Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2024

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

RE: CCN: 245425
Cycle Start Date: October 15, 2024

Dear Administrator:

On October 28, 2024, we notified you a remedy was imposed. On November 13, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 8, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 12, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 28, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 15, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 28, 2024

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

RE: CCN: 245425
Cycle Start Date: October 15, 2024

Dear Administrator:

On October 15, 2024, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 13, 2024, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 12, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 12, 2024 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 12, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy

must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 15, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Thorne Crest Retirement Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 15, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245425	A. BUILDING ______ B. WING ______	C 10/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 10/10/24, 10/11/24, 10/13/24, and 10/15/24 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F600 began on 10/6/24 when facility failed to immediately implement appropriate interventions to protect female residents from sexual abuse from R1. The administrator, director of nursing (DON) and assistant director of nursing (ADON) were notified of the IJ on 10/11/24 at 4:43 p.m. The IJ was removed on 10/13/24 at 9:11 a.m.

The above findings constituted Substandard Quality of Care and an extended survey was conducted on 10/15/24.

The following complaints were reviewed: H54259386 (MN00107282) with a deficiency cited at F600 and incidental finding at F609.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 11/04/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to immediately implement appropriate interventions to protect residents from sexual abuse from R1 who had sexual behaviors that were inflicted on 6 residents (R2, R3, R4, R6, R7, R9) in the facility which resulted in a potential risk of serious harm identifying immediate jeopardy. The IJ began on 10/6/24, when facility failed to implement protection measures after staff observed R1 inappropriately touching R2's breast/chest area on 10/6/24. The administrator, director (DON) and assistant director of nursing (ADON) were notified of the IJ on 10/11/24 at	F 600	Affected Resident(s): R1s care plan was reviewed and updated to include 1:1 supervision during waking hours and baby monitor monitoring to alert staff when he arises. POA was notified and agrees to the monitoring plan. R1s medications were adjusted and reviewed by the practitioners as scheduled on 10/17/2024 no changes in medication were made at that time, subsequently on 10/24/2024 the MD discontinued the medication as recommended by the pharmacist.	11/8/24

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F 600	Continued From page 2 4:43 p.m. The immediate jeopardy was removed on 10/13/24 at 9.11 a.m. but noncompliance remained at the lower scope and severity level 2 E - pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of facility reported incident dated 10/7/24 at 3:05 p.m., indicated on 10/6/24 around 11:50 a.m., nursing assistant (NA-A) walked out to the day room and saw R1 had his right hand under R2's shirt and appeared to be doing a rubbing/grabbing in a circular motion on R2's chest area. NA-A ran over to R1, grabbed his hand, and said "no". NA-A stayed with R1 and R2 and called for licensed practical nurse (LPN-A) to come right away to the day room. LPN-A removed R2 to behind the nurse' station and NA-A took R1 to his room. R1's face sheet included diagnoses of dementia without behavioral disturbance, memory deficit following a cerebrovascular disease, epilepsy (seizure disorder) and hearing loss. R1 was admitted to facility on 6/11/24 from another skilled facility. R1's quarterly Minimum Data Set (MDS) dated 9/12/24, indicated moderately impaired cognition, poor decisions, required cues and supervision, with signs and symptoms of delirium without inattention, disorganized thinking or altered level of consciousness. R1 used a walker and a wheelchair with maximal assistance from staff for dressing, transfers, and bed mobility. R1 had no delusions or hallucinations, no behaviors,	F 600	Potential Affected Resident(s): All female residents have the potential to be affected by R1s behavior. Measures/Systematic Changes: " The Abuse Prevention Policy was reviewed and updated on 10.11.24 to include types of abuse including sexual abuse and the requirement to report any incidents or allegations immediately. " Resident R1s care plan was reviewed and modified to include the 1:1 during waking hours as well as the use of a baby monitor for monitoring when he arises from his bed. POA is in agreement to the use of the baby monitor. " The admission checklist was revised to include the check of the sexual offender registry. " Education was provided to all staff prior to the start of their shift, any new staff, agency staff or staff off on leave of absence will be educated prior to the start of their work shift regarding the Abuse Prevention Policy, signs of sexual abuse, how to manage R1 if he demonstrates any inappropriate behavior and R1s care plan, in addition all staff after receiving the education are completing a sexual abuse quiz to ensure comprehension of the required education. Starting on 11/8/2024, all Nursing staff will be educated prior to their next workday on updating of MD on new or increased behaviors in addition to completion of clinical documentation on new and/or increased behaviors in the medical record for the resident, any vulnerable adults and any residents who are the initiator of	

