Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 2, 2026

Administrator
Thorne Crest Retirement Center
1201 GARFIELD AVENUE
ALBERT LEA, MN 56007

RE: CCN: 245425
Cycle Start Date: September 18, 2025

Dear Administrator:

On November 19, 2025, 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.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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January 2, 2026

Administrator
Thorne Crest Retirement Center
1201 GARFIELD AVENUE
ALBERT LEA, MN 56007

Re: Reinspection Results
Event ID: 1D705A-H2

Dear Administrator:

On November 19, 2025, 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 September 18, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 1, 2025

Administrator
Thorne Crest Retirement Center

1201 GARFIELD AVENUE
ALBERT LEA, MN 56007

RE: CCN:245425
Cycle Start Date: September 18, 2025

Dear Administrator:

On September 18, 2025, a survey was completed at your facility by the Minnesota Departments 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 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, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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 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 December 18, 2025, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 18, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Electronically delivered

October 1, 2025

Administrator
Thorne Crest Retirement Center
1201 GARFIELD AVENUE
ALBERT LEA, MN 56007

Re: State Nursing Home Licensing Orders
Event ID: 1D705A-H1

Dear Administrator:

The above facility survey was completed on 09/18/2025 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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.

Sincerely,

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	**1201 GARFIELD AVENUE , ALBERT LEA, Minnesota, 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
F0000	INITIAL COMMENTS On 9/16/25, 9/17/25 and 9/18/25, 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. The following complaint was reviewed H54254480C (2614794), with a deficiency cited at F580, F684, F755 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		10/01/2025
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due	F0580	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident 1 representative had at that time been informed of changes. Nurse was immediately educated on Notification policy. 9/17/25 2. Identification of other residents having the potential to be affected was accomplished by:	10/10/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	**1201 GARFIELD AVENUE , ALBERT LEA, Minnesota, 56007**

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F0580 SS = D	Continued from page 1 to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to notify a resident's representative of a change in condition for 1 of 3 residents (R3) reviewed for quality of care. Findings include: R1’s quarterly minimum data set (MDS) dated 9/3/25, identified R1’s cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle	F0580	Continued from page 1 The facility has determined that all residents have the potential to be affected. Audit of all patients with Change in condition reviewed- 0 issues noted. 10/3/2025 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Director of Nursing and Infection preventionist provided education to all Nurses on Facility Notification policy. Director of Nursing or Infection preventionist reviewing change of condition daily on weekdays at stand up/IDT meetings. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing Services, or Infection Preventionist, will conduct a random pull audit of residents monthly for 3 months then quarterly. These residents will be assessed to ensure that any declines have been identified and communicated to the appropriate people. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met.	

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F0580 SS = D	Continued from page 2 control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's nursing progress note dated 9/4/25 at 1:00 p.m., identified acetaminophen 500 mg given due to complaint of right eye pain and soreness. At 1:20 p.m., an additional note indicated R1's right eye hurt some and was a little red and irritated…will continue to keep an eye on it for now. R1's nursing progress note dated 9/5/25 at 11:24 a.m., R1 again commented his eye was sore to the director of nursing (DON) who happened to look at it and let her know this started on 9/4/25. R1's eyebrow was a little swollen and now was pinkish red and warm to the touch, and the DON wondered if cellulitis was developing. Note identified that the DON would call nurse practitioner to get an order for something, and some eye drops also. Called and left a voicemail for the nurse practitioner. R1's Telemedicine Visit dated 9/5/25 at 2:37 p.m., identified nursing asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1's primary care provider started eye drops yesterday, unfortunately they have not arrived yet from the pharmacy. R1 reported 3 out of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, sandy feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 milligram (mg) per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics.	F0580		

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F0580 SS = D	Continued from page 3 R1's electronic health record was reviewed and does not identify R1's representative was notified of a change in condition with his right eye. During an interview on 9/17/25 at 2:24 p.m., assistant director of nursing (ADON) reviewed R1's electronic health record and stated it does not look like anyone notified R1's family of his change in condition with his right eye and they should have. ADON stated anytime a resident has a change in condition the resident representative should be notified immediately and should be documented in the resident's medical record. During an interview on 9/17/25 at 2:29 p.m., licensed practical nurse (LPN)-A indicated on 9/4/25, R1 had a change in condition when R1 was complaining of soreness in his right eye. LPN-A stated R1 had redness in his right eye and his eye lid that extended above his eyebrow. LPN-A further stated his eye worsened on 9/5/25 due to swelling and warmth. LPN-A stated she did not notify FM-B of R1's change in condition and should have. During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25. FM-B stated she was R1's resident representative and was upset the facility never contacted her about R1's eye infection. FM-B stated they should have called me when R1's eye first started getting red. FM-B stated she wanted to be notified of any changes R1 had. FM-B stated she didn't find out until she went to the facility to visit R1. During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 indicated when he has changes in his health, he would like the facility to notify FM-B. During an interview on 9/17/25 at 3:38 p.m., director of nursing (DON) reviewed R1's electronic medical record and stated there was no documentation that FM-B was notified of R1's change in condition of his right eye. DON indicated FM-B should have been notified immediately and should have been documented in R1's medical record. Facility policy regarding notification with a change in condition was requested and not received.	F0580		
F0684 SS = D	Quality of Care CFR(s): 483.25	F0684	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its	10/10/2025

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F0684 SS = D	Continued from page 4 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to monitor for signs and symptoms of infection for 1 of 1 resident (R1) reviewed for change in condition. In addition, the facility failed to safely transport 1 of 1 resident (R1) to an outside appointment reviewed for resident safety. Findings include: Infection monitoring: R1’s care plan dated 9/2/25, identified a focus that R1 was at risk for infection due to refusal of vaccinations. Interventions included to educate R1 and resident representative of techniques to prevent infections such as handwashing, adequate rest, nutrition, avoidance of crowds, to monitor for signs and symptoms of infection and staff to follow standard precautions including proper handwashing techniques to minimize microorganism growth. R1’s quarterly minimum data set (MDS) dated 9/3/25, identified R1’s cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1’s nursing progress note dated 9/4/25 at 1:00 p.m., identified acetaminophen 500 milligram (mg) given due to complaint that his right eye hurt and was sore. At 1:20 p.m., an additional note indicated R1’s right eye hurt some and was a little red and irritated…will continue to keep an eye on it for now. R1’s nursing progress note dated 9/5/25 at 11:24 a.m., R1 again commented his eye was sore to the director of nursing (DON) who happened to look at it and let her	F0684	Continued from page 4 employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility’s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Immediate addition to MAR, an order for monitoring and documentation of s/s of infection twice daily. Started on 9/17/25. RI requires the use of specialty w/c for mobility needs. All future transports will be handled by EMS or specialty transport van service that can accommodate patients motorized w/c. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving skilled services have the potential to be affected. Director or Nursing or Infection preventionist to monitor patients with infections daily weekdays. Addition to MAR as needed to monitor/document sx of infection/progression. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Education to all nursing staff on proper and safe transportation as care planned. Education provided to facility Van Driver on Proper and Safe Transportation. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing or Infection preventionist will conduct patients with infections audits daily on weekdays at IDT meetings. The Director or Nursing or Infection Preventionist will do random pull of patient audits of appointments/transportation monthly three times then Quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 GARFIELD AVENUE , ALBERT LEA, Minnesota, 56007

