DEPARTMENT OF HEA	. –					DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: YMLL
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00833
1. MEDICARE/MEDICAID PRO           (L1)         245425           2.STATE VENDOR OR MEDICA           (L2)         144343700		3. NAME AND AI (L3) <b>THORNE C</b> (L4) <b>1201 GARF</b> (L5) <b>ALBERT LI</b>	REST RETIR	EMENT (	CENTER (L6) 56007	4. TYPE OF ACTION: <u>7</u> (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE (L9)</li> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATUS: 0 Unaccredited 1 T. 2 AOA 3 0</li> </ol>	08/31/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 08/31
<ul> <li>11LTC PERIOD OF CERTIFICA</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> </ul>	ATION 52 (L18)	Complianc 1. A	nce With equirements te Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
13.Total Certified Beds	<b>52</b> (L17)		npliance with Prog ents and/or Appli		: * Code: A	(L12)
14. LTC CERTIFIED BED BREA	KDOWN				15. FACILITY MEETS	
18 SNF 18/19 52		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38	3) (L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY	REMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	YAPPROVAL Date:
Kathryn Serie, Unit	Supervisor	0	09/07/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 09/08/2015 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIC          1. Facility is Eligible          2. Facility is not Elic	e to Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	<b>MENT</b>	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION <b>02/01/1987</b>	BEGINNINC	<b>G</b> DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change
(L27		spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division <u>Kamala.Fiske-Downing@state.mn.us</u> 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,

Kumala Fiske Downing

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

#### **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 245425	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 8/31/2015
Name	e of Facility		Street Address, City, State, Zip Code	
T⊦	ORNE CREST RETIREMENT CENT	ER	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	(Y	5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
	483.20(d), 483.20(k)(1)			483.20(k)(3)(ii)		Correction Completed 08/13/2015			483.25		Correction Completed 08/13/2015
LSC		-	LSC					LSC			_
0	F0312 483.25(a)(3)	Correction Completed 08/13/2015	ID Prefix Reg. #			Correction Completed 08/13/2015		ID Prefix			Correction Completed
ID Prefix Reg. # LSC		Correction Completed 				Correction Completed		Reg. #			Correction Completed
Reg. #			Reg. #			Correction Completed					
Reg. #			Reg. #			Correction Completed		D			
Reviewed B	3y Reviewe	d By	Date:	Signature	of Sur	veyor:				Date:	
State Agen	cy KS/kfd		09/07/20	_		-	048				08/31/2015
Reviewed E CMS RO	By Reviewe	d By	Date:	Signature	of Sur		<u></u> 10			Date:	
Followup t	o Survey Completed o 7/23/2015	n:		Check for any Uncorrected					Summary of the Facility?	YES	NO

#### **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 245425	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 9/4/2015
Name of Facility		Street Address, City, State, Zip Code	
THORNE CREST RETIREMENT CENT	ER	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	(Y4) Item		(Y5) Date (	Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 08/13/2015	ID Prefix		Correction Completed 08/13/2015	ID Prefix		Correction Completed
0	NFPA 101		•	NFPA 101		Reg. #		
LSC	K0011		LSC	K0144				
		Correction			Correction			Correction
ID Prefix		Completed			Completed			Completed
Reg. #			Reg. #			Pog #		
LSC						LSC		
		Correction			Correction			Correction
ID Prefix		Completed			Completed	ID Prefix		Completed
Reg. #			Reg. #					
						LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #								
LSC			LSC			LSC		
		Correction Completed			Correction Completed			Correction Completed
Reg. #			Reg. #			Dog #		
						LSC		
Reviewed E	By Revie	ewed By	Date:	Signature	of Surveyor:		Date:	
State Agen	cy GS/I	xfd	09/07/202	15		25822		09/04/2015
Reviewed E CMS RO	By Revie	ewed By	Date:	Signature	of Surveyor:		Date:	
Followup t	o Survey Complete 7/21/2015					encies. Was a Sum S-2567) Sent to the F		NO

DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL FE SURVEY AGENCY	ID: YMLL Facility ID: 00833
1. MEDICARE/MEDICAID PROVIDE           (L1)         245425           2.STATE VENDOR OR MEDICAID NO           (L2)         144343700	R NO.	3. NAME AND AE (L3) THORNE C (L4) 1201 GARFI (L5) ALBERT LI	DRESS OF FAC REST RETIR IELD AVENUI	ULITY EMENT (		4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9)		7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07/23/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 08/31
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	<ul><li>52 (L18)</li><li>52 (L17)</li></ul>	Complianc 1. A X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	2. Technical Personnel     3. 24 Hour RN     4. 7-Day RN (Rural SN     5. Life Safety Code	The Following Requirements:        6. Scope of Services Limit        7. Medical Director         IF)      8. Patient Room Size        9. Beds/Room         (L12)
		Kequitein	ents and/or Apph	eu warvers.	15. FACILITY MEETS	(E12)
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF	19 SNF	ICF	IID		13. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
52 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Connie Brady, HFE NE	II	C	08/12/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 09/03/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILI</li> <li>1. Facility is Eligible to Pa</li> <li>2. Facility is not Eligible</li> </ol>			IPLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>02/01/1987</b>	BEGINNINC	G DATE	ENDING DAT	ГЕ	VOLUNTARY     00       01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE: (L27)	-	n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
	B. Rescind St	uspension Date:	(L45)			
28. TERMINATION DATE:	29	). INTERMEDIARY/	. ,		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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 <u>Kathryn.serie@state.mn.us</u> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	•		0	<u>MB NO.</u>	. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY IPLETED
		245425	B. WING			07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMEN	IT CENTER			201 GARFIELD AVENUE LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 0	00			
F 279 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has beet your verification. 483.20(d), 483.20(f COMPREHENSIVE A facility must use to to develop, review a comprehensive plat The facility must deeplan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with (1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's n of care. evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive t describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment	F 2	79			8/13/15
LABORATORY	UIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI			TITLE		(X6) DATE
	ically Signed	0000					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.

