, wash walls and ceilings as needed."	F 456		

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	245425	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Thorne Crest Retirement Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 08/12/2015

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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	245425	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/21/2015

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Thorne Crest Retirement Center is a 1-story building, with no basement. The facility was built in 1973 and was determined to be of Type II(111) construction. The facility is fully sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 41 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved	K 011		8/13/15

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K 011	Continued From page 2 self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour fire rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 19.1.1.4.1. The deficient practice could affect all 12 out 41 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 07/21/2015, observation revealed, that in the TCU tub room , the 2 hour fire rated building separation wall between the nursing home and memory care the following was found : 1. Open penetrations around and end of electrical conduit 2. There is an exhaust duct running through wall without a fire/smoke damper NOTE: Check all 2 hour fire rated building separation walls These deficient practices were confirmed by the Facility Maintenance Director (EH) at the time of discovery.	K 011	Per life safety code 19.1.1.4.1, 19.1.1.4.2 Thorne Crest will use an approved fire caulk on the open penetrations around electrical conduit. A fire damper was installed along the exhaust duct work running through the wall. All work will be completed by August 13th, 2015.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		8/13/15

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 41 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 07/21/2015, documentation review of the monthly emergency generator testing log (August 2014 to July 2015), indicated that the facility did not test the natural gas emergency generator by one of the following means: a. loading that maintains the operating range of the water temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) This deficient practice was confirmed by the Facility Maintenance Director (EH) at the time of discovery.	K 144	Per the requirements of 2000 NFPA 101-9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2 Thorne Crest maintenance department will perform weekly and monthly audits to ensure that our natural gas emergency generator is inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1. These will be ongoing weekly and monthly per NFPA 99 3.4.4.1. A load test will be completed by the end of the day August 13th, 2015.	

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K 144	Continued From page 4 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 3, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5425026

Dear Mr. Schulz:

The above facility was surveyed on July 20, 2015 through July 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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 ____	07/23/2015

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On July 20, 21, 22, and 23, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a plan of care related to activities of daily living (ADL) assistance for 1 of 3 residents (R9) reviewed for ADL's. Findings include: R9's care plan lacked interventions for ADL's. R9's diagnoses included dementia and blindness in both eyes. R9 was observed on 7/20/15, at 2:00 p.m. to have long chin hair as well as long, dirty and jagged fingernails. R9 was also observed on 7/22/15, at 1:00 p.m. and 7/23/15, at 9:16 a.m. sitting in the day room. Chin hair was still present and nails continued to be long, jagged and dirty.	2 560	CORRECTED	8/13/15

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2 560	Continued From page 3 The quarterly Minimum Data Set (MDS) dated 4/27/15, identified R9 as having a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairments, needing extensive assistance of one person with personal hygiene and dressing and physical assistance in part of bathing. The Care Area Assessment (CAA) dated 7/29/14, identified that ADL's would be addressed in the care plan. Review of the care plan dated 6/29/12, did not identify ADL assistance needed and no interventions were evident. During interview with the director of nursing on 7/23/15, at 10:33 a.m. she verified the care plan did not identify the deficit in ADL's and that ADL's should be addressed on the residents plan of care (R9). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		8/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 2 of 2 residents (R9, R70) reviewed for non pressure related skin issues. Findings include: R9's plan of care was not followed regarding bruising. R9's diagnoses included dementia, blindness both eyes and chronic microcytic anemia. The care plan dated 6/29/12, identified an alteration to skin integrity. Interventions included facility protocol for routine skin care and SWAT (skin wound assessment tool) PRN (as needed), report reddened, open, irritated, swollen areas to nurse immediately. During initial interview and observation on 7/20/15, at 2:00 p.m. R9 was noted to have purple and red bruises up the left arm and a purple bruise to the right wrist. On 7/22/15, at 7:17 p.m. bruising remained on right wrist and up left arm. Observation on 7/23/15, at 8 a.m. R9 was in bed with hospital gown on. Bruising was noted to left forearm from elbow to wrist as well as on right wrist. Bruises were dark purple in color. R9 was unable to state where the bruises came from. Review of the medical record did not identify any of the bruising to R9's left arm or right wrist. During an interview with registered nurse B (RN-B) on 7/23/15 at 10:57 a.m. she stated there should be documentation regarding the bruising. She stated she was not aware of the bruising and they had not been reported to her.	2 565	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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) COMPLETE DATE
2 565	Continued From page 5 During an interview with the director of nursing on 7/23/15, at 10:33 a.m. she verified that R9's care plan had not been followed regarding reporting of skin conditions. Review of the care plan last revised 6/26/15, identified R70 was on anticoagulant therapy (Coumadin) related to diagnosis of atrial fibrillation. The interventions included: "Daily skin inspection. Report abnormalities to the nurse." During observation and interview on 7/20/15, at 3:45 p.m. R70 was observed seated in her room in her recliner. R70 was observed to have a large purple bruise on her left forearm, a fading purplish bruise on the lower aspect of her right thumb extending to the wrist, and a fading purplish bruise across the top of the right hand. R70 stated she bruises easily due to being prescribed Coumadin (an anticoagulant medication). Review of the physician order dated 7/22/15 indicated to continue same Coumadin dose of 1.5 milligrams (mg) daily every Sunday and 1 mg daily all other days. Review of the Green Hall Bath Schedule indicated R70 received a bath once a week on Friday evening. The skin/wound progress note dated 7/17/15 at 20:00 (8:00 p.m.) indicated: "Skin check completed after bath. No red or open areas present. Scattered bruising on arms." The treatment administration record dated July 2015 did not include monitoring of bruises for R70. When interviewed on 7/23/15, at 11:49 a.m.	2 565		