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F0684 SS = D	Continued from page 5 know this started on 9/4/25, noted his eyebrow was a little swollen and now was pinkish red and warm to the touch, was wondering if cellulitis was developing. Will call nurse practitioner to get an order for something and some eye drops also, called and left a voicemail for her. R1's Telemedicine Visit dated 9/5/25, at 2:37 p.m., identified nurse asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1 reported level 3 of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, sandy feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 mg per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics. Review of R1's electronic health record does not identify consistent daily comprehensive monitoring of eye infection from 9/5/25 through 9/16/25. During an interview on 9/17/25 at 2:29 p.m., licensed practical nurse (LPN)-A indicated on 9/4/25 R1 had a change in condition when R1 developed redness to his right eye and eye lid that extended above his eyebrow and R1 said it was sore. LPN-A further stated his eye worsened on 9/5/25 due to swelling and warmth and she had nurse practitioner (NP)-A see R1 through a	F0684		

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F0684 SS = D	Continued from page 6 telehealth visit and NP -A ordered oral and eye antibiotics for orbital cellulitis to be started that day. NP-A also had us use a black marker to draw around R1's redness around his right eye and told us if the redness spreads beyond the black marker it would be ok to send him to the emergency department for intravenous (IV) antibiotics. LPN-A reviewed R1's electronic health record and verified there was no daily monitoring of signs and symptoms of infection for R1's right eye cellulitis from 9/5/25 to 9/16/25. LPN-A stated when she worked on 9/10/25, she noticed R1 had developed six to seven papules (small, red, solid bumps that quickly turn into fluid filled blisters with shingles) above his right eye. LPN-A stated she called the physician assistant (PA)-A on 9/10/25 and PA-A thought R1 could have shingles and gave orders to send R1 to the emergency department (ED) right away to have a maxillofacial cat scan (CT) to rule out infection spread, a herpes zoster swab to rule out shingles and some lab tests. During an interview on 9/17/25 at 2:52 p.m., assistant director of nursing (ADON) reviewed R1's electronic health record and verified there was no daily monitoring or comprehensive assessments for signs and symptoms of infection for R1's right eye cellulitis. ADON stated when R1 was put on antibiotics a nursing order should have been placed to do comprehensive assessing and monitoring of R1's infection every shift to assess for a change in condition. During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25. FM-B stated she was R1's resident representative and was concerned the facility did not have R1 seen in person by a provider from 9/5/25 through 9/10/25. FM-B stated R1 developed shingles in his right eye that looked really infected and was worried about vision loss and infection spread. FM-B stated R1 ended up in the hospital to be treated with IV antibiotics due to the infection being in his eye and so close to his brain. During an interview on 9/17/25 at 3:38 p.m., DON reviewed R1's electronic health record and stated there was no documentation of assessments and monitoring for infection from 9/5/25 to 9/16/25 and there should have been a nursing order put in to monitor for cellulitis every shift so the nurses are reminded what to monitor for and to be alerted to a change in condition so they can notify the provider timely. During a phone interview on 9/18/25 at 11:30 a.m., nurse practitioner (NP)-A stated she saw R1 through a	F0684		

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F0684 SS = D	Continued from page 7 telehealth visit on 9/5/25, and gave orders for the facility to start oral and eye drop antibiotics for concerns with right eye orbital cellulitis to start that day. NP-A stated, on 9/5/25 R1 did not have any vesicles (small fluid filled blisters) on his right eye lid or forehead NP-A further stated she directed staff to draw a black marker around the redness surrounding the eye and to send to ED if redness spreads for IV antibiotics. NP-A would expect assessments of the eye infection every shift to notice any changes to include, itching, fever, increased pain, fatigue, burning, light sensitivity blurred vision and spread of the redness and notify the provider immediately of any changes. Facility policy was requested for infection assessment and monitoring and was not received. Appointments: R1's care plan dated 12/5/24, identified a focus for mobility, needed assist with transfers and bed mobility related to cerebral palsy. Intervention dated 3/4/25, mechanical wheelchair to be taken out of room at night once in bed. Plug in to charge overnight in West supply closet entrance. An additional intervention dated 12/5/24, identified staff to assist with doors, elevators, inclines and tight spaces as needed. An additional focus dated 9/14/25, identified R1 had weakness and needed his electric cart to move around. Intervention dated 9/14/25, identified staff will bring R1 to events he enjoys…will attend current event sessions that he enjoys when he feels better. Care plan does not identify level of assist for mobility in a manual wheelchair when outside the facility. R1's nursing progress note dated 9/10/25 at 10:46 a.m., identified physician assistant (PA)-A ordered R1 to be sent to the hospital and have varicella-zoster PCR (a highly accurate and fast lab test that detects the virus responsible for chickenpox and shingles) completed to right eye, and CT maxillofacial to be completed. Called FM-B to get a verbal bed hold, left voicemail due to no answer, R1 agreed to go to the hospital. At 11:33 a.m., R1 left the facility van to hospital at 11:20 a.m., waiting for return call from FM-B, called the ED to give report to the nurse. During an interview on 9/18/25 at 8:31 a.m., family member (FM)-B indicated she was the resident representative for R1 and stated there was a big miscommunication when R1 had to be sent to the ED on 9/10/25, for tests for a CT scan and the swab for	F0684		

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F0684 SS = D	Continued from page 8 shingles to be done. FM-B stated normally if she can't be at an appointment for R1 someone from the facility will go with him because when the facility transports him in their van, he can't use his electric wheelchair they have no way to strap it down. FM-B further stated the facility had to put him in a manual wheelchair and R1 was not safe to be left unattended due to being immobile from his cerebral palsy. FM-B stated the facility had tried calling her on 9/10/25, to notify her but she was at work and did not get the message right away. FM-B indicated when she finally got the message, she was unsure what hospital they sent R1 to, so she had to call the facility to find out, when she arrived at the ED the staff had told her R1 hadn't checked in yet. FM-B stated she jumped back in her car and went to the clinic side of the hospital and while enroute had called the facility to find out where R1 was, and the facility told her they were sending a driver to come get him because he was done with his appointment. FM-B stated she got to the clinic and found R1 seated in the manual wheelchair slouched over to his left side, he had to lift his head way up to see me coming. FM-B stated R1 had no core strength due to the cerebral palsy and scoliosis (sideways curvature of the spine) and being in an upright position was very uncomfortable for him. FM-B stated guessed R1 had been seated unattended for about 25 minutes with no way to move himself. FM-B stated R1 hated to be a burden on anyone and had always tried to be independent and that he will not ask for help. FM-B stated she did take R1 to the ED to get his tests done and the driver from the facility brought him back when he was done. During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 stated on 9/10/25, he had to go to the ED to get testing done for his right eye problem and had to be transferred in a manual wheelchair because the facility van does not have room for his electric wheelchair that he normally used. R1 stated the manual wheelchair was uncomfortable but he was able to tolerate for short durations. R1 further stated the driver brought him to the clinic and someone tried to check him in on the monitor thing and he didn't have an appointment, and he was left in the waiting room because the driver got a call about another appointment. R1 stated he was unable to wheel himself in the manual wheelchair, so he had to wait for someone to help. R1 stated it was a lack of communication that he was left and when FM-B found him she was not happy. FM-B stated he guessed he waited about 20 to 25 minutes before FM-B got there and she got me to the ED where they did my tests. During an interview on 9/18/25 at 10:49 a.m., director	F0684		