PRINTED: 08/12/2015

		AND HUMAN SERVICES				FORM	: 08/12/2015 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION		E SURVEY IPLETED
		245425	B. WING			07/	23/2015
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
THORNE	E CREST RETIREMEN	IT CENTER			ARFIELD AVENUE RT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 1	F 2	79			
	by: Based on observar review, the facility f related to activities assistance for 1 of ADL's. Findings include: R9's care plan lack R9's diagnoses inc in both eyes. R9 was observed of have long chin hair jagged fingernails. 7/22/15, at 1:00 p.m sitting in the day ro and nails continued The quarterly Minin 4/27/15, identified F Interview for Menta severe cognitive im assistance of one p and dressing and p bathing. The Care A 7/29/14, identified t in the care plan. Re 6/29/12, did not ide and no intervention During interview wi 7/23/15, at 10:33 a did not identify the	NT is not met as evidenced tion, interview, and document ailed to develop a plan of care of daily living (ADL) 3 residents (R9) reviewed for ed interventions for ADL's. luded dementia and blindness on 7/20/15, at 2:00 p.m. to as well as long, dirty and R9 was also observed on n. and 7/23/15, at 9:16 a.m. om. Chin hair was still present to be long, jagged and dirty. num Data Set (MDS) dated R9 as having a BIMS (Brief Il Status) score of 4 indicating pairments, needing extensive berson with personal hygiene ohysical assistance in part of Area Assessment (CAA) dated hat ADL's would be addressed eview of the care plan dated ontify ADL assistance needed is were evident. th the director of nursing on .m. she verified the care plan deficit in ADL's and that ADL's ed on the residents plan of		con resi For revi on care All o con 8/12 IDT con 8/12 IDT con was wou plan con men ass dev will occ IDT revi	s the policy of the facility to dev nprehensive plan of care for all idents, which would include AD resident R9 resident; s care pl iewed and updated revisions to 7/23/15 to include grooming an e. care plans were audited for nprehensive ADL care plan whi npleted by the IDT and complet 2/2015. Thet on 8/6/15 to review nprehensive care planning polic s decided that beginning 8/10/1 uld add reviewing/monitoring can s of residents due for care iference, during our weekly ber eting. IDT will be responsible to ure the comprehensive plan of reloped for each resident. Care be updated at time of review a ur on an on-going basis as ind will report the number of care iewed and number of changes, committee monthly.	L¿s. an was ADL¿s d nail ch was ted on cy. It 5, IDT are navioral o care is e plans nd also icated. plans	

If continuation sheet Page 2 of 14

		AND HUMAN SERVICES			F	ORM	08/12/2015 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X		E SURVEY PLETED
		245425	B. WING			07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMEN	T CENTER			201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED ARE PLAN	F 2	282			8/13/15
	must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review the facility fa for 2 of 2 residents pressure related sk Findings include: R9's plan of care w bruising. R9's diag blindness both eyes anemia. The care p an alteration to skir included facility pro SWAT (skin wound needed), report red areas to nurse imm During initial intervit 7/20/15, at 2:00 p.n purple and red bruis purple bruise to the 7:17 p.m. bruising	as not followed regarding noses included dementia, s and chronic microcytic blan dated 6/29/12, identified n integrity. Interventions tocol for routine skin care and assessment tool) PRN (as dened, open, irritated, swollen			It is the policy of this facility to follow 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 non-pressure related skin issues inclu bruises was reviewed by DON and revised on 8/5/15, which includes a S Monitoring Report form that will be us by CNAs to report skin concerns to th 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 Nurse on 8/6/15 and CNAs on 8/11/15 relate the updated policy that includes the S	5. g of uding Skin sed ne t es ed to	
	noted to left forearr as on right wrist. B	spital gown on. Bruising was n from elbow to wrist as well ruises were dark purple in le to state where the bruises			Monitoring Report form for communication, assessment and monitoring of non-pressure related sk issues, including bruises. Non-pressure related skin issues suc bruising, will be reviewed as the Skin	h as	

Facility ID: 00833

If continuation sheet Page 3 of 14

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	245425	B. WING _		07/2	23/2015
PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODI	=	
CREST RETIREMEN	IT CENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIC DATE
Review of the med of the bruising to R During an interview (RN-B) on 7/23/15 should be document She stated she was they had not been in During an interview 7/23/15, at 10:33 a plan had not been in skin conditions. Review of the care identified R70 was (Coumadin) related fibrillation. The inter- skin inspection. Re- nurse." During observation 3:45 p.m. R70 was in her recliner. R70 purple bruise on the purplish bruise on the purplish bruise acro R70 stated she bru prescribed Couman- medication). Review of the phys- indicated to continu- milligrams (mg) da daily all other days.	ical record did not identify any 9's left arm or right wrist. 7 with registered nurse B at 10:57 a.m. she stated there intation regarding the bruising. 8 not aware of the bruising and reported to her. 7 with the director of nursing on .m. she verified that the care followed regarding reporting of 9 plan last revised 6/26/15, on anticoagulant therapy d to diagnosis of atrial erventions included: "Daily eport abnormalities to the 9 and interview on 7/20/15, at observed seated in her room 0 was observed to have a large er left forearm, a fading the lower aspect of her right o the wrist, and a fading oss the top of the right hand. ises easily due to being din (an anticoagulant scician order dated 7/22/15 ue same Coumadin dose of 1.5 ily every Sunday and 1 mg	F 28	Monitoring Report forms are re the DON or designee and audi through this process on an on- basis. Concerns will be addres staff education and findings wi	ts will occur going sed with Il be	
	PROVIDER OR SUPPLIER <b>CREST RETIREMEN</b> SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From pa Review of the med of the bruising to R During an interview (RN-B) on 7/23/15 should be document She stated she was they had not been During an interview 7/23/15, at 10:33 at plan had not been skin conditions. Review of the care identified R70 was (Coumadin) related fibrillation. The interview skin inspection. Refined nurse." During observation 3:45 p.m. R70 was in her recliner. R70 purple bruise on the purplish bruise acrossi Review of the physi indicated to continu- milligrams (mg) dad daily all other days Review of the Gree	DF CORRECTION       IDENTIFICATION NUMBER:         245425         PROVIDER OR SUPPLIER         CREST RETIREMENT CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 across the top of the right thumb extending to the wrist, and a fading purplish bruise across the top of the 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	TOF DEFICIENCIES DE CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDIN         245425       B. WING         PROVIDER OR SUPPLIER       245425         CREST RETIREMENT CENTER       ID REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 3       F 28         Review of the medical record did not identify any of the bruising to R9's left arm or right wrist.       F 28         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 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 Schedul	CP DEFICIENCIES       [X1] PROVIDERSUPPLER/CLA       (X2) MULTIPLE CONSTRUCTION         DENTIFICATION NUMBER:       245425       B. WING         ECREST RETIREMENT CENTER       STREET ADDRESS, CITY, STATE, 2IP CODI         SUMMARY STATEMENT OF DEFICIENCIES       STREET ADDRESS, CITY, STATE, 2IP CODI         VECAPTION NUMBER:       1201 CARFIELD AVENUE         ALBERT LEA, MN 56007       LEA, MN 56007         SUMMARY STATEMENT OF DEFICIENCIES       PROVIDER'S PLANO PCORRECTIVE ACTION SH         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         Continued From page 3       PREVIEW 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       Monitoring Report forms are refine the DON or designee and audi through this process on an on-RN-102/315 at 10:375 a.m. she stated there should be documentation regarding 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 reported to her.       Monitoring Report forms are refined that the care plan had not been reported to her.         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 seated in her room in her recliner. R70 was observed seated in her room in her lower aspect of her right thrube seating the top of the right hand. R70 stated she bruise across the top of the right hand. R70 stated she bruise canal to top of the right hand. R70 stated sh	CP DEFICIENCIES       (X1) PROVIDERSUPPLERICLA IDENTIFICATION NUMBER:       (X2) MULTIFICE CONSTRUCTION       (X3) DATA         A BUILDING       245425       B. WING       07/         PROVIDER OR SUPPLER       245425       B. WING       07/         COMMONSTATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIDE ALBERT LEA, MIN 56007       07/         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 and they had not been reported to her.       F 282         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.       F 282         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         During observation and interview on 7/20/15, at 3:45 p.m. R70 was observed bare along the right thumb extending to the wrist, and a fading purplish bruise across the top of the 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 Green Hall Bath Schedule