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F 600

Continued From page 3
wandering or rejection of cares noted.

During an interview on 10/15/24 at 2:32 p.m., family member (FM)-B stated R1's wife would complain about R1 being touchy, towards the end of her life. R1 had problems with inappropriately touching female residents at previous facility and was why R1 was moved to this facility. FM-B was hopeful that the move would resolve the problem.

R1's progress note dated 6/10/24 at 2:21 p.m., R1 was admitted to facility. The note did not identify history of behaviors.

R1's physician visit note dated 6/13/24, indicated new admit from a previous facility with behavioral issues and was having problems swallowing his medications whole. R1's Depakote (antiseizure medication also used for behaviors) and Paroxetine (antidepressant) were discontinued. The note indicated R1 had normal behavior, mood, and affect.

R1's physician visit dated 6/21/24, noted R1 had lots of behavioral problems, specially making sexual advances towards women at previous facility and continued at this facility. This behavior was a source of concern and embarrassment for family, and they asked for a medication to decrease R1's libido. MD-A re-started low dose of paroxetine to help with behaviors. Nurses to continue with respiratory and behavior monitoring. In review of R1's record, there was no documentation of any behaviors that were referenced in the physician note.

R1's progress note dated 6/22/24 at 12:59 p.m., indicated staff reported to nurse, with "wake up" cares R1 was "grabby" with the staff and

F 600

resident-to-resident altercations. A checklist was created for nurses to follow to ensure that all steps necessary are completed.
" The Administrator, Directors of Nursing, Director of Medical Records and the Social Worker who participate in the admission process were educated regarding the admission checklist for sexual offender registry on 10/11/2024 by the Corporate Nurse .
" All current residents were reviewed on the sexual offender registry on 10/11/2024, no residents were found on the registry including resident R1. All residents prior to admission are checked on the registry.
" On 10/14/2024 the residents identified as potentially affected by R1s behavior had a trauma informed care assessment completed and their care plans adjusted as necessary by the Director of Social Services.

On 11/8/2024 the Administrator and Social Services Director, verified every resident with behavior had a target behavior, that the target behavior is addressed in the care plan, is included on the Kardex and the MAR.

During the morning meeting Monday through Friday new behaviors and behaviors documented in the progress notes will be reviewed during the IDT meeting.