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F0684 SS = D	Continued from page 9 of therapy (DOT)-A stated she was unaware that when the facility transports residents who use an electric wheelchair outside the facility, they transfer the resident to a manual wheelchair before they load them in the van. DOT-A stated R1 had never been assessed for safety in a manual wheelchair and was concerned of how he would be safe in one without a proper assessment due to his cerebral palsy, contractures (permanent shortening or tightening of muscles, tendons, or other tissues that restricts movement) and scoliosis. During an interview on 9/18/25 at 9:51 a.m., receptionist (R)-A stated the ADON told her that R1 needed a ride to the clinic for an eye appointment, so she called the transport driver (TD)-A and asked him to bring R1 in. During an interview on 9/18/25 at 11:05 a.m., TD-A stated he got a call from R-A, and she told him R1 needed a ride to the clinic for an eye appointment. TD-A stated normally when he takes a resident to an appointment, they send paperwork with. TD-A stated he had no paperwork for R1 and assumed R1 had an eye appointment. TD-A stated he got him to the clinic at the eye part and the girl at the clinic put his name in the kiosk and said she didn't think R1 had an appointment. TD-A thought the girl at the clinic would take R1 to his appointment, so he left. TD-A stated when he got back to the facility, he found out he was supposed to have taken R1 to the ED, he stated he felt terrible about the mix up. During an interview on 9/17/25 at 3:38 p.m., DON indicated she was not aware that R1 was left unattended at the ED on 9/10/25, while he was in a manual wheelchair and stated it was not safe for R1 because he was immobile in the manual wheelchair. DON was unsure if R1 was ever assessed for safety in a manual wheelchair and normally used his specialized electric wheelchair that he was independent with mobility in. Facility policy for transporting residents to outside appointments was requested and not received.	F0684		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if	F0755	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found	10/10/2025

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F0755 SS = D	Continued from page 10 State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R1) reviewed for quality of care. Findings include: R1's quarterly minimum data set (MDS) dated 9/3/25, identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's Telemedicine Visit dated 9/5/25, at 2:37 p.m., identified nurse asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying	F0755	Continued from page 10 to have been affected include: The unit manager performed a Medication Reconciliation on R1 on 9/17/2025. The physician was notified. 2. Identification of other residents having the potential to be affected was accomplished by: All residents with daily routine medication orders have the potential to be affected by this practice. Missed Medication report run for September 2025 on 10-3-25 with no issues. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility procedure regarding reordering medications was revised and reviewed on9/I7/2025 by the IDT team. The Director of Nursing Services reeducated on Medication administration and reordering on medication policy/procedures with nursing staff on 9/22/2025-10/10/2025. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: DON or designee will audit Missed Medication Reports monthly for 3 months then quarterly to ensure compliance. Audit results will be reviewed by Risk Management/QAPI until such a time consistent substantial compliance has been achieved as determined by the committee.	

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F0755 SS = D	Continued from page 11 tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1's primary care provider started eye drops yesterday unfortunately they have not arrived yet from the pharmacy. R1 reported level 3 of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, sandy feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 milligram (mg) per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start Polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics. R1's nurse practitioner (NP) verbal order on 9/4/25, regarding initiation of antibiotic eye drops was requested several times and not given. R1's medication administration record (MAR) dated September 2025, identified an order with a start date of 9/6/25, at 7:00 a.m., for amoxicillin-pot clavulanate to give one tablet by mouth two times a day for 5 days for early preseptal cellulitis. 9/5/25 identified an "x" was marked on morning and evening shift, indicating the medication was not started on 9/5/25, as per provider orders. An additional order with a start date of 9/5/25 at 2:30 p.m., for Polymyxin-B-Trimethoprim ophthalmic solution 100000-01 Units/milliliter (ML)-% to instill one eye drop four times a day for right eye conjunctivitis, discontinue when no longer needed. R1's evening and NOC (night shift) dose were left blank, indicating the dose was not started on 9/5/25 per provider orders. During a phone interview on 9/16/25 at 11:00 a.m., family member (FM)-A stated that FM-B was R1's resident representative and found out that R1's right eye was infected and was supposed to start antibiotics on 9/5/25, and they were not started until 9/6/25.	F0755		

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F0755 SS = D	Continued from page 12 During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25 and was supposed to start antibiotics right away but R1 did not get them until the following day on 9/6/25. FM-B was concerned about the facility not starting the eye drops right away like the provider wanted because R1's right eye was so red, the redness was spreading to his eyelids and looked infected. During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 stated one day a nurse came in with a monitor and a female doctor was on the monitor and had saw him for his right eye. R1 stated his right eye was red, painful and was itching and swollen. R1 stated the doctor prescribed him eye drops and antibiotics for his right eye infection and could not remember when exactly the medications were started. R1 stated he was never informed of a medication error. During a phone interview on 9/18/25 at 11:30 a.m., nurse practitioner (NP)-A stated she saw R1 through a telehealth visit on 9/5/25 and gave orders for the facility to start oral and eye drop antibiotics for concerns with right eye orbital cellulitis to start that day. During an interview on 9/18/25 at 1:01 p.m., licensed practical nurse (LPN)-A stated she was present on 9/5/25, and had assisted with the telehealth visit R1 had on 9/5/25. LPN-A stated the physician assistant (PA) that saw R1 had ordered oral and eye antibiotics on 9/5/25 and wanted them to start that day. LPN-A reviewed R1's electronic health record and verified the antibiotics were not started per the provider order on 9/5/25, rather were started on 9/6/25 and was unsure why. LPN-A stated this would be considered a medication error. LPN-A stated the process for a medication error was to fill out a paper medication error form and notify the resident, the director of nursing (DON) and the provider and follow whatever the direction they give you. The medication error should also be documented in risk management. During an interview on 9/18/25 at 1:19 p.m., assistant director of nursing (ADON) stated R1's oral and eye drop antibiotics were supposed to be started on 9/5/25 and were not actually started until 9/6/25 and indicated this would be a medication error because the providers orders were not followed. ADON stated when a medication error was identified we use a paper medication form that would be filled out and documented in risk management. ADON stated the resident would be	F0755		

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F0755 SS = D	Continued from page 13 assessed, notify the resident, family, DON and provider and follow provider direction. ADON stated the DON would be responsible to investigate the medication error to look for the root cause to put a prevention plan in place to prevent it from occurring again. During an interview on 9/18/25 at 1:39 p.m., DON stated R1 had a telehealth visit on 9/5/25 and was ordered oral and eye drop antibiotics that were to be started that day and indicated they were not started until 9/6/25. DON stated this would be a medication error for not following the providers orders. DON further stated the facility process for a medication error would be to document the event in risk management and the facility staff should not be using a paper form. DON stated with a medication error you would assess the resident, notify the resident, family, provider and follow any orders given. DON indicated she would be the one to investigate the medication error to look for a root cause and place interventions for prevention of future medication errors. DON stated she was not aware of R1's medication error until this surveyor pointed it out. Review of Facility policy, Medication Error copyright 2025, identified It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. "Medication error" means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services… Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services… 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report.	F0755		

