



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 17, 2024

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

RE: CCN: 245425
Cycle Start Date: May 8, 2024

Dear Administrator:

On June 5, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2024

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

Re: Reinspection Results
Event ID: DHS612

Dear Administrator:

On June 5, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 8, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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



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May 15, 2024

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

RE: CCN: 245425
Cycle Start Date: May 8, 2024

Dear Administrator:

On May 8, 2024, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

Thorne Crest Retirement Center

May 15, 2024

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the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

Thorne Crest Retirement Center

May 15, 2024

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occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 8, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 8, 2024 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Thorne Crest Retirement Center

May 15, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is cursive and somewhat stylized, with the first letter of the last name being a large, prominent 'H'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: DHS611

Dear Administrator:

The above facility was surveyed on May 8, 2024 through May 8, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Thorne Crest Retirement Center

May 15, 2024

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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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 05/28/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2024
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NAME OF PROVIDER OR SUPPLIER THORNE CREST RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 GARFIELD AVENUE ALBERT LEA, MN 56007
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 5/8/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H54253551C (MN00103045) with a deficiencies cited at F880.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p>	F 880		5/29/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/24/2024
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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.

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

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F 880	<p>Continued From page 1</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p>	F 880		

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

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F 880	<p>Continued From page 2</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene during personal cares and wound care for 2 of 2 residents (R1,R2) observed for activities of daily living.</p> <p>Finding include:</p> <p>R1's face sheet identified diagnoses that included dementia, traumatic brain injury, and weakness.</p> <p>R1's admission minimum data set (MDS) dated 12/28/23, identified R1 had adequate hearing and vision, had severe cognitive impairment, and required substantial assistance with dressing and grooming activities.</p> <p>During an observation on 5/8/24 at 11:00 a.m., nursing assistant (NA)-A assisted R1 with personal cares. NA-A applied gloves and lowered R1's pants. NA-A removed R1's soiled brief that contained stool and provided incontinent cares.</p>	F 880	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance.</p> <p>1. How corrective action will be accomplished for those residents found to be by the deficient practices. " Resident #2 has not had any change in status related to the lack of hand hygiene and nursing personnel have been observed maintaining proper hand hygiene during cares. " Resident #1 has not had any change in status related to the lack of hand</p>	