If continuation sheet Page 4 of 14

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245425	B. WING		07/	23/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THORNE	CREST RETIREMEN	IT CENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	dated 7/17/15 at 20 "Skin check complet open areas present The treatment adm 2015 did not includ R70. When interviewed of nursing assistant (N issue such as a bru- with a resident she immediately. When interviewed of registered nurse (R issue is identified for laceration, or skin t evaluated, treated if RN-B further stated be initiated and the least weekly; monit to the treatment ad p.m., RN-B observer forearm and right h arms a new purple R70's right elbow. should be reported unsure if this had b reviewing R70's me administration reco RN-B confirmed the evaluated or monito stated in the care p Review of the prog 13:34 (1:34 p.m.) in measurements of b	2:00 (8:00 p.m.) indicated: eted after bath. No red or t. Scattered bruising on arms." inistration record dated July e monitoring of bruises for on 7/23/15, at 11:49 a.m. NA)-C stated when a new skin uise or skin tear is identified would notify the charge nurse on 7/23/15, at 12:18 p.m. N)-B stated when a new skin or a resident such as a bruise, ear, the area should be if necessary, and measured. d a Wound/Skin sheet should e area should be measured at coring of the area is also added ministration record. At 12:28 ed the bruising to R70's left and. When observing R70's bruise was also noted to RN-B confirmed the bruising and monitored though was been completed. After edical record, treatment ord, and wound/skin sheets, e bruising was not identified, ored and should have been as	F 2			

Facility ID: 00833

If continuation sheet Page 5 of 14

		AND HUMAN SERVICES			FO	ED: 08/12/20 RM APPROV IO. 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY
		245425	B. WING			07/23/2015
NAME OF F	PROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
THORNE	CREST RETIREMEN	IT CENTER			201 GARFIELD AVENUE LBERT LEA, MN 56007	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
F 282	Continued From pa bruise 3 - right elbo left forearm 9 cm x	w 5.5 cm x 3.8 cm, bruise 4 -	F 2	282		
F 309 SS=D		CARE/SERVICES FOR	F3	809		8/13/15
	provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on observa review the facility fa	NT is not met as evidenced tion, interview, and document ailed to identify and monitor esidents (R9, R70) reviewed lated skin issues.			It is the policy of this facility to identify a monitor bruising. (Same POC as for the F282 above)	Ind
	Findings include:					
	2:00 p.m. R9 was of her wheelchair. R9 and red bruises loo	and interview on 7/20/15, at observed seated in her room in was observed to have purple cated on the left forearm up ilso had a large purple bruise				
	assessment dated extensive assistant dressing, toilet use limited assistance The Brief Interview	terly Minimum Data Set (MDS) 4/27/15, indicated R9 required ce with bed mobility, transfer, and personal hygiene, and with locomotion on/off the unit. for Mental Status (BIMS) severe cognitive impairment.				

If continuation sheet Page 6 of 14

STATEMEN	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	TIPLE CONSTRUCTION	(X3) I	NO. 0938-039 DATE SURVEY COMPLETED
		245425	B. WING			07/23/2015
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STAT		
THORNE		NT CENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE	(X5) COMPLETIC DATE
F 309	Review of the med of the bruising note wrist. The care pla alteration to skin in facility protocol for (skin wound assess report reddened, on nurse immediately) Review of the Greet indicated R9 receive Wednesday days. found for 7/22/15 at administration reco- include monitoring When interviewed licensed practical r R9 had received he unaware of any bru When interviewed trained medication given R9 a bath ye noticed the bruises nurse. When interviewed registered nurse (F issue is identified f laceration, or skin evaluated, treated RN-B further stated be initiated and the least weekly; moni- to the treatment ac p.m., RN-B observ forearm and right f	ical record did not identify any ed on R9's left arm and right an dated 6/29/12, identified an itegrity. Interventions included routine skin care and SWAT sment tool) PRN (as needed), pen, irritated, swollen areas to whether the state of the state of the state record a bath once a week on No skin/wound note was after bath. The treatment ord dated July 2015 did not of bruises for R9. on 7/23/15, at 10:28 a.m. hurse B (LPN-B) verified that er bath on 7/22/15. She was	F 3	309		

If continuation sheet Page 7 of 14

		AND HUMAN SERVICES				FORM	08/12/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245425	B. WING			07/:	23/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	E CREST RETIREMEN	TCENTER			201 GARFIELD AVENUE ILBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	stated this had not i reviewing R9's med administration reco RN-B confirmed the evaluated or monito Review of the progr 12:43 p.m. included of bruises: Bruise r cm (centimeters) put has several bruises Measurements 3 x and 1 x 1 cm dark p During observation 3:45 p.m. R70 was in her recliner. R8 purple bruise on the purplish bruise on the purplish bruise on the thumb extending to purplish bruise acro R70 stated she bru prescribed Coumad medication). Review of the 30-da assessment dated extensive assistant dressing, eating, to locomotion on/off th 15/15, indicating int Review of the care identified R70 was (Coumadin) related fibrillation. The inter	been completed. After dical record, treatment rd, and wound/skin sheets, e bruising was not identified, ored and should have been. ress notes dated 7/23/15, at d the following measurements right forearm measures 5.7 x 3 urple yellow, right lower arm s scattered up arm. 2 cm, 4.5 x 4 cm, 2 x 1 cm ourple to light purple. and interview on 7/20/15, at observed seated in her room was observed to have a large er left forearm, a fading he lower aspect of her right to the wrist, and a fading oss the top of the right hand. ises easily due to being din (an anticoagulant ay Minimum Data Set (MDS) 6/24/15 indicated R70 required ce with bed mobility, transfer, ilet use, personal hygiene, and ne unit. The BIMS score was	F 3	809			

If continuation sheet Page 8 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245425	B. WING	ì		07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMEN	T CENTER			1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	indicated to continu milligrams (mg) dai daily all other days. Review of the Gree indicated R70 recei Friday evening. Th dated 7/17/15 at 20 "Skin check comple open areas present The treatment adm 2015 did not include R70. When interviewed of nursing assistant (N issue such as a bruw with a resident she immediately. When interviewed of registered nurse (R issue is identified for laceration, or skin the evaluated, treated i RN-B further stated be initiated and the least weekly; moniti to the treatment add p.m., RN-B observer forearm and right h knew about the bru easily due to her Co observing R70's arr also noted to R70's the bruising should though was unsure	cian order dated 7/22/15 e same Coumadin dose of 1.5 ly every Sunday and 1 mg	F	309			