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F0755 SS = D	Continued from page 14 Review of facility paper Medication Error Report form, revised 5/2000, identified Part 1 description of error, outcome to resident, corrective action taken and measures to prevent the reoccurrence of similar errors. Part 2-Assessment and Summary of error that included type of error, and reason for error. Further identified a disnature and date was needed for person making the error, person finding the error, DON, attending physician, medical director, pharmacist and administrator. Facility policy does not identify resident or resident representative notification or documentation of resident assessment.	F0755		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Hospitality Aide was immediately in-serviced on proper hand hygiene and PPE procedures by infection preventionist on 9/17/25. Transmission based Precaution Bins immediately moved to the outside door of patient rooms on 9/17/2025. R1 was also educated on hand hygiene; he was unaware of the issue. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. All patients audited and assure that all transmission-based precaution bins are outside of rooms. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	10/10/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	1201 GARFIELD AVENUE , ALBERT LEA, Minnesota, 56007

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F0880 SS = D	Continued from page 15 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 staff were following standard precautions by not performing hand hygiene before and after resident contact and failed to use personal protective equipment (PPE) for one of one resident (R1) that was on transmission-based precautions to reduce the risk of infection spread reviewed for quality of care. In addition, the facility failed to place the PPE cart directly outside R1's	F0880	Continued from page 15 All staff provided education on the facility's policy for hand hygiene on 9/22/2025-10/10/2025. All Staff education on all transmission-based precautions, donning/doffing and PPE was provided on 9/22/2025-10/10/2025. Corrective action is provided as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing, Infection Preventionist, or designee, will complete random audits on the timing and technique of hand hygiene procedure, as well as use of PPE on five employees monthly times 3 and then quarterly to ensure personnel are performing the procedure in accordance with our facility's policy.	

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F0880 SS = D	Continued from page 16 doorway to mitigate the risk for spread. Findings include: R1's quarterly minimum data set (MDS) dated 9/3/25, identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's lab result dated 9/11/25, identified R1's test for varicella zoster virus (herpes virus that causes shingles that can be transmitted through contact with an infected persons fluid from the blisters. A person is contagious for a couple of days before the rash appears until all blisters have crusted over) was positive indicating R1 had active shingles (a viral infection that affects the nerves around the eye) to the right eye area. R1's nursing progress note dated 9/11/25 at 6:10 p.m., placed call to clinic/hospital ED, was informed of R1 being sent to the hospital for admission for right orbital cellulitis a common bacterial infection surrounding the tissues of the eye that typically causes redness, swelling, pain, and warmth in the affected area) with shingles. R1's nursing progress note dated 9/15/25 at 3:31 p.m., identified R1 arrived back to the facility by private transport service via wheelchair and identified a new skin issue to right eye, shingles area is pink, wound is new, has erythema/painful. Pain was sharp and intermittent. R1 was on Valtrex (antiviral medication used to treat shingles) for a diagnoses of herpes zoster (a viral infection that causes a painful rash of blisters on one side of the body). Pain concerns to watch for are herpes zoster to right eye. R1's nursing progress note dated 9/16/25 at 1:03 p.m., R1 was told he needed to stay in his room after he got up and proceeded to come out and then told he had to go back to his room. R1 refused breakfast and lunch. During an observation on 9/17/25 at 9:11 a.m., of R1 the door to his room had a yellow laminated sign on the door identified at the top of the sign in black bold letters, "Contact Precautions." Below that in bold typed red letters was "Everyone Must:" To the left and	F0880		

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F0880 SS = D	Continued from page 17 right of these words was a picture of a red stop sign. Below this in smaller black bold letters was “clean their hands, including before entering and when leaving the room.” Below that in large bold red letters was “Providers and Staff Must Also:” below this in smaller black bold letter was “put on gloves before room entry.” To the left of this was a picture of a blue pair of gloves. Discard gloves before room exit. To the left of this was a picture of a blue gown. Below this "put on gown before room entry, discard gown before room exit." In red bold letter, “Do not wear the same gown and gloves for the care of more than one person.” In black bold letters, “use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person.” To the left of this was a picture of a blue stethoscope. At the bottom right-hand corner of the sign was a handwritten in red marker was an asterix followed by 9.2 and was underlined. There was no PPE cart outside of R1’s room. Hospitality aide (HA)-A was carrying a breakfast tray and walked into R1’s room to deliver the tray and set it on his tray table. HA-A did not perform hand hygiene prior to entering the room and did not follow the contact precaution sign on the door which indicated to don gowns and gloves. R1 stated he was not ready to eat breakfast yet and told HA-A to leave it on his tray table. HA-A walked back out of the room without performing hand hygiene. The contact precaution sign on the door indicated to don gloves and gown prior to entry to the room. During an interview on 9/17/25 at 9:14 a.m., HA-A stated she had no idea why there was a contact precautions sign on the door or for which resident it was for or what staff was supposed to do. HA-A stated she should have washed her hands prior to entering the room and after leaving the room and could not articulate the need for use of PPE as directed by the contact precaution sign on the door. During an interview on 9/17/25 at 9:18 a.m., licensed practical nurse (LPN)-A stated R1 was on contact precautions due to the shingles on his right eye. LPN-A stated he still has one blister that was open above his eye while rest of the blisters were crusted over. Staff should always wash their hands when entering and exiting a room with a resident who is on contact precautions, also gowns and gloves would be expected to be used. During an interview on 9/17/25 at 9:22 a.m., nursing assistant (NA)-A verified there was no PPE cart outside R1’s room and indicated there was no room in the hall	F0880		

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F0880 SS = D	Continued from page 18 for the PPE cart so they keep it in R1's room. NA-A indicated R1 was on contact precautions due to shingles in his right eye. During an interview on 9/17/25 at 12:43 p.m., assistant director of nursing (ADON) stated she was also the infection control nurse. ADON stated R1 was on contact precautions due to having herpes zoster to his right eye and staff should be using gown and gloves with any direct contact with R1. ADON stated that is why we have the contact precautions sign on R1's door. ADON stated she initially had the PPE cart inside his room, but R1's family member (FM)-B had tried to put the cart in the bathroom because of lack of space in his room, so she moved the PPE cart to the hall. ADON walked to R1's room and verified the PPE cart was not in the hallway in front of R1's room rather was inside R1's room by his bed that R1 was in. When asked what the expectation for infection control precautions would be with meal delivery to R1, ADON stated all staff should be washing hands upon entrance to his room and upon exit. Gowns and gloves should be used with cares and with any potential of touching contaminated items in his room such as the delivery of a meal tray. During an interview on 9/17/25 at 3:38 p.m., director of nursing (DON) stated when a resident is on contact precautions the staff member should wash their hands upon entrance and exit of their room that would be standard precautions, along with the use of gowns and gloves. When asked where PPE carts should be located, DON indicated the carts could be stored in resident rooms and that all of their current residents that are on infection control precautions have their PPE carts in their rooms. DON was unable to articulate that having PPE carts in the rooms could potentially contaminate the PPE. DON was unable to articulate how staff would don PPE upon entrance to a room if the PPE cart was not available to do so. Facility policy, Isolation-categories of Transmission-Based Precautions, revised September 2022, identified Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy interpretation and Implementation 1. Standard precautions are used when caring for all residents at all times regardless of their suspected or confirmed infection status. 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the	F0880		