Monitoring:
The Administrator or Designee is

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F 600	Continued From page 4 attempting to touch staff buttocks. Staff kindly removed R1's hands and reminded R1 to keep to himself. Note further indicated after lunch time another staff reported R1 was sitting at in the dining room with residents that needed staff assistance to eat when R1 went up to the resident from [room x-unidentified resident]. and put both his hands on her shoulders. Staff intervened and reminded R1 to keep his hands to himself. R1's progress note dated 7/3/24 at 9:50 a.m., care conference held and indicated the Paxil started on 6/21/24 had been helpful with R1's behaviors. R1's behavior care plan initiated on 7/18/24, included "Problematic manner in which resident acts characterized by inappropriate sexual behavior (verbal and physical) related to R1 makes inappropriate remarks, resident touches other female residents and/or staff inappropriately" The care plan directed the following: -Avoid type of conversation that could encourage or initiate inappropriate behavior, dated, 7/18/24; -Constant supervision in recreation programs, dated 7/18/24; -distract R1 if possible, dated 7/18/24; -document a summary of each episode, dated 7/18/24; -Remove R1 from the public area when behavior was disruptive/unacceptable. Talk with R1 in low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity, date 7/18/24. R1's progress note dated 7/23/24 at 10:49 p.m., indicated R1 went into other resident's rooms,	F 600	responsible for compliance. An Audit is being conducted to ensure that every admission is checked prior to admission on the Sexual offender registry. This will be audited for 12 weeks with compliance results reported to the Quality Assurance meeting monthly. In addition, the Director of Social services will interview 5 residents a week and 3 staff a week for any concern regarding abuse by staff or other residents. The results will be logged in an audit form for 12 weeks. During the Monthly Behavior-Psych Pharm meeting review of target behaviors will be completed and adjusted or updated as deemed necessary by the IDT. An Audit will be completed daily Monday through Friday during the morning meeting to review 5 residents with Target behaviors that the required target behavior documentation is being completed for 3 weeks, then it will be completed Monday, Wednesday and Friday for three weeks, then it will be completed Monday and Thursday for 3 weeks, and then every Wednesday for three weeks. The results will be reported at the monthly Quality Assurance Meeting with ongoing frequency and duration to be determined through analysis and review of results. The results of the audits will be reported to the facility Quality Assurance meeting monthly with ongoing frequency and duration to be determined through analysis and review of results.	

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	245425	A. BUILDING ______ B. WING ______	C 10/15/2024

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especially [room x-unidentified resident]. R1 was removed and easily redirected. No further occurrences from R1.

R1's progress note dated 7/24/24 at 5:25 p.m., indicated R1 was noted to enter other residents' rooms on 7/23/24, no physical contact was made. R1 has history of inappropriate behaviors. Care conference scheduled for 8/2/24 with FM-B and MD-A to review plan of care and current medications to see what else can be done to manage R1's behaviors. R1 put on 15-minute checks to ensure R1 has no behaviors towards other residents.

R1's behavioral care plan was revised on 7/24/24, included 15-minute checks to protect other residents from R1's behavior and entering other residents' rooms, dated 7/24/24.

During an interview on 10/10/24 at 4:39 p.m., social worker (SW-A), indicated R1 had inappropriate sexual behaviors at previous facility when he was admitted to Thorncrest. SW-A stated no preventative or protection interventions were put into place until 15-minute checks were implemented on 7/24/24, when R1 had inappropriate interactions with R3.

R1's progress note dated 7/30/24 at 10:44 p.m., staff member mentioned they overheard R1 in living room state to visitors "I'd like to borrow your keys to take R3 out on a date." After super R1 was noted to be moving self-closer to R3. R1 was redirected and moved away female residents. No further concerns noted or reported, will continue to monitor.

R1's progress note dated 8/1/24 4:43 p.m., writer

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noted R1 sitting right in front of R3, who R1 has bothered in the past. R3 looked uncomfortable as R1 was directly in front of R3's wheelchair. Writer took female resident aside. R3 informed writer R1 was not doing or saying anything but would prefer R1 not sitting by her. Writer informed nurse and nurse aide working to monitor. R3's record included a progress note dated 8/1/24, that identified the aforementioned encounter.

R3's quarterly MDS dated 8/15/24, indicated R3 did not have cognitive impairment. R3 had diagnoses of end stage renal disease and diabetes. R3 required moderate assistance with ADLs, wheelchair use and did not walk.

R3's progress note dated 6/15/24, identified staff reported R3 initiated hand holding with R1 and R3 told staff she was old friends with R1, R1's record did not identify this encounter.

R3's record included a progress note dated 7/19/24, identified activity aide (AA)-A overheard R1 asking R3 for a kiss in the dayroom but R3 denied R1 and R1 moved to a different area of the dayroom, R1 record did not identify this encounter.