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F 880	<p>Continued From page 3</p> <p>With the same gloves on, NA-A applied a new brief and pulled up R1's pants. NA-A then removed her gloves but did not perform hand hygiene. NA-A assisted R1 to sit up in bed, applied transfer belt around R1's waist, placed the walker in front of R1, and then NA-A and NA-B assisted R1 to wheelchair. NA-A pushed R1 from his room to the dining room. NA-A then used hand sanitizer.</p> <p>During an interview on 5/8/24 at 11:12 a.m., NA-A verified that she did not change gloves and perform hand hygiene when she was supposed to and should have.</p> <p>R2's face sheet identified R2 had diagnoses that included malignant neoplasm of pancreas and adult failure to thrive</p> <p>R2's care area assessment (CAA) dated 2/20/24, identified pressure injury stage two on coccyx.</p> <p>During an observation on 5/8/24 at 11:39 a.m., R2 was lying in bed. Licensed practical nurse (LPN)-A and trained medication aide (TMA)-A entered the room. LPN-A applied gloves. TMA-A gave R1 his medications, removed gloves, and left the room. Upon returning to R2's TMA-A did perform hand hygiene her hands prior to putting on her gloves. LPN-A removed soiled dressing from R2's coccyx wound, removed gloves, and applied new gloves without performing hand hygiene. LPN-A applied a gauze soaked in Vashe wash (wound cleanser) to wound bed that was left in place for five minutes in accordance to physician order. While the wound "soaked", LPN-A scratched R2's back per her request. After LPN-A scratched R2's back, she removed gloves and applied new gloves without performing hand</p>	F 880	<p>hygiene and the wound has remained stable and nurses have been observed maintaining proper hand hygiene during dressing changes.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected.</p> <p>3. What measure will be put into place or systemic changes made, to ensure that the deficient practice will not reoccur. " The hand hygiene and dressing change procedures were reviewed and remain current. " The licensed nurse and CNA were provided re-education on the importance of handwashing/hand hygiene when performing dressing changes and doing patient care. i. Training areas included: How to prevent, detect, investigate, and control infections in the facility. Importance of hand hygiene in preventing the transmission of healthcare associated infections. Use of gloves does not replace hand washing/hand hygiene. Proper handwashing techniques. Review of proper clean dressing changes in relation to proper infection control practices. " All nursing personnel will complete online re-training on handwashing/hand hygiene " Licensed staff to be re-educated on clean dressing changes and the infection control practices needed to prevent the development and transmission of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2024
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F 880	<p>Continued From page 4</p> <p>hygiene. LPN-A then removed gauze from the wound. LPN-A measured the depth of the wound by inserting a cotton swab into the wound three times; the swab had bloody drainage on it. LPN-A then removed her gloves and without performing hand hygiene applied new gloves. LPN-A applied saline soaked gauze 4x4's with a q-tip into the wound bed and applied a foam cover dressing to the site. LPN-A and TMA applied R2's incontinent brief, positioned pillows around R2, and gave R2 her call light. LPN-A removed her gloves and applied a new pair then gave R2 a drink of water. LPN-A and TMA-A removed gown and gloves and left room.</p> <p>During an interview on 5/8/24 at 12:10 p.m., LPN-A verified she did not perform hand hygiene when she should have.</p> <p>During an interview with the administrator, director of nursing (DON) and assistant director of nursing (ADON) expected staff to perform hand hygiene according to the facility policy and procedure.</p> <p>The facility handwashing/hand hygiene policy revision dated 10/23, identified hand hygiene is indicated immediately before touching a resident, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the residents environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene.</p>	F 880	<p>healthcare associated infections. " All education will be completed by May29th or their next scheduled shift.</p> <p>4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " The DON and or designee will monitor nursing staff personnel weekly for compliance with hand washing/hand hygiene weekly for x1 month; then monthly x3 months. " The DON will document the audit results and report these findings monthly during the facilities Quality Assurance and Performance Improvement (QAPI) meeting. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.</p> <p>5. The date that each deficiency will be corrected. May 29th, 2024, or before the start of their next scheduled shift.</p> <p>6. An electronic acknowledgement signature and date by an official facility representative</p>	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00833	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2024
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NAME OF PROVIDER OR SUPPLIER THORNE CREST RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 GARFIELD AVENUE ALBERT LEA, MN 56007
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>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.</p> <p>INITIAL COMMENTS: On 5/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/24/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00833	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2024
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NAME OF PROVIDER OR SUPPLIER THORNE CREST RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 GARFIELD AVENUE ALBERT LEA, MN 56007
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Continued From page 1</p> <p>when they will be completed.</p> <p>The following complaints were reviewed: H54253551C (MN00103045) with a licensing order issued at 1390.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p>	2 000		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00833	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2024
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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		5/24/24