If continuation sheet Page 9 of 14

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MELT	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
		245425	B. WING		07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMEN	TCENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 309	sheets, RN-B confir identified, evaluated have been.	ation record, and wound/skin med the bruising was not d or monitored and should	F 30	9		
F 312 SS=D	13:34 (1:34 p.m.) in measurements of b thumb/hand measu 6 cm, bruise 2 - rig bruise 3 - right elbo left forearm 9 cm x 483.25(a)(3) ADL C	ARE PROVIDED FOR	F 31	2		8/13/15
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal				
	by: Based on observat review the facility fa personal hygiene for reviewed who was daily living (ADL's). Findings include: R9 was unable to p and did not receive nail care. R9's diag blindness both eyes	NT is not met as evidenced ion, interview and document iled to provide grooming and ir 1 of 3 residents (R9) unable to perform activities of erform ADL's independently assistance with shaving and mosis included dementia and s. and interview on 7/20/15, at		It is the policy of this facility to pr necessary services for grooming person hygiene. R9 grooming and hygiene was co on 7/23/15. Audit was done to ensure all resi had or received an electric razor 8/4/15. Policy for nail care and shaving v reviewed by DON on 8/5/15. Education to Licensed Nurses or and CNAs on 8/11/15 related to g and hygiene, specifically nail care shaving. Skin Monitoring Form v	and ompleted dents on was 8/6/15 grooming e and	

Facility ID: 00833

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	NG	CON	IFLETED
		245425	B. WING _			23/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THORNE	E CREST RETIREMEN	T CENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 312	<ul> <li>2:00 p.m. R9 was o her wheelchair. R9 long hair on her chi to be long, jagged a underneath the nail</li> <li>Review of the quart assessment dated a extensive assistance dressing, toilet use limited assistance w The Brief Interview scored 4 indicating</li> <li>Review of the Gree indicated R9 receive Wednesday days. found for 7/22/15, a</li> <li>When interviewed of licensed practical n R9 had received he</li> <li>When interviewed of trained medication a given R9 a bath yes not trimmed nor cle stated she had not her own razor. TM/ were very dirty and</li> <li>When interviewed of director of nursing ( should be done with nails should be don also as needed. St</li> </ul>	bserved seated in her room in was observed to have several n. R9's fingernails were noted and have a black substance s. erly Minimum Data Set (MD'S) 4/27/15, indicated R9 required the with bed mobility, transfer, and personal hygiene, and with locomotion on/off the unit. for Mental Status (BIMS) severe cognitive impairment. n Hall Bath Schedule ed a bath once a week on No skin/wound note was after bath. on 7/23/15, at 10:28 a.m. urse B (LPN-B) verified that	F 31	developed for communication related issues from CNA to also includes checking facia nails with bathing. This form forwarded to DON for review purposes and on-going more Concerns will be addressed education and reported to the committee monthly.	nurse which al hair and n is then v for auditing nitoring. with staff	

		AND HUMAN SERVICES				FORM	08/12/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245425	B. WING			07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	• • •	
THORNE	CREST RETIREMEN	T CENTER			01 GARFIELD AVENUE _BERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 312	Review of the facilit Fingernails/Toenails	ge 11 ty policy revised 2010: Care of s: General Guidelines 1. Nail cleaning and regular trimming.	F 3	:12			
F 456 SS=C	OPERATING CON The facility must m	aintain all essential cal, and patient care	F 4	.56			8/13/15
	by: Based on observative review, the facility for freezer was maintanice build-up to ensure condition. This had foods integrity whice who eat at the facilitation access this freezer for Findings include: During the initial kitan. with cook (C)-observed to have an inches by ½ inch the the doorway and and ice buildup on the formation observed to favore and the doorway and and the doorway and and the doorway and and the doorway and and the factor observed to the factor observed to the factor of the factor of the doorway and and the doorway and and the factor of the factor of the factor of the factor observed to the factor of th	NT is not met as evidenced tion, interview and document ailed to ensure the walk-in ined with a minimal amount of the potential to affect the h is served to all 41 residents ty and the safety of staff who on a daily basis.			Per regulation 483.70 (c) (2) essent equipment, safe operating condition Thorne Crest maintenance placed m plastic curtains in freezer to prevent build-up. Maintenance will also perfor weekly audit of freezer to maintain a remove ice build up that could affect integrity of the food and safety of ou These audits will start August 13th 2 and will be ongoing for the next two months.	nore ice orm a and t the r staff. 2015	

Facility ID: 00833

If continuation sheet Page 12 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245425       B. WING       07/23/2015         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       1201 GARFIELD AVENUE         THORNE CREST RETIREMENT CENTER       ADDREST IS A WING       ADDREST IS A WING			AND HUMAN SERVICES				FORM	08/12/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       THOBNE CREST RETIREMENT CENTER     1201 GARFIELD AVENUE	STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,				
THORNE CREST RETIREMENT CENTER 1201 GARFIELD AVENUE			245425	B. WING			07/2	23/2015
THORNE CREST RETIREMENT CENTER	NAME OF I	PROVIDER OR SUPPLIER					•	
AI BEBT I FA, MN 56007	THORNE	E CREST RETIREMEN	IT CENTER			201 GARFIELD AVENUE ALBERT LEA, MN 56007		
Image: Complexity of the second se	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 456     Continued From page 12 builds up too much.     F 456       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. A record of service provided and dated 11/21/5, 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. 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) (it) is was done after surveyor inquired about ice buildup. RD-A	F 456	builds up too much On 7/22/15, at 3:03 (RD)-A verified beir in the walk-in freez buildup on the top of freezer as well as 4 thickness ice buildu bottom. RD-A state (reference to repair replace the seal." T refrigeration compa Refrigeration. A red dated 1/12/15, indit walk-in freezer was service were provid RD-A verified that if having ice buildup doorway an on the good to have ice ch have them (Founta On 7/22/15, at 4:57 piece of equipment then staff would first then contact mainten have expected staff in the freezer." On 7/23/15, at 10:5 walk-in freezer was "That would include walk-in freezer. Typ concerns are identit would alert me and maintenance." RD was notified yester	A. B p.m. Registered Dietician ng unaware of any ice buildup er. RD-A verified there was ice of the ceiling of the walk-in 4-5 inches and ½ inch up along the doorway and ed, "We've had refrigeration r person) come. They did The facility contracts with a any called Fountain cord of service provided and cated that a door trim on the s installed. No other records of ded related to the freezer. t was an accident hazard by along either side of the floor. RD-A stated, "It's not hunks by the door. We will in Refrigeration) come back." 7 p.m. RD-A stated that if a t was not functioning properly st report to RD-A who would enance. RD-A stated, "I would if to notify me of the ice buildup 51 a.m. RD-A stated that the s cleaned weekly. RD-A stated, e monitoring of ice in the bically, when equipment ified, it comes to me first. Staff a then I would notify I-A stated that maintenance day (7/22/15) (this was done	F 4	456			

