Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 17, 2026

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

RE: CCN: 245425
Cycle Start Date: May 20, 2026

Dear Administrator:

On July 9, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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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Re: Reinspection Results
Event ID: 232A63-H2

Dear Administrator:

On July 9, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 20, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

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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 05/20/2026

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 5/19/26, and 5/20/26, 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 complaints were reviewed: H54255982C (2739571) with a deficiency issued at F686. 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		06/12/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	Immediate Corrections R1 is currently deceased. R2’s wound had resolved. A Braden Scale with Skin Risk Evaluation was completed on June 9, 2026, which showed a mild risk score of 16. Appropriate revisions were made to her care plan to reflect all current pressure injury prevention interventions including turning and repositioning. Identification of others Braden scale with Skin Risk Evaluation were completed for Hospice residents and residents that were chairbound and bedbound. Any resident showing moderate to high risk, their care plans were revised to ensure a turning and repositioning schedule that is appropriate based on their risk	06/12/2026

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

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F0686 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess and evaluate care plan interventions for effectiveness, and develop individualized repositioning program to prevent pressure ulcer development and/or deterioration for 2 of 3 residents (R1, R2) reviewed for pressure ulcers. Findings include: Stage 2 pressure ulcer: partial-thickness loss of skin that presents as a shallow, open wound with a red or pink wound bed without exposure of fat or deeper tissues. Deep tissue injury: affects the deeper layers of tissue beneath the skin including muscles, subcutaneous fat, and sometimes bone which disrupt blood flow and oxygen delivery to the tissue. Braden Scale for Predicting Pressure Sore Risk is a standardized tool to assess the risk of developing pressure injuries. The scale evaluates six categories: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. Each category is scored from 1-4, except friction/shear which is scored 1-3. Scores are categorized as 19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, and 9 or less very high risk. R1 R1's face sheet dated 5/19/26, identified diagnoses of unspecified fracture of lower end of left femur (upper leg bone), subsequent encounter for closed fracture with routine healing, hypertension, obesity, and chronic peripheral venous insufficiency (not enough blood flow to legs). R1's hospital discharge after visit summary dated 1/9/26, identified a Braden Scale score of 15. R1's facility Braden Scale with Skin Risk Evaluation dated 1/9/26, identified a score of 16. Skin Evaluation Risk included: acute condition, decreased range of motion, cast/brace/splint, limited mobility/bedfast. No ulcers were present on admission. Treatments included pressure-reducing device for chair and bed. R1 was to have an immobilizer on left leg at all times. R1's care plan dated 1/13/26, identified R1 was incontinent of bowel and bladder. R1 was dependent	F0686	Continued from page 1 factors, as well as other pressure injury prevention interventions. Actions taken to reduce risk of future occurrence The facility policy regarding Pressure Injury Prevention was updated to include pressure injury risk assessment and skin assessment to be completed upon admission, quarterly, with change of condition and as needed. Nursing staff were in-serviced on the updated facility policy, prevention interventions such as turning and repositioning, and timely reporting of skin concerns. During daily clinical meetings, the IDT will review new admit residents' Braden scale and skin risk evaluation, and newly reported skin issues especially for residents with high risk for skin impairment so that they are care planned for appropriate interventions and treatment. How corrective action will be monitored Audits will be conducted for new admits and at least 2 moderate to high-risk residents 3x a week for 4 weeks then weekly x 4 then monthly x 2 on timely completion of Braden scale with Skin Risk Evaluation, observation of staff to ensure care plan interventions are in place and followed, and have appropriate care plan interventions based on their current evaluations. Results of audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	06/12/2026