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21390	<p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene during personal cares and wound care for 2 of 2 residents (R1,R2) observed for activities of daily living.</p> <p>Finding include:</p> <p>R1's face sheet identified diagnoses that included dementia, traumatic brain injury, and weakness.</p> <p>R1's admission minimum data set (MDS) dated 12/28/23, identified R1 had adequate hearing and vision, had severe cognitive impairment, and required substantial assistance with dressing and grooming activities.</p> <p>During an observation on 5/8/24 at 11:00 a.m., nursing assistant (NA)-A assisted R1 with personal cares. NA-A applied gloves and lowered R1's pants. NA-A removed R1's soiled brief that contained stool and provided incontinent cares. With the same gloves on, NA-A applied a new brief and pulled up R1's pants. NA-A then removed her gloves but did not perform hand hygiene. NA-A assisted R1 to sit up in bed, applied transfer belt around R1's waist, placed the walker in front of R1, and then NA-A and NA-B assisted R1 to wheelchair. NA-A pushed R1 from his room to the dining room. NA-A then used hand sanitizer.</p> <p>During an interview on 5/8/24 at 11:12 a.m., NA-A verified that she did not change gloves and perform hand hygiene when she was supposed to and should have.</p> <p>R2's face sheet identified R2 had diagnoses that</p>	21390	<p>Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance.</p> <ol style="list-style-type: none"> How corrective action will be accomplished for those residents found to be by the deficient practices. <ul style="list-style-type: none"> Resident #2 has not had any change in status related to the lack of hand hygiene and nursing personnel have been observed maintaining proper hand hygiene during cares. Resident #1 has not had any change in status related to the lack of hand hygiene and the wound has remained stable and nurses have been observed maintaining proper hand hygiene during dressing changes. How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected. What measure will be put into place or systemic changes made, to ensure that the deficient practice will not reoccur. <ul style="list-style-type: none"> The hand hygiene and dressing change procedures were reviewed and 	
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21390	<p>Continued From page 4</p> <p>included malignant neoplasm of pancreas and adult failure to thrive</p> <p>R2's care area assessment (CAA) dated 2/20/24, identified pressure injury stage two on coccyx.</p> <p>During an observation on 5/8/24 at 11:39 a.m., R2 was lying in bed. Licensed practical nurse (LPN)-A and trained medication aide (TMA)-A entered the room. LPN-A applied gloves. TMA-A gave R1 his medications, removed gloves, and left the room. Upon returning to R2's TMA-A did perform hand hygiene her hands prior to putting on her gloves. LPN-A removed soiled dressing from R2's coccyx wound, removed gloves, and applied new gloves without performing hand hygiene. LPN-A applied a gauze soaked in Vashe wash (wound cleanser) to wound bed that was left in place for five minutes in accordance to physician order. While the wound "soaked", LPN-A scratched R2's back per her request. After LPN-A scratched R2's back, she removed gloves and applied new gloves without performing hand hygiene. LPN-A then removed gauze from the wound. LPN-A measured the depth of the wound by inserting a cotton swab into the wound three times; the swab had bloody drainage on it. LPN-A then removed her gloves and without performing hand hygiene applied new gloves. LPN-A applied saline soaked gauze 4x4's with a q-tip into the wound bed and applied a foam cover dressing to the site. LPN-A and TMA applied R2's incontinent brief, positioned pillows around R2, and gave R2 her call light. LPN-A removed her gloves and applied a new pair then gave R2 a drink of water. LPN-A and TMA-A removed gown and gloves and left room.</p> <p>During an interview on 5/8/24 at 12:10 p.m., LPN-A verified she did not perform hand hygiene</p>	21390	<p>remain current.</p> <ul style="list-style-type: none"> The licensed nurse and CNA were provided re-education on the importance of handwashing/hand hygiene when performing dressing changes and doing patient care. Training areas included: How to prevent, detect, investigate, and control infections in the facility. Importance of hand hygiene in preventing the transmission of healthcare associated infections. Use of gloves does not replace hand washing/hand hygiene. Proper handwashing techniques. Review of proper clean dressing changes in relation to proper infection control practices. All nursing personnel will complete online re-training on handwashing/hand hygiene Licensed staff to be re-educated on clean dressing changes and the infection control practices needed to prevent the development and transmission of healthcare associated infections. All education will be completed by May29th or their next scheduled shift. <p>4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.</p> <ul style="list-style-type: none"> The DON and or designee will monitor nursing staff personnel weekly for compliance with hand washing/hand hygiene weekly for x1 month; then monthly x3 months. The DON will document the audit results and report these findings monthly during the facilities Quality Assurance and Performance Improvement (QAPI) 	
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21390	<p>Continued From page 5</p> <p>when she should have.</p> <p>During an interview with the administrator, director of nursing (DON) and assistant director of nursing (ADON) expected staff to perform hand hygiene according to the facility policy and procedure.</p> <p>The facility handwashing/hand hygiene policy revision dated 10/23, identified hand hygiene is indicated immediately before touching a resident, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the residents environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene.</p> <p>SUGGESTED METHOD OF CORRECTION: The Infection Control Preventionist (ICP) or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes and for staff performing clean to dirty techniques. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring.</p> <p>TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS</p>	21390	<p>meeting. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.</p> <p>5. The date that each deficiency will be corrected. May 29th, 2024, or before the start of their next scheduled shift.</p> <p>6. An electronic acknowledgement signature and date by an official facility representative</p>	
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