Facility ID: 00833

If continuation sheet Page 13 of 14

PRINTED: 08/12/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/12/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245425	B. WING	ì		07/:	23/2015
NAME OF I	PROVIDER OR SUPPLIER	•	<u></u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	E CREST RETIREMEN	IT CENTER			1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 456	buildup in walk-in fr done. RD-A stated, to notify me of the i On 7/23/15, at 10:5 Fountain Refrigerati ice buildup in the w On 7/23/15, at 12:4 Fountain Refrigerati buildup in the walk- time of the year the and so it would be o on the ceiling. RD-/ Refrigeration had a walk-in freezer sho prevent warm air fr air from escaping; i shut as much as po another curtain will the curtains will the condensation build A copy of the facility A.M. Cook was pro to sweep the walk-in <i>7/22/15</i> and the las 7/21/15. The facilities Clean Freezers Cleaning	reezer from staff) weren't "I would have expected staff ice buildup in the freezer." 59 a.m. RD-A stated that tion had been notified of the ralk-in freezer. Al p.m. RD-A stated that tion commented on the ice -in freezer. RD-A stated at this ere is more humidity in the air expected to have frost buildup A stated that Fountain idvised that the curtains in the uld overlap at the doorway to om entering and to keep cold it is also good to keep the door ossible. RD-A stated that be put in the freezer so that en overlap to help prevent up in the walk-in freezer. y's Cleaning Schedule for the ovided which directed the staff in freezer once a week before ected staff to organize the er delivery. It showed that the n freezer was swept was on at time it was organized was on	F	456			

If continuation sheet Page 14 of 14

	TMENT OF HEALTH AND HUMAN SERVICES RS FOR MEDICARE & MEDICAID SERVICES			PRINTED: 0 FORMAF	PROVED
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPLE	URVEY
	245425	B. WING _		07/21	/2015
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMENT CENTER	1	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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE C	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 00	0		
	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.		2		
	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.				
n) M	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.		EDOC		
	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:		EFUU	<u>'</u>	
	Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:				
ABORATORY	DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	ΤΠΓΕ		) DATE
	cally Signed	NORE			/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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YMLL21

Facility ID: 00833

		AND HUMAN SERVICES			FORM	: 08/19/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY MPLETED
		245425	B. WING		07/	/21/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMEN	IT CENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	Marian Whitney@s Angela Kappenmar	tate.mn.us and	K 00	0		
		T INCLUDE ALL OF THE				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.				
	2. The actual, or pr	oposed, completion date.				
		r title of the person ection and monitoring to nce of the deficiency.				
	building, with no ba	Retirement Center is a 1-story sement. The facility was built termined to be of Type II(111)				
	alarm system with p corridors and space	prinkled. The facility has a fire partial smoke detection in the is open to the corridor that is natic fire department				
		pacity of 52 beds and had a at the time of the survey.				
	NOT MET as evider	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD	K 01	1		8/13/15
	nonconforming build barrier having at lea rating constructed o addition. Communi	common wall with a ting, the common wall is a fire st a two-hour fire resistance f materials as required for the cating openings occur only in otected by approved				

Event ID: YMLL21

Facility ID: 00833

If continuation sheet Page 2 of 5

	MENT OF HEALTH AND HUMAN SERVICES		FOR	D: 08/19/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION UMBER:	1		ATE SURVEY DMPLETED
	245425	B. WING		7/21/2015
NAME OF F	PROVIDER OR SUPPLIER	รา	REET ADDRESS, CITY, STATE, ZIP CODE	***********
THORNE	CREST RETIREMENT CENTER		01 GARFIELD AVENUE LBERT LEA, MN 56007	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 2 self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2	K 011		
	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.		Per life safety code 19.1.1.4.1, 19.1.1.4. 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.	2
	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. NFPA 101 LIFE SAFETY CODE STANDARD	K 144		8/13/15
SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

Event ID: YMLL21

Facility ID: 00833

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES				08/19/20 APPROVE 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 7	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED
		245425	B. WING		07/2	21/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THORNE	CREST RETIREMEN	IT CENTER		1201 GARFIELD AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 144	Continued From pa	ige 3	K 14	4		
				· · · · · · · · · · · · · · · · · · ·		
	Based on docume interview, the facilit generators in accor of 2000 NFPA 101	s not met as evidenced by: ntation review and staff y failed to test the emergency dance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents.		Per the requirements of 2000 NF 101-9.1.3 and 1999 NFPA 110 6-4 (b) and 6-4.2.2 Thorne Crest main department will perform weekly ar monthly audits to ensure that our gas emergency generator is inspe	.2 (a) & Itenance Id natural Icted	
	Findings include:			weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1. These will be ongoing		
	on 07/21/2015, doc monthly emergency 2014 to July 2015)	veen 8:00 AM and 11:00 AM umentation review of the y generator testing log (August , indicated that the facility did gas emergency generator by means:		weekly and monthly per NFPA 99 A load test will be completed by th the day August 13th, 2015.		
	the water temperati manufacturer or	aintains the operating range of ures as recommended by the 30 percent or more of the				
	c. 2 hour load ba	nk test (first 30 minutes - es - 50%, and last 1 hour -				
		ce was confirmed by the e Director (EH) at the time of				

Event ID: YMLL21

Facility ID: 00833

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES			FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
	PROVIDER OR SUPPLIER	245425	ST   12	REET ADDRESS, CITY, STATE, ZIP COD 01 GARFIELD AVENUE -BERT LEA, MN 56007		21/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 144	Continued From pa	ge 4	K 144			
	*TEAM COMPOSI Gary Schroeder, Li	FION* fe Safety Code Spc.				
		,				
	67 (02-99) Previous Versions	Obsolete Event ID: YM	LL21 Facil	ity ID: 00833 If c	ontinuation shee	Page 5 of



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 \$5425026

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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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,

Kumalu Fiske Downing

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

## PRINTED: 08/12/2015 FORM APPROVED

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00833	B. WING		07/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THORNE	CREST RETIREMEN	T CENTER	RFIELD AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/12/15

Electronically Signed

If continuation sheet 1 of 17

#### PRINTED: 08/12/2015 FORM APPROVED

Minnesota Department of Health           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	00833		B. WING		07/	07/23/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HORNE	CREST RETIREMEN		RFIELD AVEN	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic beess, under the heading he date your orders will be electronically submitting to the nent of Health.					
	this Department's s and the following c Please indicate in y correction that you	2, and 23, 2015 surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, te when they will be completed					
	the State Licensing federal software.	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMI "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE					

YMLL11

#### PRINTED: 08/12/2015 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00833	B. WING		07/23/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
THORNE	CREST RETIREMEN		RFIELD AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLET DATE	
2 000	Continued From page 2		2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		8/13/15	
	comprehensive plat objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review, the facility fa related to activities	ent is not met as evidenced on, interview, and document ailed to develop a plan of care of daily living (ADL) 3 residents (R9) reviewed for		CORRECTED		
	Findings include:					
		ed interventions for ADL's. uded dementia and blindness				
	have long chin hair jagged fingernails. 7/22/15, at 1:00 p.n sitting in the day roo	n 7/20/15, at 2:00 p.m. to as well as long, dirty and R9 was also observed on n. and 7/23/15, at 9:16 a.m. om. Chin hair was still present to be long, jagged and dirty.				