During an interview on 10/11/24 at 9:44 a.m., R3 was sitting in her wheelchair in her room watching TV. R3 stated she knew R1 from the past. R1 on several occasions would roll up to her in his wheelchair, reach over and hold her hand. R3 was okay with this until R1 rolled into her room and told her "You and me" and pointed to her bed. R3 put on call light and staff came to remove R1 from R3's room. R3 recalled another incident where R1 was holding her hand and tried to move her had to his private area (penis). R3 stated that

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made her very uncomfortable. Staff saw what R1 was doing so they removed him from her personal space. Staff have told both R1 and R3 they needed to stay 4 feet away from each other. R3 was not able to remember the dates of either incidents. R3 did not want to ever be close to R1 as she felt he was inappropriate with his actions. In review of R1's and R3's records it did not address these encounters as R3 described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.

During an interview on 10/11/24 at 10:19 a.m., NA-C stated she thought R1 behaviors started a couple of months ago, not sure on date but was able to remember when R1 was admitted, it was mentioned that he had sexual inappropriate touching at previous facility. NA-C stated R1 and R3 needed to be kept separated and R1 was on 15-minute checks since his behaviors had started. NA-C did not think the 15 minute checks were adequate; R1 was independent with wheelchair mobility.

During an interview on 10/11/24 at 9:22 a.m., LPN-B stated she did the admission for R1 when he first came to facility in June of 2024. R1's record from the previous facility included notes about R1 sexually touching female residents inappropriately. After R1 was admitted here he started holding hands with R3 and going into R3's room. R3 did not like this, so staff were to try to keep an eye on him and do 15-minute checks. LPN-B did not think the 15- minute checks were adequate because R1 was independent in his wheelchair and he was quick.

During and interview on 10/11/24 at 12:41 p.m.

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R5 who was a male resident reported he was familiar with R1. One day he witnessed R1 rolling up behind a female resident and put his hands right up her shirt. R5 could not recall if there had been staff in the vicinity at the time nor remember if he had reported the incident to staff. R5 could not recall the female residents name she had discharged and could not remember the date but "That is something you will never forget!" R5's quarterly MDS dated 10/3/24, identified R5 had moderate cognitive impairment.

R1's progress note dated 9/26/24 at 2:09 p.m., indicated R1 followed a resident into their room. R1 was removed and redirected. The note did not identify if R1 had been directly observed going into the room.

R1's progress note dated 10/4/24 at 11:17 a.m., indicated R1 was attempting to hold a female resident's hand while she was sleeping. Nurse intervened and separated residents. The note did not identify which female resident, location of this interaction nor the duration.

R1's progress note dated 10/5/24 at 11:32 a.m., R1 wandered into a resident's room. Was easily redirected. The note did not identify if R1 was directly observed going into resident's room and what R1 was doing or where R1 was in the room when he was redirected.

An undated and untimed facility video recording that was approximately two minutes long was reviewed. At the start of the video a total of 14 residents sat in a semi-circle facing the same direction in front of the nursing station. R1 sat in his wheelchair next to R2's left side. R1 was holding onto R2's right lower arm while R2 had

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her head resting on her left hand with her eyes closed. Housekeeper (HSK-A) can be seen riding a floor cleaning machine directly behind the residents; he made several passes and did not look towards R1 and R2. At 42 seconds, R1 looked toward R2 and moved his hand up her arm towards R2's chest. HSK-A came back into the picture and did not look toward R1 or R2. At 54 seconds, R1 moved his right hand around R2's chest area and held R2's right hand with his left hand. At one minute marker, R1's right hand went under R2's shirt. At 1 minute 15 seconds, a staff member walked directly behind R1 and R2, she did not turn her head to see R1's hand was up R2's shirt; the staff continued to walk by without intervention. At one minute 18 seconds, licensed practical nurse (LPN)-A brought a resident into the commons area by the medication cart and left without looking toward R1 and R2. R1 continued to move his right hand around under R2 shirt while holding R2's right lower arm with his left hand. At one minute 30 seconds, R1 placed R2's right hand on his right thigh as he continued to move his right hand under R2's shirt as HSK-A went by again in the floor cleaning machine. At 1 minute 35 seconds, R2 leaned back in her wheelchair and lifted her head up. At one minute 45 seconds, a female staff person in blue and white returns and as she went by looked at R1 and R2 and stopped, turned around and told R1 "No" in a stern voice and removed his hand from under R2's shirt. Staff person pulled down R2's shirt and called out for LPN-A to come right away at one minute 54 seconds. The video concludes when LPN-A entered the room.