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F0686 SS = D	Continued from page 2 on staff for toileting, staff to offer toileting on wake up, after meals, and at bedtime. R1's care plan dated 1/21/26, identified R1 had potential for impaired skin integrity related to immobility due to femur fracture and urinary incontinence. Interventions included to apply moisture barrier as needed, Braden Scale on admission, every week for four weeks, quarterly, and with any significant change, nursing assistants (NA) to observe skin with morning and evening cares and report any abnormalities to the nurse, maintain good skin hygiene, moisturize dry skin as needed, observe for alteration in skin integrity and report to physician, skin inspected weekly per schedule, pressure reducing mattress on bed and cushion in wheelchair. On 2/9/26, every two-hour repositioning and blue pressure relieving boots to feet at all times for pressure relief were added. Although R1's care plan called for repositioning every two hours, there was no documentation of a comprehensive assessment supporting that interval or demonstrating that R1 could tolerate pressure for two-hour periods without increased risk of skin breakdown. R1's Hospice Admission dated 2/3/26, identified R1 admitted to hospice services with decline in condition including 6.61% weight loss in the past 6 months, meal intake decline in the past 6 months typically only eating 0-25% of breakfast and nothing for lunch or supper, bedbound, incontinent of bladder, and sleeping 20-22 hours/day. R1's record identified R1 did not have a Braden Scale with Skin Risk Evaluation completed weekly between 1/9/26 and 2/4/26. R1's facility Braden Scale with Skin Risk Evaluation dated 2/5/26, indicated R1 had developed pressure ulcers since admission. The evaluation identified a score of 14 indicating R1 was at moderate risk for pressure ulcers (even though R1 had developed two pressure ulcers). Skin Evaluation Risk included: chronic incontinence, cognitive impairment, decreased range of motion, muscle wasting, pale skin, cast/brace/splint, limited mobility/bedfast. R1 had one or more unhealed pressure ulcers/injuries, however did not identify how many ulcers R1 had or location. Treatment included pressure-reducing device for chair and bed, turning and repositioning program, pressure ulcer/injury care. Interventions included to elevate edematous (fluid retention)/affected extremities.	F0686		06/12/2026

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F0686 SS = D	Continued from page 3 Review of R1's record did not include a comprehensive assessment of the pressure ulcers that were noted on the Braden Scale Evaluation dated 2/5/26. Although R1's record identified developed pressure areas there was no indication the care plan interventions were evaluated for effectiveness, there was no change identified in the reposition program, and no new additional interventions were developed or implemented to prevent deterioration or new ulcer development. R1's progress note dated 2/7/26, identified R1 refused supper, was incontinent of urine once, and had a bed bath with no new skin issues identified. R1's progress note dated 2/9/26, identified R1 had been in bed all day and not been eating. Hospice registered nurse (HRN)-A and family was present. A deep tissue injury was noted on right heel. The area was closed, discolored and non-blanchable (redness or discoloration on skin does not turn white when gentle pressure applied). Pressure relieving boots applied and an air alternating mattress was ordered. A reddened line that measured 8 centimeters (cm) across R1's lower buttock was blanchable (turns white with gentle pressure applied) and appeared to have been caused by edge of R1's brief being rolled down. A small stage 2 pressure ulcer was noted on R1's coccyx in a "V" shape. HRN-A was increasing visits to daily due to R1's declining condition. R1's Client Coordination Notes Report from hospice dated 2/9/26, identified R1 was in bed upon visit arrival, minimally responsive with Cheyne-Stokes (abnormal breathing pattern) and 40 second apnea (no breathing). No mottling (blotchy, red, purple, bluish discoloration of skin) noted. Suspected deep tissue injury noted to right heel, HRN-A notified assistant director of nursing (ADON) and director of nursing (DON). Stage 2 pressure sore noted to coccyx, non-blanchable areas noted to upper right and left buttocks. Incontinence brief had been soiled with urine. R1 positioned on left side. Reviewed positioning frequency, floating heels, and pressure injury prevention with nurse and nursing assistant. R1's Client Coordination Notes Report from hospice dated 2/10/26, identified family was present and stated R1 had been repositioned every two hours and that R1 tolerated that well. Light mottling noted to lower extremities. Review of R1's record between 2/5/26 through 2/10/26 revealed no indication of a comprehensive pressure ulcer assessment was completed that would identify measurements, drainage, and pain.	F0686		06/12/2026