YMLL11

If continuation sheet 3 of 17

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	00833	B. WING		07/	07/23/2015	
PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
CREST RETIREMEN	IT CENTER 1201 GA	RFIELD AVEN	UE			
	ALBERT	-				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLE DATE	
Continued From pa	age 3	2 560				
4/27/15, identified I Interview for Menta severe cognitive im assistance of one p and dressing and p bathing. The Care of 7/29/14, identified t in the care plan. Re 6/29/12, did not ide and no intervention During interview wi 7/23/15, at 10:33 a did not identify the should be addresso	R9 as having a BIMS (Brief al Status) score of 4 indicating pairments, needing extensive berson with personal hygiene ohysical assistance in part of Area Assessment (CAA) dated that ADL's would be addressed eview of the care plan dated entify ADL assistance needed as were evident. The director of nursing on 					
SUGGESTED MET The director of nurs the policy and proc as needed, staff tra monitored and eva comprehensive pla lists measurable of meet each resident TIME PERIOD FOR	sing or designee could assure redures are reviewed, revised ained and systems assessed, luated to assure the an of care is developed and ojectives and timetables to ts individual needs.					
MN Rule 4658.040	5 Subp. 3 Comprehensive	2 565			8/13/15	
Subp. 3. Use. A c	Il personnel involved in the					
	OF CORRECTION PROVIDER OR SUPPLIER <b>CREST RETIREMEN</b> SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa The quarterly Minir 4/27/15, identified I Interview for Menta severe cognitive im assistance of one p and dressing and p bathing. The Care 7/29/14, identified f in the care plan. Re 6/29/12, did not ide and no interventior During interview wi 7/23/15, at 10:33 a did not identify the should be addresse care (R9). SUGGESTED ME The director of nur- the policy and protonas as needed, staff tra- monitored and eva comprehensive pla- lists measurable of meet each residen TIME PERIOD FO (21) days. MN Rule 4658.040 Plan of Care; Use Subp. 3. Use. A c	OF CORRECTION         IDENTIFICATION NUMBER:           00833         00833           PROVIDER OR SUPPLIER         STREET A           1201 GA         ALBERT           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ALBERT           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.         MN Rule 4658.0405 Subp. 3 Comprehensive	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00833       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         1201 GARFIELD AVENUE ALBERT LEA, MN 56007       IDENTIFICATION NUMBER:         SUMMARY STATEMENT OF DEFICIENCIES       ID         ICACH TEREMENT CENTER       ID         NEGULATORY OR LSC IDENTIFYING INFORMATION)       ID         PREVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 3       2 560         Continued From page 3       2 560         Continued From page 3       2 560         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 7/29/14, identified that 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	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     COM       00833     B. WING     07/       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1201 GARFIELD AVENUE       CREST RETIREMENT CENTER     1201 GARFIELD AVENUE     CROSS REFERENCED TO THE APPROPRIATE       REQULATORY OR LSC IDENTIFYING INFORMATION)     ID     PROVIDERS PLAN OF CORRECTION SHOULD BE       REQULATORY OR LSC IDENTIFYING INFORMATION)     ID     PREFIX     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY WIST BE PRECEDED BY FULL     ID     PREFIX     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY ON LSC IDENTIFYING INFORMATION)     ID     PREFIX     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY     Continued From page 3     2 560     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY     Continued From page 3     2 560     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY     Continued From page 3     2 560     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY     Continued From page 3     2 560     CROSS REFERENCED TO THE APPROPRIATE       DEFICIENCY     Continued From page 3     2 560     CROSS REFERENCED TO THE APPROPRIATE       During interview with the director of nursing on former plan dated     G/29/12, did not identify ADL assistance in part of bathing, The Care Area Assessment (CA) dated     CROSS anderes are reviewed, revised       SUGG	