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F0880 SS = D	Continued from page 19 specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3. The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission and recommended precautions. 4. The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy. 6. When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible… Contact Precautions I. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified… 6. The individual on contact precautions is placed in a private room if possible. If a private room is not available, the infection preventionist will assess various risks associated with other resident placement options (e.g., cohorting, placing with a low-risk roommate). 7. Staff and visitors wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). b. Gloves are removed and hand hygiene performed before leaving the room. c. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is	F0880		

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F0880 SS = D	Continued from page 20 removed... Facility policy, Equipment and Supplies Used During Isolation, revised October 2018, identified appropriate infection prevention and control equipment and supplies are obtained, stored and used in accordance with current guidelines and manufacturer instructions. 1. All equipment and supplies needed to implement transmission-based (isolation) precautions are obtained from an approved vendor. 2. Infection prevention and control supplies are stored and maintained in accordance with current guidelines and manufacturer's recommendations. 3. The infection preventionist (or designee) oversees the availability and inventory of infection prevention and control supplies. The facility policy did not identify where PPE carts should be placed for a resident on contact precautions. Facility policy, Standard Precautions revised September 2022, identified Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Policy Interpretation and Implementation 1. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. 2. Personnel are trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations. 3. Residents and family members are provided with information pertaining to standard precautions and the prevention of infection upon the resident's admission to the facility. 4. Visitors are reminded and encouraged to maintain hand hygiene and follow instructions regarding infection prevention and control while in the facility. Standard precautions include the following practices: 1. Hand hygiene a. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water. b. Hand hygiene is performed with ABHR or soap and water: (1) before and after contact with the resident…(4) after contact with items in the residents room.	F0880		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/16/25, 9/17/25 and 9/18/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		10/01/2025

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaint was reviewed: H54254480C (2614794) with licensing orders issued at 0830, 1375, 1555 and 1830. 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. 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 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. 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.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to	20830	Completed	10/10/2025

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20830	Continued from page 2 remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to monitor for signs and symptoms of infection for 1 of 1 resident (R1) reviewed for change in condition. In addition, the facility failed to safely transport 1 of 1 resident (R1) to an outside appointment reviewed for resident safety. Findings include: Infection monitoring: R1's care plan dated 9/2/25, identified a focus that R1 was at risk for infection due to refusal of vaccinations. Interventions included to educate R1 and resident representative of techniques to prevent infections such as handwashing, adequate rest, nutrition, avoidance of crowds, to monitor for signs and symptoms of infection and staff to follow standard precautions including proper handwashing techniques to minimize microorganism growth. R1's quarterly minimum data set (MDS) dated 9/3/25, identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's nursing progress note dated 9/4/25 at 1:00 p.m., identified acetaminophen 500 milligram (mg) given due to complaint that his right eye hurt and was sore. At 1:20 p.m., an additional note indicated R1's right eye hurt some and was a little red and irritated…will continue to keep an eye on it for now. R1's nursing progress note dated 9/5/25 at 11:24 a.m., R1 again commented his eye was sore to the director of nursing (DON) who happened to look at it and let her know this started on 9/4/25, noted his eyebrow was a little swollen and now was pinkish red and warm to the touch, was wondering if cellulitis was developing. Will call nurse practitioner to get an order for something and some eye drops also, called and left a voicemail for her. R1's Telemedicine Visit dated 9/5/25, at 2:37 p.m.,	20830		

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20830	Continued from page 3 identified nurse asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1 reported level 3 of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, sandy feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 mg per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics. Review of R1's electronic health record does not identify consistent daily comprehensive monitoring of eye infection from 9/5/25 through 9/16/25. During an interview on 9/17/25 at 2:29 p.m., licensed practical nurse (LPN)-A indicated on 9/4/25 R1 had a change in condition when R1 developed redness to his right eye and eye lid that extended above his eyebrow and R1 said it was sore. LPN-A further stated his eye worsened on 9/5/25 due to swelling and warmth and she had nurse practitioner (NP)-A see R1 through a telehealth visit and NP -A ordered oral and eye antibiotics for orbital cellulitis to be started that day. NP-A also had us use a black marker to draw around R1's redness around his right eye and told us if the redness spreads beyond the black marker it would be ok to send him to the emergency department for intravenous (IV) antibiotics. LPN-A reviewed R1's electronic health record and verified there was no daily monitoring of	20830		

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20830	Continued from page 4 signs and symptoms of infection for R1's right eye cellulitis from 9/5/25 to 9/16/25. LPN-A stated when she worked on 9/10/25, she noticed R1 had developed six to seven papules (small, red, solid bumps that quickly turn into fluid filled blisters with shingles) above his right eye. LPN-A stated she called the physician assistant (PA)-A on 9/10/25 and PA-A thought R1 could have shingles and gave orders to send R1 to the emergency department (ED) right away to have a maxillofacial cat scan (CT) to rule out infection spread, a herpes zoster swab to rule out shingles and some lab tests. During an interview on 9/17/25 at 2:52 p.m., assistant director of nursing (ADON) reviewed R1's electronic health record and verified there was no daily monitoring or comprehensive assessments for signs and symptoms of infection for R1's right eye cellulitis. ADON stated when R1 was put on antibiotics a nursing order should have been placed to do comprehensive assessing and monitoring of R1's infection every shift to assess for a change in condition. During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25. FM-B stated she was R1's resident representative and was concerned the facility did not have R1 seen in person by a provider from 9/5/25 through 9/10/25. FM-B stated R1 developed shingles in his right eye that looked really infected and was worried about vision loss and infection spread. FM-B stated R1 ended up in the hospital to be treated with IV antibiotics due to the infection being in his eye and so close to his brain. During an interview on 9/17/25 at 3:38 p.m., DON reviewed R1's electronic health record and stated there was no documentation of assessments and monitoring for infection from 9/5/25 to 9/16/25 and there should have been a nursing order put in to monitor for cellulitis every shift so the nurses are reminded what to monitor for and to be alerted to a change in condition so they can notify the provider timely. During a phone interview on 9/18/25 at 11:30 a.m., nurse practitioner (NP)-A stated she saw R1 through a telehealth visit on 9/5/25, and gave orders for the facility to start oral and eye drop antibiotics for concerns with right eye orbital cellulitis to start that day. NP-A stated, on 9/5/25 R1 did not have any vesicles (small fluid filled blisters) on his right eye lid or forehead NP-A further stated she directed staff to draw a black marker around the redness surrounding the eye and to send to ED if redness spreads for IV	20830		