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F0686 SS = D	Continued from page 4 Further not evident of a comprehensive analysis that determined causal factors of pressure ulcer development so that appropriate interventions could be developed and implemented that would negate the risk of deterioration and/or new ulcer development. R1's Client Coordination Notes Report from hospice dated 2/11/26, identified HRN-A requested tasks be added for facility aides to reposition R1 every two hours. R1's Skin Issues progress note dated 2/11/26, identified left gluteus pressure ulcer acquired in-house, unknown how long the wound had been present. Measurement was 10.16 cm length by 1.27 cm width with intact surrounding tissue. No drainage, or odor present. R1's physician orders dated 2/11/26, identified pressure ulcer care to coccyx and deep tissue injury to right heel beginning 2/9/26. Blue pressure relieving boots to bilateral feet at all times beginning 2/9/26. During an interview on 5/19/26 at 3:13 p.m., registered nurse (RN)-A stated residents were at risk for pressure injuries if they laid in one position for extended periods or were unable to move by themselves. RN-A would not implement heel protectors unless a resident had boggy heels. If a resident had a pressure ulcer they should go on a more frequent turning and repositioning schedule such as every 2-3 hours. The NA's should just know by word of mouth to reposition residents every 2-3 hours if it was not in the care plan. R1 admitted to facility for therapy and planned to return to community when completed. Therapy was not progressing, and R1 initiated enrolling in hospice for personal reasons. R1 had started to decline around the time he started hospice and could not vocalize his needs as much. RN-A recalled working with R1 the weekend prior to 2/9/26, and R1 had stayed in bed most of the shift. RN-A thought R1 was on a 2–3-hour repositioning plan but was unable to locate when reviewing R1's care plan and Kardex. R1 should have been on a turning/repositioning schedule and heels offloaded prior to developing a deep tissue injury and pressure ulcer. During an interview on 5/20/26 at 8:58 a.m., RN-B stated the Braden Scale is used to determine specific things like a repositioning schedule, need for air mattresses, pressure reducing cushions for chairs. If a resident deteriorated RN-B would complete a Braden, update care plan, add	F0686		06/12/2026

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F0686 SS = D	Continued from page 5 interventions of heel protectors or float heels in bed, turn/reposition every two hours, toilet every 2-3 hours. NA's should automatically float all residents heels when they are in bed. RN-B reviewed R1's care plan, Kardex and Braden Scale; RN-B stated R1 was missing Braden Scale assessments as he should have had one weekly since admission and did not have a turn/reposition program in care plan or Kardex. During a phone interview on 5/20/26 at 12:54 p.m., HRN-A stated staff should reposition residents every two hours and elevate extremities in places with high risk of pressure injuries such as elbows, heels, coccyx. HRN-A recalled finding the deep tissue injury to R1's right heel on 2/9/26, "it was not mottling". The deep tissue injury could have been avoidable if R1's heels were elevated. R2 R2's face sheet dated 5/20/26, identified diagnoses of unspecified urinary incontinence, and atherosclerotic heart disease of native coronary artery without angina pectoris (plaque in the arteries). R2's annual Minimum Data Set (MDS) dated 3/26/26, identified R2 had some cognitive issues. R2 required substantial/maximum assistance with toileting and dressing lower body; moderate assistance for sit to stand. R2 was frequently incontinent of bladder and had occasional bowel incontinence. R2 was at risk of developing pressure injuries but did not currently have any. R2 had a pressure relieving device for chair and bed. R2's skin integrity care plan dated 10/6/25, identified R2 had potential for impaired skin integrity related to immobility, lower extremity edema, urinary incontinence and history of falls with skin issues. Interventions included to apply moisture barrier as needed, Braden Skin Risk Evaluation on admission, every week for four weeks, quarterly, and with any significant change, NA's to observe skin with morning and evening cares and report any abnormalities to the nurse, maintain good skin hygiene, moisture dry skin as needed, observe for alteration in skin integrity and report to physician, weekly licensed nurse skin inspection, pressure relieving mattress on bed and cushion in chair. R2's Braden Scale with Skin Risk Evaluation dated 3/11/26, identified a score of 16, which was a mild risk of developing pressure ulcers. Skin risk included chronic incontinence, cognitive impairment,	F0686		06/12/2026