STATE FORM

YMLL11

If continuation sheet 4 of 17

Minneso	ta Department of He	alth			-	_
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00833	B. WING		07/2	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THORNE	CREST RETIREMEN	TCENTER	RFIELD AVEN LEA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview and document illed to follow the plan of care (R9, R70) reviewed for non in issues.		CORRECTED		
	Findings include:					
	bruising. R9's diag blindness both eyes anemia. The care p an alteration to skir included facility pro SWAT (skin wound	as not followed regarding noses included dementia, s and chronic microcytic blan dated 6/29/12, identified n integrity. Interventions tocol for routine skin care and assessment tool) PRN (as dened, open, irritated, swollen rediately.				
	7/20/15, at 2:00 p.n purple and red bruis purple bruise to the 7:17 p.m. bruising left arm. Observati was in bed with hos noted to left forearn as on right wrist. B color. R9 was unab came from. Review of the medi of the bruising to R During an interview (RN-B) on 7/23/15 a should be documer	ew and observation on n. R9 was noted to have ses up the left arm and a right wrist. On 7/22/15, at remained on right wrist and up on on 7/23/15, at 8 a.m. R9 spital gown on. Bruising was n from elbow to wrist as well ruises were dark purple in le to state where the bruises cal record did not identify any 9's left arm or right wrist. with registered nurse B at 10:57 a.m. she stated there ntation regarding the bruising. s not aware of the bruising and				
Minnesota D	they had not been r					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00833	B. WING		07/23/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HORNE	CREST RETIREMEN		RFIELD AVENI LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 5	2 565			
	7/23/15, at 10:33 a	v with the director of nursing or .m. she verified that R9's care followed regarding reporting of				
	identified R70 was (Coumadin) related fibrillation. The inter	plan last revised 6/26/15, on anticoagulant therapy d to diagnosis of atrial erventions included: "Daily eport abnormalities to the				
	3:45 p.m. R70 was in her recliner. R70 purple bruise on he purplish bruise on t thumb extending to purplish bruise acro R70 stated she bru	and interview on 7/20/15, at observed seated in her room 0 was observed to have a large er left forearm, a fading the lower aspect of her right o the wrist, and a fading oss the top of the right hand. lises easily due to being din (an anticoagulant	)			
	indicated to continu	iician order dated 7/22/15 ue same Coumadin dose of 1.5 ily every Sunday and 1 mg	5			
	indicated R70 rece Friday evening. Th dated 7/17/15 at 20 "Skin check comple open areas presen The treatment adm	en Hall Bath Schedule ived a bath once a week on he skin/wound progress note 0:00 (8:00 p.m.) indicated: eted after bath. No red or t. Scattered bruising on arms. hinistration record dated July le monitoring of bruises for	n			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00833	B. WING		07/	07/23/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
THORNE	CREST RETIREMEN	IT CENTER	RFIELD AVEN LEA, MN 560				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 6	2 565				
	issue such as a bru	NA)-C stated when a new skin uise or skin tear is identified would notify the charge nurse					
	registered nurse (F issue is identified f laceration, or skin t evaluated, treated RN-B further stated be initiated and the least weekly; monit to the treatment ad p.m., RN-B observe forearm and right h arms a new purple R70's right elbow. should be reported unsure if this had be reviewing R70's me administration reco RN-B confirmed th evaluated or monit stated in the care p						
	13:34 (1:34 p.m.) in measurements of b thumb/hand measu 6 cm, bruise 2 - ri	ress notes dated 7/23/15 at ncluded the following pruises: Bruise 1 - Right ures 5 cm (centimeters) x (by) ght top of hand 5 cm x 5 cm, ow 5.5 cm x 3.8 cm, bruise 4 - 4 cm.					
	The director of nur- develop, review, ar procedures to ensu- plans according to	THOD OF CORRECTION: sing (DON) or designee could nd/or revise policies and ure the facility develops care the residents individualized r of nursing (DON) or designee					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/23/2015	
		00833	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
THORNE	CREST RETIREMEN	IT CENTER	RFIELD AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ОВЕ СОЙ	X5) IPLET ATE
2 565	Continued From pa	ge 7	2 565			
	and procedures. The	opropriate staff on the policies ne director of nursing (DON) or relop monitoring systems to mpliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		8/13	/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	1			
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview, and document ailed to identify and monitor esidents (R9, R70) reviewed lated skin issues.		CORRECTED		
	Findings include:					
	2:00 p.m. R9 was c her wheelchair. R9	and interview on 7/20/15, at observed seated in her room in was observed to have purple cated on the left forearm up				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00833	B. WING	B. WING		23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THORNE		IT CENTER	RFIELD AVEN LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 8	2 830			
	to the elbow. She a on her right wrist.	also had a large purple bruise				
	assessment dated extensive assistand dressing, toilet use limited assistance The Brief Interview	terly Minimum Data Set (MDS) 4/27/15, indicated R9 required ce with bed mobility, transfer, and personal hygiene, and with locomotion on/off the unit. for Mental Status (BIMS) severe cognitive impairment.				
	of the bruising note wrist. The care pla alteration to skin in facility protocol for (skin wound asses	ical record did not identify any ed on R9's left arm and right in dated 6/29/12, identified an tegrity. Interventions included routine skin care and SWAT sment tool) PRN (as needed), pen, irritated, swollen areas to				
	indicated R9 receiv Wednesday days. found for 7/22/15 a	en Hall Bath Schedule ved a bath once a week on No skin/wound note was fter bath. The treatment ord dated July 2015 did not of bruises for R9.				
	licensed practical r	on 7/23/15, at 10:28 a.m. hurse B (LPN-B) verified that er bath on 7/22/15. She was hising.				
	trained medication given R9 a bath ye	on 7/23/15, at 10:35 a.m. aide A (TMA-A) stated she had sterday. She stated she had on R9's arms and told the	k			
		on 7/23/15, at 10:57 a.m. RN)-B stated when a new skin				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00833	B. WING		07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HORNE	CREST RETIREMEN		RFIELD AVENI LEA, MN 560	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	issue is identified for laceration, or skin the evaluated, treated in RN-B further stated be initiated and the least weekly; monit to the treatment ad p.m., RN-B observer forearm and right he bruising should be stated this had not reviewing R9's media administration reco RN-B confirmed the evaluated or monitor Review of the prog 12:43 p.m. included of bruises: Bruise cm (centimeters) p has several bruises Measurements 3 x and 1 x 1 cm dark p During observation 3:45 p.m. R70 was in her recliner. R8 purple bruise on the purplish bruise on the purplish bruise acro R70 stated she bru prescribed Coumad medication). Review of the 30-d assessment dated	br a resident such as a bruise, gear, the area should be if necessary, and measured. d a Wound/Skin sheet should area should be measured at coring of the area is also added ministration record. At 12:00 ed the bruising to R9's left hand. RN-B confirmed the reported and monitored and been completed. After dical record, treatment ord, and wound/skin sheets, e bruising was not identified, ored and should have been. ress notes dated 7/23/15, at d the following measurements right forearm measures 5.7 x 3 urple yellow, right lower arm a scattered up arm. 2 cm, 4.5 x 4 cm, 2 x 1 cm purple to light purple. and interview on 7/20/15, at observed seated in her room was observed to have a large er left forearm, a fading the lower aspect of her right o the wrist, and a fading oss the top of the right hand. hises easily due to being din (an anticoagulant ay Minimum Data Set (MDS) 6/24/15 indicated R70 required	3	DEFICIENC	2Υ) 	
	R70 stated she bru prescribed Coumac medication). Review of the 30-d assessment dated extensive assistant dressing, eating, to	ises easily due to being din (an anticoagulant ay Minimum Data Set (MDS)				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00833	B. WING		07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THORNE	CREST RETIREMEN	II CENTER	RFIELD AVEN LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	15/15, indicating in	tact cognition.				
	identified R70 was (Coumadin) related fibrillation. The inter	plan last revised 6/26/15, on anticoagulant therapy I to diagnosis of atrial erventions included: "Daily eport abnormalities to the				
	indicated to continu	ician order dated 7/22/15 ie same Coumadin dose of 1.5 ily every Sunday and 1 mg	5			
	indicated R70 rece Friday evening. Th dated 7/17/15 at 20 "Skin check comple open areas presen The treatment adm	en Hall Bath Schedule ived a bath once a week on le skin/wound progress note 0:00 (8:00 p.m.) indicated: eted after bath. No red or t. Scattered bruising on arms. inistration record dated July e monitoring of bruises for	"			
	nursing assistant (I issue such as a bru	on 7/23/15, at 11:49 a.m. NA)-C stated when a new skin uise or skin tear is identified would notify the charge nurse				
	registered nurse (F issue is identified for laceration, or skin t evaluated, treated in RN-B further stated	on 7/23/15, at 12:18 p.m. RN)-B stated when a new skin or a resident such as a bruise, ear, the area should be if necessary, and measured. d a Wound/Skin sheet should				
	least weekly; monit to the treatment ad	area should be measured at oring of the area is also addec ministration record. At 12:28 ed the bruising to R70's left	1			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00833	B. WING		07/	07/23/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HORNE	CREST RETIREMEN		RFIELD AVENU LEA, MN 560				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 11	2 830				
	knew about the bru easily due to her C observing R70's ar also noted to R70's the bruising should though was unsure completed. After ro treatment administ sheets, RN-B confi identified, evaluate have been.	hand. R70 stated the staff hising and stated she bruises oumadin use. When ms a new purple bruise was s right elbow. RN-B confirmed be reported and monitored whether this had been eviewing R70's medical record ration record, and wound/skin rmed the bruising was not d or monitored and should ress notes dated 7/23/15 at					
	13:34 (1:34 p.m.) in measurements of b thumb/hand measu 6 cm, bruise 2 - ri	ncluded the following pruises: Bruise 1 - Right ures 5 cm (centimeters) x (by) ght top of hand 5 cm x 5 cm, pw 5.5 cm x 3.8 cm, bruise 4 -					
	The director of nurse educate all license non-pressure skin skin conditions pre admission to the fa	THOD OF CORRECTION: sing, or designee, could d staff on the need to monitor conditions and/or non-pressure sent on residents upon cility. The director of nursing udit to monitor staff e policy.	e				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One					
2 860	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860			8/13/15	
		or determining adequate and riteria for determining er care include:					