R1's progress note dated 10/7/24 at 11:39 a.m., indicated R1 was caught with his hands up a

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F 600	Continued From page 10 female resident (R2) shirt in the day room on 10/6/24 at 11:50 a.m. It was reported R1's right hand was under R2's shirt and R1 was rubbing, grabbing, and making circular motions on R2 chest area. Staff immediately intervened by removing R1 back to his room. R1 was not allowed to sit next to other female residents in the day room or dining room, this will continue to prevent another inappropriate interaction. NP-A was consulted on medications and order received to increase Paxil to 20 mg daily and to follow up with physician assistant (PA) on 10/17/24 for effectiveness. R1's care plan was not revised to identify the intervention for R1 to not allowed to sit next to female residents in the dinning room and the day room. Additionally, R1's record did not identify a comprehensive assessment that would identify the level of supervision R1 required, no changes were made to duration in which R1 was "checked" on. R2's quarterly MDS dated 9/17/24, indicated R2 had severe cognitive impairment, required moderate assistance with her activities of daily living (ADLs). R2's diagnoses included cancer, heart failure, and depression. R2's care plan dated 10/10/24 did not address her vulnerabilities. Review of R2's progress note dated 10/7/24 at 12:01 p.m., addressed the incident in which R1 inappropriately touched R2 on 10/6/24 at 11:50 a.m. LPN-A was notified and took R2 behind the nurses' station for observation. R2 did not appear to be disturbed or upset by this happening. No marks noted on skin.	F 600		

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During an interview on 10/10/24 at 2:29 p.m., R2 was not able to articulate the correct date or year, however was aware she was in Albert Lea, Minnesota. R2 denied anyone touched her inappropriately.

During an interview on 10/15/24 at 2:49 p.m., NA-L stated she would feel embarrassed, feel very violated and affect her dignity if someone were to come up to her and start feeling their chest area.

During an interview on 10/15/24 at 3:05 p.m., ADON stated would feel violated if someone were to come up to her and start feeling their chest area.

During an interview on 10/15/24 at 3:08 p.m. NA-C stated she would feel very upset, violated, and fearful if someone were to come up to her and start feeling their chest area.

During an interview on 10/11/24 at 9:15 a.m., a white board was used to communicate with R1. R1 articulated the month, the year, and the town he lived in. R1 denied inappropriately touching female residents, stating "bullshit", when asked. R1 denied any problems with the staff or other residents.

During an interview on 10/11/24 at 9:01 a.m., HSK-A stated his job was to take care of the floors. He had not been told to monitor or keep an eye on any specific resident.

During an interviews on 10/10/24 at 4:15 p.m. and 10/11/24 at 10:03 a.m., NA-A stated when R1 was first admitted to the facility she was not