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F0686 SS = D	Continued from page 6 history of refusal of care or treatment, edema, pale skin. R2 did not have unhealed pressure ulcers. Treatment included pressure reducing device for chair and bed, elevate edematous/affected extremities. R2's progress note dated 3/19/26, identified hospice nurse notified ADON of new skin issue of a stage 2 pressure wound to left buttock. Added NA tasks for turning and repositioning every two hours, encourage repositioning out of recliner, sit in other areas and lay in bed at night. R2's record did not identify any documentation of a comprehensive assessment that demonstrated how long R2 could tolerate pressure without increased risk of skin breakdown. R2's physician order dated 3/19/26, identified stage 2 pressure ulcer to left buttock. Cleanse wound with wound wash, apply Mepilex (bordered foam dressing) and change every three days and as needed. R2's Skin Evaluation dated 3/19/26, identified stage 2 pressure ulcer/injury to left gluteal fold acquired in-house. Measurements 1.0 cm by (x) 0.4 cm x 1.5 cm depth. No undermining or tunneling. R2's Skin Evaluation dated 3/25/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.8 cm x 1.2 cm x 0.4 cm depth. Partial-thickness skin loss with exposed dermis (middle layer of skin). R2's Skin Evaluation dated 4/8/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.8 cm x 1.2 cm x 0.4 cm. R2's Skin Evaluation dated 4/14/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.9 cm x 1.3 cm x 0.4 cm. R2's Skin Evaluation dated 4/22/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.7 cm x 1.5 cm x 0.2 cm. R2's Skin Evaluation dated 5/5/26, identified left gluteal cleft was healed. R2's Kardex dated 5/20/26, identified staff to monitor-turn and reposition-need to encourage to get out of recliner, sit in more areas, lay in bed at night. During an observation on 5/20/26 at 10:16 a.m., staff pointed out where R2 slept in the main living	F0686		06/12/2026

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F0686 SS = D	Continued from page 7 room area. R2 slept on a recliner chair that had a cloth pad on the seat for incontinence and a tie blanket hanging over the arm of the chair. R2 was not in the chair at the time. During an interview on 5/19/26 at 3:08 p.m., NA-A stated all residents are repositioned every 2-3 hours. Bedbound residents would also be repositioned every 2-3 hours. During an interview on 5/20/26 at 8:47 a.m., NA-B stated she would put barrier cream on all incontinent residents to protect their skin. Incontinent residents should be on a two-hour toileting schedule and if bedbound they should also have two-hour turn/reposition schedule. R2 rarely uses her bed to sleep in and prefers the recliner. R2 does not have a pressure relieving device for the recliner chair. During an interview on 5/20/26 at 8:58 a.m., RN-B stated R2 usually slept in the recliner in the front room and the NA's use a pillow to offload her position. RN-B would expect R2 to have a pressure-relieving device in her chair. During a phone interview on 5/20/26 at 12:54 p.m., HRN-A stated she was the nurse who cared for R2 and recommended good peri care and reposition every two hours after she developed her stage 2 pressure ulcer. Turning and repositioning is very important to prevent pressure ulcers from occurring. During an interview on 5/20/26 at 1:28 p.m., assistant director of nursing (ADON) stated the Braden Scale provides a score and tells the risk of skin based off the assessment. Braden Scales are completed on admission, quarterly, annually, or if ADON visually saw a decline in a resident such as not getting out of bed or if the resident was on hospice. Bed bound residents should be repositioned every 2-3 hours. The facility does not do tissue tolerance assessments on residents. Nurses complete weekly skin checks on residents with baths and if reddened skin was reported, ADON would readjust plan of care. Residents would be provided with heel boots if facility noticed they were in bed more, not able to reposition themselves, and not mobile. If staff were also seeing redness that was not blanchable (skin would turn white when pressure applied and return to original color) on heels the facility may put heel boots on the resident. R1 should have been reassessed with a Braden Scale when he began declining as a decline would show signs his skin was at risk. R1's pressure injuries probably would have been avoidable. R2 sleeps in a recliner most of the time and does not	F0686		06/12/2026

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F0686 SS = D	Continued from page 8 have a pressure relieving device in the recliner. Facility does not put pressure relieving devices in recliners because of the risk of residents sliding off them. R2 was on a toileting schedule but would also alert staff when she needed to use the bathroom although she would already be incontinent. During an interview on 5/20/26 at 2:21 p.m., director of nursing (DON) stated the facility does not do tissue tolerance on residents. Braden Scale should be done on admission, quarterly, if a new ulcer appears, or with a change of condition. Braden Scale would “kind of tell you” if a resident needed to be on a turning/repositioning schedule but if someone had a stage one or two pressure ulcer they would automatically be placed on a two-hour repositioning schedule. NA’s look at skin constantly and nurses observe skin weekly with baths and any skin issues would be identified through them. DON stated the facility did not have a policy for tissue tolerance or Braden Scales. The facility Wound Treatment Management dated 2/11/26, identified facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Treatment decisions will be based on: Etiology of the wound: Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. Surgical. Incidental (i.e. skin tear, medical adhesive related skin injury). Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis). Characteristics of the wound: Pressure injury stage (or level of tissue destruction if not a pressure injury). Size – including shape, depth, and presence of tunneling and/or undermining. Volume and characteristics of exudate.	F0686		06/12/2026