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20830	Continued from page 5 antibiotics. NP-A would expect assessments of the eye infection every shift to notice any changes to include, itching, fever, increased pain, fatigue, burning, light sensitivity blurred vision and spread of the redness and notify the provider immediately of any changes. Facility policy was requested for infection assessment and monitoring and was not received. Appointments: R1's care plan dated 12/5/24, identified a focus for mobility, needed assist with transfers and bed mobility related to cerebral palsy. Intervention dated 3/4/25, mechanical wheelchair to be taken out of room at night once in bed. Plug in to charge overnight in West supply closet entrance. An additional intervention dated 12/5/24, identified staff to assist with doors, elevators, inclines and tight spaces as needed. An additional focus dated 9/14/25, identified R1 had weakness and needed his electric cart to move around. Intervention dated 9/14/25, identified staff will bring R1 to events he enjoys…will attend current event sessions that he enjoys when he feels better. Care plan does not identify level of assist for mobility in a manual wheelchair when outside the facility. R1's nursing progress note dated 9/10/25 at 10:46 a.m., identified physician assistant (PA)-A ordered R1 to be sent to the hospital and have varicella-zoster PCR (a highly accurate and fast lab test that detects the virus responsible for chickenpox and shingles) completed to right eye, and CT maxillofacial to be completed. Called FM-B to get a verbal bed hold, left voicemail due to no answer, R1 agreed to go to the hospital. At 11:33 a.m., R1 left the facility van to hospital at 11:20 a.m., waiting for return call from FM-B, called the ED to give report to the nurse. During an interview on 9/18/25 at 8:31 a.m., family member (FM)-B indicated she was the resident representative for R1 and stated there was a big miscommunication when R1 had to be sent to the ED on 9/10/25, for tests for a CT scan and the swab for shingles to be done. FM-B stated normally if she can't be at an appointment for R1 someone from the facility will go with him because when the facility transports him in their van, he can't use his electric wheelchair they have no way to strap it down. FM-B further stated the facility had to put him in a manual wheelchair and R1 was not safe to be left unattended due to being immobile from his cerebral palsy. FM-B stated the	20830		

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20830	Continued from page 6 facility had tried calling her on 9/10/25, to notify her but she was at work and did not get the message right away. FM-B indicated when she finally got the message, she was unsure what hospital they sent R1 to, so she had to call the facility to find out, when she arrived at the ED the staff had told her R1 hadn't checked in yet. FM-B stated she jumped back in her car and went to the clinic side of the hospital and while enroute had called the facility to find out where R1 was, and the facility told her they were sending a driver to come get him because he was done with his appointment. FM-B stated she got to the clinic and found R1 seated in the manual wheelchair slouched over to his left side, he had to lift his head way up to see me coming. FM-B stated R1 had no core strength due to the cerebral palsy and scoliosis (sideways curvature of the spine) and being in an upright position was very uncomfortable for him. FM-B stated guessed R1 had been seated unattended for about 25 minutes with no way to move himself. FM-B stated R1 hated to be a burden on anyone and had always tried to be independent and that he will not ask for help. FM-B stated she did take R1 to the ED to get his tests done and the driver from the facility brought him back when he was done. During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 stated on 9/10/25, he had to go to the ED to get testing done for his right eye problem and had to be transferred in a manual wheelchair because the facility van does not have room for his electric wheelchair that he normally used. R1 stated the manual wheelchair was uncomfortable but he was able to tolerate for short durations. R1 further stated the driver brought him to the clinic and someone tried to check him in on the monitor thing and he didn't have an appointment, and he was left in the waiting room because the driver got a call about another appointment. R1 stated he was unable to wheel himself in the manual wheelchair, so he had to wait for someone to help. R1 stated it was a lack of communication that he was left and when FM-B found him she was not happy. FM-B stated he guessed he waited about 20 to 25 minutes before FM-B got there and she got me to the ED where they did my tests. During an interview on 9/18/25 at 10:49 a.m., director of therapy (DOT)-A stated she was unaware that when the facility transports residents who use an electric wheelchair outside the facility, they transfer the resident to a manual wheelchair before they load them in the van. DOT-A stated R1 had never been assessed for safety in a manual wheelchair and was concerned of how he would be safe in one without a proper assessment due to his cerebral palsy, contractures (permanent	20830		

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20830	Continued from page 7 shortening or tightening of muscles, tendons, or other tissues that restricts movement) and scoliosis. During an interview on 9/18/25 at 9:51 a.m., receptionist (R)-A stated the ADON told her that R1 needed a ride to the clinic for an eye appointment, so she called the transport driver (TD)-A and asked him to bring R1 in. During an interview on 9/18/25 at 11:05 a.m., TD-A stated he got a call from R-A, and she told him R1 needed a ride to the clinic for an eye appointment. TD-A stated normally when he takes a resident to an appointment, they send paperwork with. TD-A stated he had no paperwork for R1 and assumed R1 had an eye appointment. TD-A stated he got him to the clinic at the eye part and the girl at the clinic put his name in the kiosk and said she didn't think R1 had an appointment. TD-A thought the girl at the clinic would take R1 to his appointment, so he left. TD-A stated when he got back to the facility, he found out he was supposed to have taken R1 to the ED, he stated he felt terrible about the mix up. During an interview on 9/17/25 at 3:38 p.m., DON indicated she was not aware that R1 was left unattended at the ED on 9/10/25, while he was in a manual wheelchair and stated it was not safe for R1 because he was immobile in the manual wheelchair. DON was unsure if R1 was ever assessed for safety in a manual wheelchair and normally used his specialized electric wheelchair that he was independent with mobility in. Facility policy for transporting residents to outside appointments was requested and not received. TIME ALLOWED FOR CORRECTION: 21 DAYS SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with infections to assure they are receiving ongoing monitoring and assessment along with the necessary treatment/services to promote improvement. The director of nursing or designee could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of infections not being cared for properly. SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure staff are educated on policies and procedures ensuring residents are transported safely to scheduled outpatient appointments. The DON or designee could identify and audit all residents who have outside appointments and update/implement measures to ensure	20830		

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20830	Continued from page 8 residents reach their outside appointments safely and with supervision as needed. Results of those findings should go to the Quality Assurance Performance Improvement (QAPI) for determination of effectiveness, compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following standard precautions by not performing hand hygiene before and after resident contact and failed to use personal protective equipment (PPE) for one of one resident (R1) that was on transmission-based precautions to reduce the risk of infection spread reviewed for quality of care. In addition, the facility failed to place the PPE cart directly outside R1's doorway to mitigate the risk for spread. Findings include: R1's quarterly minimum data set (MDS) dated 9/3/25, identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's lab result dated 9/11/25, identified R1's test for varicella zoster virus (herpes virus that causes shingles that can be transmitted through contact with an infected persons fluid from the blisters. A person is contagious for a couple of days before the rash appears until all blisters have crusted over) was positive indicating R1 had active shingles (a viral infection that affects the nerves around the eye) to the right eye area. R1's nursing progress note dated 9/11/25 at 6:10 p.m.,	21375	Completed	10/10/2025