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	00833	A. BUILDING: ______ B. WING ______	07/23/2015

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

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2 565	Continued From page 6 nursing assistant (NA)-C stated when a new skin issue such as a bruise or skin tear is identified with a resident she would notify the charge nurse immediately. When interviewed on 7/23/15, at 12:18 p.m. registered nurse (RN)-B stated when a new skin issue is identified for a resident such as a bruise, laceration, or skin tear, the area should be evaluated, treated if necessary, and measured. RN-B further stated a Wound/Skin sheet should be initiated and the area should be measured at least weekly; monitoring of the area is also added to the treatment administration record. At 12:28 p.m., RN-B observed the bruising to R70's left forearm and right hand. When observing R70's arms a new purple bruise was also noted to R70's right elbow. RN-B confirmed the bruising should be reported and monitored though was unsure if this had been completed. After reviewing R70's medical record, treatment administration record, and wound/skin sheets, RN-B confirmed the bruising was not identified, evaluated or monitored and should have been as stated in the care plan. Review of the progress notes dated 7/23/15 at 13:34 (1:34 p.m.) included the following measurements of bruises: Bruise 1 - Right thumb/hand measures 5 cm (centimeters) x (by) 6 cm, bruise 2 - right top of hand 5 cm x 5 cm, bruise 3 - right elbow 5.5 cm x 3.8 cm, bruise 4 - left forearm 9 cm x 4 cm. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee	2 565		

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2 565	Continued From page 7 could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and monitor bruising for 2 of 3 residents (R9, R70) reviewed for non-pressure related skin issues. Findings include: During observation and interview on 7/20/15, at 2:00 p.m. R9 was observed seated in her room in her wheelchair. R9 was observed to have purple and red bruises located on the left forearm up	2 830	CORRECTED	8/13/15

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2 830	Continued From page 8	2 830		

to the elbow. She also had a large purple bruise on her right wrist.

Review of the quarterly Minimum Data Set (MDS) assessment dated 4/27/15, indicated R9 required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene, and limited assistance with locomotion on/off the unit. The Brief Interview for Mental Status (BIMS) scored 4 indicating severe cognitive impairment.

Review of the medical record did not identify any of the bruising noted on R9's left arm and right wrist. The care plan dated 6/29/12, identified an alteration to skin integrity. Interventions included facility protocol for routine skin care and SWAT (skin wound assessment tool) PRN (as needed), report reddened, open, irritated, swollen areas to nurse immediately.

Review of the Green Hall Bath Schedule indicated R9 received a bath once a week on Wednesday days. No skin/wound note was found for 7/22/15 after bath. The treatment administration record dated July 2015 did not include monitoring of bruises for R9.

When interviewed on 7/23/15, at 10:28 a.m. licensed practical nurse B (LPN-B) verified that R9 had received her bath on 7/22/15. She was unaware of any bruising.

When interviewed on 7/23/15, at 10:35 a.m. trained medication aide A (TMA-A) stated she had given R9 a bath yesterday. She stated she had noticed the bruises on R9's arms and told the nurse.

When interviewed on 7/23/15, at 10:57 a.m. registered nurse (RN)-B stated when a new skin

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2 830	Continued From page 9	2 830		

issue is identified for a resident such as a bruise, laceration, or skin tear, the area should be evaluated, treated if necessary, and measured. RN-B further stated a Wound/Skin sheet should be initiated and the area should be measured at least weekly; monitoring of the area is also added to the treatment administration record. At 12:00 p.m., RN-B observed the bruising to R9's left forearm and right hand. RN-B confirmed the bruising should be reported and monitored and stated this had not been completed. After reviewing R9's medical record, treatment administration record, and wound/skin sheets, RN-B confirmed the bruising was not identified, evaluated or monitored and should have been.