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 05/20/2026

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F0686 SS = D	Continued from page 9 Presence of pain. Presence of infection or need to address bacterial bioburden. Condition of the tissue in the wound bed. Condition of peri-wound skin. Location of the wound. Goals and preferences of the resident/representative. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: Lack of progression towards healing. Changes in the characteristics of the wound (see above). Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.	F0686		06/12/2026

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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 5/19/26, and 5/20/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54255982C (2739571) with a licensing order issued at 20900.	20000		06/12/2026

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

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20000	Continued from page 1 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		06/12/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition	20900	corrected	06/12/2026

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20900	Continued from page 2 demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess and evaluate care plan interventions for effectiveness, and develop individualized repositioning program to prevent pressure ulcer development and/or deterioration for 2 of 3 residents (R1, R2) reviewed for pressure ulcers. Findings include: Stage 2 pressure ulcer: partial-thickness loss of skin that presents as a shallow, open wound with a red or pink wound bed without exposure of fat or deeper tissues. Deep tissue injury: affects the deeper layers of tissue beneath the skin including muscles, subcutaneous fat, and sometimes bone which disrupt blood flow and oxygen delivery to the tissue. Braden Scale for Predicting Pressure Sore Risk is a standardized tool to assess the risk of developing pressure injuries. The scale evaluates six categories: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. Each category is scored from 1-4, except friction/shear which is scored 1-3. Scores are categorized as 19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, and 9 or less very high risk. R1 R1’s face sheet dated 5/19/26, identified diagnoses of unspecified fracture of lower end of left femur (upper leg bone), subsequent encounter for closed fracture with routine healing, hypertension, obesity, and chronic peripheral venous insufficiency (not enough blood flow to legs). R1’s hospital discharge after visit summary dated 1/9/26, identified a Braden Scale score of 15. R1’s facility Braden Scale with Skin Risk Evaluation dated 1/9/26, identified a score of 16. Skin	20900		06/12/2026

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20900	Continued from page 3 Evaluation Risk included: acute condition, decreased range of motion, cast/brace/splint, limited mobility/bedfast. No ulcers were present on admission. Treatments included pressure-reducing device for chair and bed. R1 was to have an immobilizer on left leg at all times. R1's care plan dated 1/13/26, identified R1 was incontinent of bowel and bladder. R1 was dependent on staff for toileting, staff to offer toileting on wake up, after meals, and at bedtime. R1's care plan dated 1/21/26, identified R1 had potential for impaired skin integrity related to immobility due to femur fracture and urinary incontinence. Interventions included to apply moisture barrier as needed, Braden Scale on admission, every week for four weeks, quarterly, and with any significant change, nursing assistants (NA) to observe skin with morning and evening cares and report any abnormalities to the nurse, maintain good skin hygiene, moisturize dry skin as needed, observe for alteration in skin integrity and report to physician, skin inspected weekly per schedule, pressure reducing mattress on bed and cushion in wheelchair. On 2/9/26, every two-hour repositioning and blue pressure relieving boots to feet at all times for pressure relief were added. Although R1's care plan called for repositioning every two hours, there was no documentation of a comprehensive assessment supporting that interval or demonstrating that R1 could tolerate pressure for two-hour periods without increased risk of skin breakdown. R1's Hospice Admission dated 2/3/26, identified R1 admitted to hospice services with decline in condition including 6.61% weight loss in the past 6 months, meal intake decline in the past 6 months typically only eating 0-25% of breakfast and nothing for lunch or supper, bedbound, incontinent of bladder, and sleeping 20-22 hours/day. R1's record identified R1 did not have a Braden Scale with Skin Risk Evaluation completed weekly between 1/9/26 and 2/4/26. R1's facility Braden Scale with Skin Risk Evaluation dated 2/5/26, indicated R1 had developed pressure ulcers since admission. The evaluation identified a score of 14 indicating R1 was at moderate risk for pressure ulcers (even though R1 had developed two pressure ulcers). Skin Evaluation Risk included: chronic incontinence, cognitive impairment, decreased range of motion, muscle wasting, pale	20900		06/12/2026