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21375	Continued from page 9 placed call to clinic/hospital ED, was informed of R1 being sent to the hospital for admission for right orbital cellulitis a common bacterial infection surrounding the tissues of the eye that typically causes redness, swelling, pain, and warmth in the affected area) with shingles. R1's nursing progress note dated 9/15/25 at 3:31 p.m., identified R1 arrived back to the facility by private transport service via wheelchair and identified a new skin issue to right eye, shingles area is pink, wound is new, has erythema/painful. Pain was sharp and intermittent. R1 was on Valtrex (antiviral medication used to treat shingles) for a diagnoses of herpes zoster (a viral infection that causes a painful rash of blisters on one side of the body). Pain concerns to watch for are herpes zoster to right eye. R1's nursing progress note dated 9/16/25 at 1:03 p.m., R1 was told he needed to stay in his room after he got up and proceeded to come out and then told he had to go back to his room. R1 refused breakfast and lunch. During an observation on 9/17/25 at 9:11 a.m., of R1 the door to his room had a yellow laminated sign on the door identified at the top of the sign in black bold letters, "Contact Precautions." Below that in bold typed red letters was "Everyone Must:" To the left and right of these words was a picture of a red stop sign. Below this in smaller black bold letters was "clean their hands, including before entering and when leaving the room." Below that in large bold red letters was "Providers and Staff Must Also:" below this in smaller black bold letter was "put on gloves before room entry." To the left of this was a picture of a blue pair of gloves. Discard gloves before room exit. To the left of this was a picture of a blue gown. Below this "put on gown before room entry, discard gown before room exit." In red bold letter, "Do not wear the same gown and gloves for the care of more than one person." In black bold letters, "use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person." To the left of this was a picture of a blue stethoscope. At the bottom right-hand corner of the sign was a handwritten in red marker was an asterix followed by 9.2 and was underlined. There was no PPE cart outside of R1's room. Hospitality aide (HA)-A was carrying a breakfast tray and walked into R1's room to deliver the tray and set it on his tray table. HA-A did not perform hand hygiene prior to entering the room and did not follow the contact precaution sign on the door which indicated to don gowns and gloves. R1 stated he was not ready to eat breakfast yet and told HA-A to leave it on his tray	21375		

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21375	Continued from page 10 table. HA-A walked back out of the room without performing hand hygiene. The contact precaution sign on the door indicated to don gloves and gown prior to entry to the room. During an interview on 9/17/25 at 9:14 a.m., HA-A stated she had no idea why there was a contact precautions sign on the door or for which resident it was for or what staff was supposed to do. HA-A stated she should have washed her hands prior to entering the room and after leaving the room and could not articulate the need for use of PPE as directed by the contact precaution sign on the door. During an interview on 9/17/25 at 9:18 a.m., licensed practical nurse (LPN)-A stated R1 was on contact precautions due to the shingles on his right eye. LPN-A stated he still has one blister that was open above his eye while rest of the blisters were crusted over. Staff should always wash their hands when entering and exiting a room with a resident who is on contact precautions, also gowns and gloves would be expected to be used. During an interview on 9/17/25 at 9:22 a.m., nursing assistant (NA)-A verified there was no PPE cart outside R1's room and indicated there was no room in the hall for the PPE cart so they keep it in R1's room. NA-A indicated R1 was on contact precautions due to shingles in his right eye. During an interview on 9/17/25 at 12:43 p.m., assistant director of nursing (ADON) stated she was also the infection control nurse. ADON stated R1 was on contact precautions due to having herpes zoster to his right eye and staff should be using gown and gloves with any direct contact with R1. ADON stated that is why we have the contact precautions sign on R1's door. ADON stated she initially had the PPE cart inside his room, but R1's family member (FM)-B had tried to put the cart in the bathroom because of lack of space in his room, so she moved the PPE cart to the hall. ADON walked to R1's room and verified the PPE cart was not in the hallway in front of R1's room rather was inside R1's room by his bed that R1 was in. When asked what the expectation for infection control precautions would be with meal delivery to R1, ADON stated all staff should be washing hands upon entrance to his room and upon exit. Gowns and gloves should be used with cares and with any potential of touching contaminated items in his room such as the delivery of a meal tray. During an interview on 9/17/25 at 3:38 p.m., director	21375		

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21375	Continued from page 11 of nursing (DON) stated when a resident is on contact precautions the staff member should wash their hands upon entrance and exit of their room that would be standard precautions, along with the use of gowns and gloves. When asked where PPE carts should be located, DON indicated the carts could be stored in resident rooms and that all of their current residents that are on infection control precautions have their PPE carts in their rooms. DON was unable to articulate that having PPE carts in the rooms could potentially contaminate the PPE. DON was unable to articulate how staff would don PPE upon entrance to a room if the PPE cart was not available to do so. Facility policy, Isolation-categories of Transmission-Based Precautions, revised September 2022, identified Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy interpretation and Implementation 1. Standard precautions are used when caring for all residents at all times regardless of their suspected or confirmed infection status. 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3. The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission and recommended precautions. 4. The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy. 6. When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible… Contact Precautions I. Contact precautions are implemented for residents known	21375		

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21375	Continued from page 12 or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified… 6. The individual on contact precautions is placed in a private room if possible. If a private room is not available, the infection preventionist will assess various risks associated with other resident placement options (e.g., cohorting, placing with a low-risk roommate). 7. Staff and visitors wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). b. Gloves are removed and hand hygiene performed before leaving the room. c. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed… Facility policy, Equipment and Supplies Used During Isolation, revised October 2018, identified appropriate infection prevention and control equipment and supplies are obtained, stored and used in accordance with current guidelines and manufacturer instructions. 1. All equipment and supplies needed to implement transmission-based (isolation) precautions are obtained from an approved vendor. 2. Infection prevention and control supplies are stored and maintained in accordance with current guidelines and manufacturer's recommendations. 3. The infection preventionist (or designee) oversees the availability and inventory of infection prevention and control supplies. The facility policy did not identify where PPE carts should be placed for a resident on contact precautions. Facility policy, Standard Precautions revised September 2022, identified Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible	21375		

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Thorne Crest Retirement Center	**1201 GARFIELD AVENUE , ALBERT LEA, Minnesota, 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
21375	Continued from page 13 infectious agents. Policy Interpretation and Implementation 1. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. 2. Personnel are trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations. 3. Residents and family members are provided with information pertaining to standard precautions and the prevention of infection upon the resident's admission to the facility. 4. Visitors are reminded and encouraged to maintain hand hygiene and follow instructions regarding infection prevention and control while in the facility. Standard precautions include the following practices: 1. Hand hygiene a. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water. b. Hand hygiene is performed with ABHR or soap and water: (1) before and after contact with the resident…(4) after contact with items in the residents room. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21555	Administrationof Medications Staff designated CFR(s): MN Rule 4658.1325 Subp. 2 Subp. 2. Staff designated to administer medications. A nurse or unlicensed nursing personnel, as described in part 4658.1360, must be designated as responsible for the administration of medications during each work period. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R1) reviewed for quality of care.	21555	Completed	10/10/2025

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21555	Continued from page 14 Findings include: R1's quarterly minimum data set (MDS) dated 9/3/25, identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's Telemedicine Visit dated 9/5/25, at 2:37 p.m., identified nurse asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1's primary care provider started eye drops yesterday unfortunately they have not arrived yet from the pharmacy. R1 reported level 3 of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, sandy feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 milligram (mg) per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start Polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics. R1's nurse practitioner (NP) verbal order on 9/4/25, regarding initiation of antibiotic eye drops was requested several times and not given. R1's medication administration record (MAR) dated September 2025, identified an order with a start date of 9/6/25, at 7:00 a.m., for amoxicillin-pot clavulanate to give one tablet by mouth two times a day for 5 days for early preseptal cellulitis. 9/5/25	21555		