Review of the progress notes dated 7/23/15, at 12:43 p.m. included the following measurements of bruises: Bruise right forearm measures 5.7 x 3 cm (centimeters) purple yellow, right lower arm has several bruises scattered up arm. Measurements 3 x 2 cm, 4.5 x 4 cm, 2 x 1 cm and 1 x 1 cm dark purple to light purple.

During observation and interview on 7/20/15, at 3:45 p.m. R70 was observed seated in her room in her recliner. R8 was observed to have a large purple bruise on her left forearm, a fading purplish bruise on the lower aspect of her right thumb extending to the wrist, and a fading purplish bruise across the top of the right hand. R70 stated she bruises easily due to being prescribed Coumadin (an anticoagulant medication).

Review of the 30-day Minimum Data Set (MDS) assessment dated 6/24/15 indicated R70 required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and locomotion on/off the unit. The BIMS score was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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2 830	Continued From page 10	2 830		

15/15, indicating intact cognition.

Review of the care plan last revised 6/26/15, identified R70 was on anticoagulant therapy (Coumadin) related to diagnosis of atrial fibrillation. The interventions included: "Daily skin inspection. Report abnormalities to the nurse."

Review of the physician order dated 7/22/15 indicated to continue same Coumadin dose of 1.5 milligrams (mg) daily every Sunday and 1 mg daily all other days.

Review of the Green Hall Bath Schedule indicated R70 received a bath once a week on Friday evening. The skin/wound progress note dated 7/17/15 at 20:00 (8:00 p.m.) indicated: "Skin check completed after bath. No red or open areas present. Scattered bruising on arms." The treatment administration record dated July 2015 did not include monitoring of bruises for R70.

When interviewed on 7/23/15, at 11:49 a.m. nursing assistant (NA)-C stated when a new skin issue such as a bruise or skin tear is identified with a resident she would notify the charge nurse immediately.

When interviewed on 7/23/15, at 12:18 p.m. registered nurse (RN)-B stated when a new skin issue is identified for a resident such as a bruise, laceration, or skin tear, the area should be evaluated, treated if necessary, and measured. RN-B further stated a Wound/Skin sheet should be initiated and the area should be measured at least weekly; monitoring of the area is also added to the treatment administration record. At 12:28 p.m., RN-B observed the bruising to R70's left

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2 830	Continued From page 11 forearm and right hand. R70 stated the staff knew about the bruising and stated she bruises easily due to her Coumadin use. When observing R70's arms a new purple bruise was also noted to R70's right elbow. RN-B confirmed the bruising should be reported and monitored though was unsure whether this had been completed. After reviewing R70's medical record, treatment administration record, and wound/skin sheets, RN-B confirmed the bruising was not identified, evaluated or monitored and should have been. Review of the progress notes dated 7/23/15 at 13:34 (1:34 p.m.) included the following measurements of bruises: Bruise 1 - Right thumb/hand measures 5 cm (centimeters) x (by) 6 cm, bruise 2 - right top of hand 5 cm x 5 cm, bruise 3 - right elbow 5.5 cm x 3.8 cm, bruise 4 - left forearm 9 cm x 4 cm. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate all licensed staff on the need to monitor non-pressure skin conditions and/or non-pressure skin conditions present on residents upon admission to the facility. The director of nursing could develop an audit to monitor staff compliance with the policy. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 860		8/13/15

Minnesota Department of Health

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	00833	A. BUILDING: ______ B. WING ______	**07/23/2015**

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2 860	Continued From page 12 E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming and personal hygiene for 1 of 3 residents (R9) reviewed who was unable to perform activities of daily living (ADL's). Findings include: R9 was unable to perform ADL's independently and did not receive assistance with shaving and nail care. R9's diagnosis included dementia and blindness both eyes. During observation and interview on 7/20/15, at 2:00 p.m. R9 was observed seated in her room in her wheelchair. R9 was observed to have several long hair on her chin. R9's fingernails were noted to be long, jagged and have a black substance underneath the nails. Review of the quarterly Minimum Data Set (MD'S) assessment dated 4/27/15, indicated R9 required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene, and limited assistance with locomotion on/off the unit. The Brief Interview for Mental Status (BIMS) scored 4 indicating severe cognitive impairment. Review of the Green Hall Bath Schedule indicated R9 received a bath once a week on Wednesday days. No skin/wound note was found for 7/22/15, after bath.	2 860	CORRECTED	