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20900	Continued from page 4 skin, cast/brace/splint, limited mobility/bedfast. R1 had one or more unhealed pressure ulcers/injuries, however did not identify how many ulcers R1 had or location. Treatment included pressure-reducing device for chair and bed, turning and repositioning program, pressure ulcer/injury care. Interventions included to elevate edematous (fluid retention)/affected extremities. Review of R1's record did not include a comprehensive assessment of the pressure ulcers that were noted on the Braden Scale Evaluation dated 2/5/26. Although R1's record identified developed pressure areas there was no indication the care plan interventions were evaluated for effectiveness, there was no change identified in the reposition program, and no new additional interventions were developed or implemented to prevent deterioration or new ulcer development. R1's progress note dated 2/7/26, identified R1 refused supper, was incontinent of urine once, and had a bed bath with no new skin issues identified. R1's progress note dated 2/9/26, identified R1 had been in bed all day and not been eating. Hospice registered nurse (HRN)-A and family was present. A deep tissue injury was noted on right heel. The area was closed, discolored and non-blanchable (redness or discoloration on skin does not turn white when gentle pressure applied). Pressure relieving boots applied and an air alternating mattress was ordered. A reddened line that measured 8 centimeters (cm) across R1's lower buttock was blanchable (turns white with gentle pressure applied) and appeared to have been caused by edge of R1's brief being rolled down. A small stage 2 pressure ulcer was noted on R1's coccyx in a "V" shape. HRN-A was increasing visits to daily due to R1's declining condition. R1's Client Coordination Notes Report from hospice dated 2/9/26, identified R1 was in bed upon visit arrival, minimally responsive with Cheyne-Stokes (abnormal breathing pattern) and 40 second apnea (no breathing). No mottling (blotchy, red, purple, bluish discoloration of skin) noted. Suspected deep tissue injury noted to right heel, HRN-A notified assistant director of nursing (ADON) and director of nursing (DON). Stage 2 pressure sore noted to coccyx, non-blanchable areas noted to upper right and left buttocks. Incontinence brief had been soiled with urine. R1 positioned on left side. Reviewed positioning frequency, floating heels, and pressure injury prevention with nurse and nursing assistant. R1's Client Coordination Notes Report from hospice	20900		06/12/2026

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20900	Continued from page 5 dated 2/10/26, identified family was present and stated R1 had been repositioned every two hours and that R1 tolerated that well. Light mottling noted to lower extremities. Review of R1's record between 2/5/26 through 2/10/26 revealed no indication of a comprehensive pressure ulcer assessment was completed that would identify measurements, drainage, and pain. Further not evident of a comprehensive analysis that determined causal factors of pressure ulcer development so that appropriate interventions could be developed and implemented that would negate the risk of deterioration and/or new ulcer development. R1's Client Coordination Notes Report from hospice dated 2/11/26, identified HRN-A requested tasks be added for facility aides to reposition R1 every two hours. R1's Skin Issues progress note dated 2/11/26, identified left gluteus pressure ulcer acquired in-house, unknown how long the wound had been present. Measurement was 10.16 cm length by 1.27 cm width with intact surrounding tissue. No drainage, or odor present. R1's physician orders dated 2/11/26, identified pressure ulcer care to coccyx and deep tissue injury to right heel beginning 2/9/26. Blue pressure relieving boots to bilateral feet at all times beginning 2/9/26. During an interview on 5/19/26 at 3:13 p.m., registered nurse (RN)-A stated residents were at risk for pressure injuries if they laid in one position for extended periods or were unable to move by themselves. RN-A would not implement heel protectors unless a resident had boggy heels. If a resident had a pressure ulcer they should go on a more frequent turning and repositioning schedule such as every 2-3 hours. The NA's should just know by word of mouth to reposition residents every 2-3 hours if it was not in the care plan. R1 admitted to facility for therapy and planned to return to community when completed. Therapy was not progressing, and R1 initiated enrolling in hospice for personal reasons. R1 had started to decline around the time he started hospice and could not vocalize his needs as much. RN-A recalled working with R1 the weekend prior to 2/9/26, and R1 had stayed in bed most of the shift. RN-A thought R1 was on a 2–3-hour repositioning plan but was unable to locate when reviewing R1's care plan and Kardex. R1 should have been on a turning/repositioning	20900		06/12/2026