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21555	Continued from page 15 identified an “x” was marked on morning and evening shift, indicating the medication was not started on 9/5/25, as per provider orders. An additional order with a start date of 9/5/25 at 2:30 p.m., for Polymyxin-B-Trimethoprim ophthalmic solution 100000-01 Units/milliliter (ML)-% to instill one eye drop four times a day for right eye conjunctivitis, discontinue when no longer needed. R1’s evening and NOC (night shift) dose were left blank, indicating the dose was not started on 9/5/25 per provider orders. During a phone interview on 9/16/25 at 11:00 a.m., family member (FM)-A stated that FM-B was R1’s resident representative and found out that R1’s right eye was infected and was supposed to start antibiotics on 9/5/25, and they were not started until 9/6/25. During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25 and was supposed to start antibiotics right away but R1 did not get them until the following day on 9/6/25. FM-B was concerned about the facility not starting the eye drops right away like the provider wanted because R1’s right eye was so red, the redness was spreading to his eyelids and looked infected. During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 stated one day a nurse came in with a monitor and a female doctor was on the monitor and had saw him for his right eye. R1 stated his right eye was red, painful and was itching and swollen. R1 stated the doctor prescribed him eye drops and antibiotics for his right eye infection and could not remember when exactly the medications were started. R1 stated he was never informed of a medication error. During a phone interview on 9/18/25 at 11:30 a.m., nurse practitioner (NP)-A stated she saw R1 through a telehealth visit on 9/5/25 and gave orders for the facility to start oral and eye drop antibiotics for concerns with right eye orbital cellulitis to start that day. During an interview on 9/18/25 at 1:01 p.m., licensed practical nurse (LPN)-A stated she was present on 9/5/25, and had assisted with the telehealth visit R1 had on 9/5/25. LPN-A stated the physician assistant (PA) that saw R1 had ordered oral and eye antibiotics on 9/5/25 and wanted them to start that day. LPN-A reviewed R1’s electronic health record and verified the antibiotics were not started per the provider order on 9/5/25, rather were started on 9/6/25 and was unsure	21555		

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21555	Continued from page 16 why. LPN-A stated this would be considered a medication error. LPN-A stated the process for a medication error was to fill out a paper medication error form and notify the resident, the director of nursing (DON) and the provider and follow whatever the direction they give you. The medication error should also be documented in risk management. During an interview on 9/18/25 at 1:19 p.m., assistant director of nursing (ADON) stated R1's oral and eye drop antibiotics were supposed to be started on 9/5/25 and were not actually started until 9/6/25 and indicated this would be a medication error because the providers orders were not followed. ADON stated when a medication error was identified we use a paper medication form that would be filled out and documented in risk management. ADON stated the resident would be assessed, notify the resident, family, DON and provider and follow provider direction. ADON stated the DON would be responsible to investigate the medication error to look for the root cause to put a prevention plan in place to prevent it from occurring again. During an interview on 9/18/25 at 1:39 p.m., DON stated R1 had a telehealth visit on 9/5/25 and was ordered oral and eye drop antibiotics that were to be started that day and indicated they were not started until 9/6/25. DON stated this would be a medication error for not following the providers orders. DON further stated the facility process for a medication error would be to document the event in risk management and the facility staff should not be using a paper form. DON stated with a medication error you would assess the resident, notify the resident, family, provider and follow any orders given. DON indicated she would be the one to investigate the medication error to look for a root cause and place interventions for prevention of future medication errors. DON stated she was not aware of R1's medication error until this surveyor pointed it out. Review of Facility policy, Medication Error copyright 2025, identified It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. "Medication error" means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services... Policy Explanation and Compliance Guidelines:	21555		

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21555	Continued from page 17 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services… 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report. Review of facility paper Medication Error Report form, revised 5/2000, identified Part 1 description of error, outcome to resident, corrective action taken and measures to prevent the reoccurrence of similar errors. Part 2-Assessment and Summary of error that included type of error, and reason for error. Further identified a disnature and date was needed for person making the error, person finding the error, DON, attending physician, medical director, pharmacist and administrator. Facility policy does not identify resident or resident representative notification or documentation of resident assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	21555		
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes	21830	Completed	10/10/2025

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21830	Continued from page 18 the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family	21830		

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21830	Continued from page 19 member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to notify a resident's representative of a change in condition for 1 of 3 residents (R3) reviewed for quality of care. Findings include: R1's quarterly minimum data set (MDS) dated 9/3/25, identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation). R1's nursing progress note dated 9/4/25 at 1:00 p.m., identified acetaminophen 500 mg given due to complaint of right eye pain and soreness. At 1:20 p.m., an additional note indicated R1's right eye hurt some and was a little red and irritated…will continue to keep an eye on it for now. R1's nursing progress note dated 9/5/25 at 11:24 a.m., R1 again commented his eye was sore to the director of nursing (DON) who happened to look at it and let her know this started on 9/4/25. R1's eyebrow was a little swollen and now was pinkish red and warm to the touch,	21830		

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21830	Continued from page 20 and the DON wondered if cellulitis was developing. Note identified that the DON would call nurse practitioner to get an order for something, and some eye drops also. Called and left a voicemail for the nurse practitioner. R1's Telemedicine Visit dated 9/5/25 at 2:37 p.m., identified nursing asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1's primary care provider started eye drops yesterday, unfortunately they have not arrived yet from the pharmacy. R1 reported 3 out of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, sandy feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 milligram (mg) per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics. R1's electronic health record was reviewed and does not identify R1's representative was notified of a change in condition with his right eye. During an interview on 9/17/25 at 2:24 p.m., assistant director of nursing (ADON) reviewed R1's electronic health record and stated it does not look like anyone notified R1's family of his change in condition with his right eye and they should have. ADON stated anytime a resident has a change in condition the resident representative should be notified immediately and should be documented in the resident's medical record. During an interview on 9/17/25 at 2:29 p.m., licensed practical nurse (LPN)-A indicated on 9/4/25, R1 had a change in condition when R1 was complaining of soreness in his right eye. LPN-A stated R1 had redness in his	21830		

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21830	Continued from page 21 right eye and his eye lid that extended above his eyebrow. LPN-A further stated his eye worsened on 9/5/25 due to swelling and warmth. LPN-A stated she did not notify FM-B of R1's change in condition and should have. During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25. FM-B stated she was R1's resident representative and was upset the facility never contacted her about R1's eye infection. FM-B stated they should have called me when R1's eye first started getting red. FM-B stated she wanted to be notified of any changes R1 had. FM-B stated she didn't find out until she went to the facility to visit R1. During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 indicated when he has changes in his health, he would like the facility to notify FM-B. During an interview on 9/17/25 at 3:38 p.m., director of nursing (DON) reviewed R1's electronic medical record and stated there was no documentation that FM-B was notified of R1's change in condition of his right eye. DON indicated FM-B should have been notified immediately and should have been documented in R1's medical record. Facility policy regarding notification with a change in condition was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the resident representative with a change in condition. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		