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2 860	Continued From page 13 When interviewed on 7/23/15, at 10:28 a.m. licensed practical nurse B (LPN-B) verified that R9 had received her bath on 7/22/15. When interviewed on 7/23/15, at 10:35 a.m. trained medication aide A (TMA-A) stated she had given R9 a bath yesterday. She stated she had not trimmed nor cleaned her fingernails. She stated she had not shaved her as R9 didn't have her own razor. TMA-A verified that R9's nails were very dirty and should have been cleaned. When interviewed on 7/23/15, at 10:57 a.m. the director of nursing (DON) stated that shaving should be done with daily cares as needed and nails should be done a least weekly with bath and also as needed. She also stated that ADL's should be addressed on the care plan and verified it was not. Review of the facility policy revised 2010: Care of Fingernails/Toenails: General Guidelines 1. Nail care includes daily cleaning and regular trimming. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff on performing activities of daily living including finger nail care for residents. The director of nursing or designee could schedule audits to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings,	21685		8/13/15

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21685	Continued From page 14 systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in freezer was maintained with a minimal amount of ice build-up to ensure it's safe operating condition. This had the potential to affect the integrity of the food which is served to all 41 residents who eat at the facility and the safety of staff who access this freezer on a daily basis. Findings include: During the initial kitchen tour on 7/20/2015 at 9:15 a.m. with cook (C)-A, the walk-in freezer was observed to have an area of approximately 4-5 inches by ½ inch thickness along both sides of the doorway and along the floor. C-A verified the ice buildup on the floor and on both sides of the doorway. C-A stated they chip the ice away if it builds up too much. On 7/22/15, at 3:03 p.m. Registered Dietician (RD)-A verified being unaware of any ice buildup in the walk-in freezer. RD-A verified there was ice buildup on the top of the ceiling of the walk-in freezer as well as 4-5 inches and ½ inch thickness ice buildup along the doorway and bottom. RD-A stated, "We've had refrigeration (reference to repair person) come. They did replace the seal." The facility contracts with a refrigeration company called Fountain Refrigeration. A record of service provided and	21685	CORRECTED	

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	00833	A. BUILDING: ____ B. WING ____	07/23/2015

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

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21685	Continued From page 15 dated 1/12/15, indicated that a door trim on the walk-in freezer was installed. No other records of service were provided related to the freezer. RD-A verified that it was an accident hazard by having ice buildup along either side of the doorway an on the floor. RD-A stated, "It's not good to have ice chunks by the door. We will have them (Fountain Refrigeration) come back." On 7/22/15, at 4:57 p.m. RD-A stated that if a piece of equipment was not functioning properly then staff would first report to RD-A who would then contact maintenance. RD-A stated, "I would have expected staff to notify me of the ice buildup in the freezer." On 7/23/15, at 10:51 a.m. RD-A stated that the walk-in freezer was cleaned weekly. RD-A stated, "That would include monitoring of ice in the walk-in freezer. Typically, when equipment concerns are identified, it comes to me first. Staff would alert me and then I would notify maintenance." RD-A stated that maintenance was notified yesterday (7/22/15) (this was done after surveyor inquired about ice buildup). RD-A verified that those processes (notification of ice buildup in walk-in freezer from staff) weren't done. RD-A stated, "I would have expected staff to notify me of the ice buildup in the freezer." On 7/23/15, at 10:59 a.m. RD-A stated that Fountain Refrigeration had been notified of the ice buildup in the walk-in freezer. On 7/23/15, at 12:41 p.m. RD-A stated that Fountain Refrigeration commented on the ice buildup in the walk-in freezer. RD-A stated at this time of the year there is more humidity in the air and so it would be expected to have frost buildup on the ceiling. RD-A stated that Fountain	21685		

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21685	Continued From page 16 Refrigeration had advised that the curtains in the walk-in freezer should overlap at the doorway to prevent warm air from entering and to keep cold air from escaping; it is also good to keep the door shut as much as possible. RD-A stated that another curtain will be put in the freezer so that the curtains will then overlap to help prevent condensation buildup in the walk-in freezer. A copy of the facility's Cleaning Schedule for the A.M. Cook was provided which directed the staff to sweep the walk-in freezer once a week before delivery; it also directed staff to organize the walk-in freezer after delivery. It showed that the last time the walk-in freezer was swept was on 7/22/15 and the last time it was organized was on 7/21/15. The facilities Cleaning Instructions: Cleaning Freezers Cleaning Policy [2008] states, "For walk-in freezers, mop floors, wash walls and ceilings as needed." SUGGESTED METHOD OF CORRECTION: The dietary supervisor could develop and maintain a schedule to keep the ice build up in the walk-in freezer at a minimum. The staff could be inserviced on the new schedule and audits could be developed and implemented to ensure the walk-in freezer equipment remains in good operating condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		