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20900	Continued from page 6 schedule and heels offloaded prior to developing a deep tissue injury and pressure ulcer. During an interview on 5/20/26 at 8:58 a.m., RN-B stated the Braden Scale is used to determine specific things like a repositioning schedule, need for air mattresses, pressure reducing cushions for chairs. If a resident deteriorated RN-B would complete a Braden, update care plan, add interventions of heel protectors or float heels in bed, turn/reposition every two hours, toilet every 2-3 hours. NA's should automatically float all residents heels when they are in bed. RN-B reviewed R1's care plan, Kardex and Braden Scale; RN-B stated R1 was missing Braden Scale assessments as he should have had one weekly since admission and did not have a turn/reposition program in care plan or Kardex. During a phone interview on 5/20/26 at 12:54 p.m., HRN-A stated staff should reposition residents every two hours and elevate extremities in places with high risk of pressure injuries such as elbows, heels, coccyx. HRN-A recalled finding the deep tissue injury to R1's right heel on 2/9/26, "it was not mottling". The deep tissue injury could have been avoidable if R1's heels were elevated. R2 R2's face sheet dated 5/20/26, identified diagnoses of unspecified urinary incontinence, and atherosclerotic heart disease of native coronary artery without angina pectoris (plaque in the arteries). R2's annual Minimum Data Set (MDS) dated 3/26/26, identified R2 had some cognitive issues. R2 required substantial/maximum assistance with toileting and dressing lower body; moderate assistance for sit to stand. R2 was frequently incontinent of bladder and had occasional bowel incontinence. R2 was at risk of developing pressure injuries but did not currently have any. R2 had a pressure relieving device for chair and bed. R2's skin integrity care plan dated 10/6/25, identified R2 had potential for impaired skin integrity related to immobility, lower extremity edema, urinary incontinence and history of falls with skin issues. Interventions included to apply moisture barrier as needed, Braden Skin Risk Evaluation on admission, every week for four weeks, quarterly, and with any significant change, NA's to observe skin with morning and evening cares and report any abnormalities to the nurse, maintain good skin	20900		06/12/2026

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20900	Continued from page 7 hygiene, moisture dry skin as needed, observe for alteration in skin integrity and report to physician, weekly licensed nurse skin inspection, pressure relieving mattress on bed and cushion in chair. R2's Braden Scale with Skin Risk Evaluation dated 3/11/26, identified a score of 16, which was a mild risk of developing pressure ulcers. Skin risk included chronic incontinence, cognitive impairment, history of refusal of care or treatment, edema, pale skin. R2 did not have unhealed pressure ulcers. Treatment included pressure reducing device for chair and bed, elevate edematous/affected extremities. R2's progress note dated 3/19/26, identified hospice nurse notified ADON of new skin issue of a stage 2 pressure wound to left buttock. Added NA tasks for turning and repositioning every two hours, encourage repositioning out of recliner, sit in other areas and lay in bed at night. R2's record did not identify any documentation of a comprehensive assessment that demonstrated how long R2 could tolerate pressure without increased risk of skin breakdown. R2's physician order dated 3/19/26, identified stage 2 pressure ulcer to left buttock. Cleanse wound with wound wash, apply Mepilex (bordered foam dressing) and change every three days and as needed. R2's Skin Evaluation dated 3/19/26, identified stage 2 pressure ulcer/injury to left gluteal fold acquired in-house. Measurements 1.0 cm by (x) 0.4 cm x 1.5 cm depth. No undermining or tunneling. R2's Skin Evaluation dated 3/25/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.8 cm x 1.2 cm x 0.4 cm depth. Partial-thickness skin loss with exposed dermis (middle layer of skin). R2's Skin Evaluation dated 4/8/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.8 cm x 1.2 cm x 0.4 cm. R2's Skin Evaluation dated 4/14/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.9 cm x 1.3 cm x 0.4 cm. R2's Skin Evaluation dated 4/22/26, identified stage 2 pressure ulcer/injury to left gluteal fold. Measurements were 1.7 cm x 1.5 cm x 0.2 cm. R2's Skin Evaluation dated 5/5/26, identified left	20900		06/12/2026