STATE FORM

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00833	B. WING		07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THORNE	CREST RETIREMEN	TCENTER	RFIELD AVEI LEA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 12	2 860			
		ention to hands and feet. nails must be kept clean and				
	by: Based on observati review the facility fa personal hygiene for reviewed who was daily living (ADL's). Findings include: R9 was unable to p and did not receive nail care. R9's diag blindness both eyes During observation 2:00 p.m. R9 was of her wheelchair. R9 long hair on her chi to be long, jagged a underneath the nail Review of the quart assessment dated extensive assistance dressing, toilet use limited assistance w The Brief Interview	and interview on 7/20/15, at observed seated in her room in was observed to have several n. R9's fingernails were noted and have a black substance		CORRECTED		
Minnocoto D	Review of the Gree indicated R9 receiv	n Hall Bath Schedule ed a bath once a week on No skin/wound note was				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00833	B. WING		07/	07/23/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE	•		
THORNE	CREST RETIREMEN	IT CENTER	ARFIELD AVENI LEA, MN 560				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 860	Continued From pa	age 13	2 860				
		on 7/23/15, at 10:28 a.m. Jurse B (LPN-B) verified that er bath on 7/22/15.					
	trained medication given R9 a bath yea not trimmed nor cle stated she had not her own razor. TM	on 7/23/15, at 10:35 a.m. aide A (TMA-A) stated she ha sterday. She stated she had eaned her fingernails. She shaved her as R9 didn't have A-A verified that R9's nails should have been cleaned.					
	director of nursing should be done wit nails should be don also as needed. Si	on 7/23/15, at 10:57 a.m. the (DON) stated that shaving h daily cares as needed and he a least weekly with bath and he also stated that ADL's ed on the care plan and	d				
	Fingernails/Toenail	ty policy revised 2010: Care o s: General Guidelines 1. Nail cleaning and regular trimming					
	The director of nurs in-service all staff of living including fing	THOD OF CORRECTION: sing or designee could on performing activities of daily er nail care for residents. The or designee could schedule or compliance.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			8/13/15	
		olant. The physical plant, prs, ceilings, all furnishings,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00833	B. WING		07/23/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
THORNE	CREST RETIREMEN	IT CENTER	RFIELD AVE LEA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21685	continuous state of with regard to the h well-being of the re routine maintenand This MN Requirem by: Based on observat	age 14 pment must be kept in a good repair and operation health, comfort, safety, and esidents according to a written ce and repair program. ent is not met as evidenced ion, interview and document failed to ensure the walk-in	21685	CORRECTED		
	ice build-up to ensu condition. This had integrity of the food residents who eat a staff who access th Findings include:	tined with a minimal amount of ure it's safe operating the potential to affect the which is served to all 41 at the facility and the safety of his freezer on a daily basis.				
	a.m. with cook (C)- observed to have a inches by ½ inch th the doorway and al ice buildup on the f	tchen tour on 7/20/2015 at 9:15 A, the walk-in freezer was an area of approximately 4-5 hickness along both sides of long the floor. C-A verified the loor and on both sides of the ed they chip the ice away if it	5			
	(RD)-A verified bein in the walk-in freez buildup on the top of freezer as well as 4 thickness ice buildu bottom. RD-A state (reference to repain replace the seal." T refrigeration compa	B p.m. Registered Dietician ng unaware of any ice buildup er. RD-A verified there was ice of the ceiling of the walk-in 4-5 inches and ½ inch up along the doorway and ed, "We've had refrigeration r person) come. They did The facility contracts with a any called Fountain cord of service provided and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00833	B. WING		07/	07/23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THORNE	E CREST RETIREMEN	IT CENTER	RFIELD AVEN LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	dated 1/12/15, india walk-in freezer was service were provid RD-A verified that i having ice buildup doorway an on the good to have ice ch have them (Founta On 7/22/15, at 4:57 piece of equipment then staff would first then contact mainte have expected staff in the freezer." On 7/23/15, at 10:5 walk-in freezer was "That would include walk-in freezer. Typ concerns are ident would alert me and maintenance." RD was notified yester after surveyor inqui verified that those p buildup in walk-in fr done. RD-A stated, to notify me of the i On 7/23/15, at 10:5 Fountain Refrigera ice buildup in the w On 7/23/15, at 12:4	cated that a door trim on the sinstalled. No other records of ded related to the freezer. t was an accident hazard by along either side of the floor. RD-A stated, "It's not hunks by the door. We will in Refrigeration) come back." 7 p.m. RD-A stated that if a t was not functioning properly st report to RD-A who would enance. RD-A stated, "I would if to notify me of the ice buildup of a.m. RD-A stated that the s cleaned weekly. RD-A stated, e monitoring of ice in the bically, when equipment ified, it comes to me first. Staff I then I would notify -A stated that maintenance day (7/22/15) (this was done ired about ice buildup). RD-A processes (notification of ice reezer from staff) weren't , "I would have expected staff ice buildup in the freezer." 59 a.m. RD-A stated that tion had been notified of the valk-in freezer.				
	Fountain Refrigera ice buildup in the w On 7/23/15, at 12:4 Fountain Refrigera buildup in the walk- time of the year the and so it would be	tion had been notified of the valk-in freezer.				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00833		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	
HORNE	CREST RETIREMEN	II CENTER	RFIELD AVEN LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page 16		21685			
	Refrigeration had a walk-in freezer sho prevent warm air fr air from escaping; shut as much as po another curtain will the curtains will the condensation build A copy of the facilit A.M. Cook was pro- to sweep the walk- delivery; it also dire walk-in freezer afte last time the walk-in 7/22/15 and the las 7/21/15. The facilities Clean Freezers Cleaning walk-in freezers, m ceilings as needed SUGGESTED MET The dietary supervi- maintain a schedul the walk-in freezer be inserviced on th could be developed	dvised that the curtains in the uld overlap at the doorway to om entering and to keep cold it is also good to keep the door ossible. RD-A stated that be put in the freezer so that on overlap to help prevent up in the walk-in freezer. y's Cleaning Schedule for the vided which directed the staff in freezer once a week before ected staff to organize the r delivery. It showed that the n freezer was swept was on it time it was organized was on ing Instructions: Cleaning Policy [2008] states, "For op floors, wash walls and ." THOD OF CORRECTION: isor could develop and e to keep the ice build up in at a minimum. The staff could e new schedule and audits d and implemented to ensure equipment remains in good				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				