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20900	Continued from page 8 gluteal cleft was healed. R2's Kardex dated 5/20/26, identified staff to monitor-turn and reposition-need to encourage to get out of recliner, sit in more areas, lay in bed at night. During an observation on 5/20/26 at 10:16 a.m., staff pointed out where R2 slept in the main living room area. R2 slept on a recliner chair that had a cloth pad on the seat for incontinence and a tie blanket hanging over the arm of the chair. R2 was not in the chair at the time. During an interview on 5/19/26 at 3:08 p.m., NA-A stated all residents are repositioned every 2-3 hours. Bedbound residents would also be repositioned every 2-3 hours. During an interview on 5/20/26 at 8:47 a.m., NA-B stated she would put barrier cream on all incontinent residents to protect their skin. Incontinent residents should be on a two-hour toileting schedule and if bedbound they should also have two-hour turn/reposition schedule. R2 rarely uses her bed to sleep in and prefers the recliner. R2 does not have a pressure relieving device for the recliner chair. During an interview on 5/20/26 at 8:58 a.m., RN-B stated R2 usually slept in the recliner in the front room and the NA's use a pillow to offload her position. RN-B would expect R2 to have a pressure-relieving device in her chair. During a phone interview on 5/20/26 at 12:54 p.m., HRN-A stated she was the nurse who cared for R2 and recommended good peri care and reposition every two hours after she developed her stage 2 pressure ulcer. Turning and repositioning is very important to prevent pressure ulcers from occurring. During an interview on 5/20/26 at 1:28 p.m., assistant director of nursing (ADON) stated the Braden Scale provides a score and tells the risk of skin based off the assessment. Braden Scales are completed on admission, quarterly, annually, or if ADON visually saw a decline in a resident such as not getting out of bed or if the resident was on hospice. Bed bound residents should be repositioned every 2-3 hours. The facility does not do tissue tolerance assessments on residents. Nurses complete weekly skin checks on residents with baths and if reddened skin was reported, ADON would readjust plan of care. Residents would be provided with heel boots if facility noticed they were in bed more, not able to reposition themselves, and	20900		06/12/2026

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Thorne Crest Retirement Center	**1201 GARFIELD AVENUE , ALBERT LEA, Minnesota, 56007**

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20900	Continued from page 9 not mobile. If staff were also seeing redness that was not blanchable (skin would turn white when pressure applied and return to original color) on heels the facility may put heel boots on the resident. R1 should have been reassessed with a Braden Scale when he began declining as a decline would show signs his skin was at risk. R1's pressure injuries probably would have been avoidable. R2 sleeps in a recliner most of the time and does not have a pressure relieving device in the recliner. Facility does not put pressure relieving devices in recliners because of the risk of residents sliding off them. R2 was on a toileting schedule but would also alert staff when she needed to use the bathroom although she would already be incontinent. During an interview on 5/20/26 at 2:21 p.m., director of nursing (DON) stated the facility does not do tissue tolerance on residents. Braden Scale should be done on admission, quarterly, if a new ulcer appears, or with a change of condition. Braden Scale would "kind of tell you" if a resident needed to be on a turning/repositioning schedule but if someone had a stage one or two pressure ulcer they would automatically be placed on a two-hour repositioning schedule. NA's look at skin constantly and nurses observe skin weekly with baths and any skin issues would be identified through them. DON stated the facility did not have a policy for tissue tolerance or Braden Scales. The facility Wound Treatment Management dated 2/11/26, identified facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Treatment decisions will be based on: Etiology of the wound: Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. Surgical. Incidental (i.e. skin tear, medical adhesive related skin injury). Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis). Characteristics of the wound:	20900		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20900	Continued from page 10 Pressure injury stage (or level of tissue destruction if not a pressure injury). Size – including shape, depth, and presence of tunneling and/or undermining. Volume and characteristics of exudate. Presence of pain. Presence of infection or need to address bacterial bioburden. Condition of the tissue in the wound bed. Condition of peri-wound skin. Location of the wound. Goals and preferences of the resident/representative. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: Lack of progression towards healing. Changes in the characteristics of the wound (see above). Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights. SUGGESTED METHOD OF CORRECTION: the DON or designee could create/review/revise policies and procedures related to pressure ulcer prevention. The DON or designee could educate staff on how to prevent pressure ulcers and identify residents at-risk of developing pressure ulcers. The DON or designee could review at-risk residents plan of care and update as needed. The DON or designee could audit at-risk residents to ensure pressure ulcers do not develop. The DON or designee could take review the findings with Quality Assurance Performance Improvement committee. TIME PERIOD FOR CORRECTION twenty-one (21) days.	20900		06/12/2026