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F 600	Continued From page 12 informed R1 had sexually inappropriate behaviors prior to admission to the facility, she was told to just watch if he tried to touch female residents but not why. She later became aware NA-A explained R1 went into other resident's rooms about three times per week, usually happened around mealtimes when staff were not available to make sure he would go back to his room after he ate. NA-A stated she had witnessed the incident between R1 and R2 on 10/6/24 around 11:50 a.m. NA-A was walking back to her unit by the dayroom, when she saw R1's right hand under R2's shirt and seemed to be grabbing and rubbing at R2's chest area. NA-A ran over to the residents and removed R1's hand from under R2's shirt and told R1 "No" and then yelled for LPN-A to come to day room. LPN-A removed R2, and NA-A took R1 to his room. NA-A did not know how long R1's hand had been under R2's shirt as was not working that unit. NA-A stated she was aware R1 had history of sexually inappropriate behaviors including inappropriately touching female residents. NA-A was aware R1 had demonstrated sexually inappropriate behaviors toward three other female residents R3, R4, and R6. NA-A explained she went into R3 and R6's room, R6 was in the bathroom on the toilet with the door open, R1 was sitting in his wheelchair watching R6 while she was in the bathroom. NA-A recalled another time where she had seen R1 holding R4's hand in the day room, however could not remember the date. NA-A stated the 15 minute check intervention had been in place for a couple of months, additional interventions were to redirect R1 back to his room and make sure he was not at a table with female residents. NA-A stated she did report the incidents with R3, R4, R6 to her nurse but because she worked with multiple nurses she could not recall which nurse	F 600		

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she had reported to. In review of R1's, R4's, and R6's records it did not address these encounters as NA-A described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.

R4's significant change MDS dated 9/26/24, indicated R4 had moderate cognitive impairment and had diagnoses of dementia and anxiety. R4 required moderate to maximal assist with ADL's. R6's quarterly MDS dated 8/3/24, indicated R6 did not have cognitive impairment with diagnoses of cancer, end stage renal disease, stroke, traumatic brain injury and depression. R6 required moderate to maximal assist with ADLs.

During an interview on 10/10/24 at 3:17 p.m., LPN-A stated on 10/6/24 she heard NA-A yell for her to come to the day room. NA-A informed her what happened, and LPN-A removed R2 from the area to behind the nurses' station and called the assistant director of nursing (ADON). LPN-A stated R1 was not to sit by any female residents in the dining room, R1 was to sit at table with all men. LPN-A reported R1 had also touched R3 inappropriately. LPN-A also remembered another incident where R9 told her R1 wheeled himself up to R9 as she was sitting by the medication cart in the day room and R1 attempted to hold her hand but R9 was able to move herself away from R1. LPN-A did not document the incident, could not remember the date of the incident, and did not report the incident and did not document the incident.

During an interview on 10/11/24 at 12:40 p.m., RN-A stated she had witnessed R1 wheel over to R4 when she slept in her wheelchair in the day room. R1 reached over, held her hand and

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F 600	Continued From page 14 rubbed it. RN-A took R1 to his room. RN-A explained in another incident R9 had told her R1 was trying to hold her hand while R9 was waiting at the medication cart but R9 was able to move herself away. RN-A reviewed R1's record and reported the incidents were not documented. During a subsequent interview on 10/15/24 at 12:11 p.m. RN-A stated she did not report these incidents to her supervisors because she thought it was harmless hand holding and did not know of R1's history of inappropriate sexual behaviors. RN-A could not remember specific dates of either incident but recalled they both had been within the last month. R9's admission MDS dated 7/31/24, indicated R9 had severe cognitive impairment with diagnoses of cancer and stroke. During an observation on 10/11/24 at 8:18 a.m., R1 sat next to R5 at a dinning room table. A female resident (R7) was brought into the dining room by NA-B and placed across from R1 and next to R5. At 8:40 a.m. R5 left the table leaving R1 alone with R7; R1 rolled his wheelchair to sit next to R7. No staff intervened. At 8:50 a.m. R1 self propelled his wheelchair out of the dining room to the dayroom where he stopped and sat 5 feet from a female resident. No staff were present in the day room, which was not in accordance to the care plan. At 8:55 a.m. an unknown staff member moved R1 away from the female resident, and returned to the nurses station. At 8:58, R1 propelled his wheelchair down the hallway to his room without staff assistance. R7's quarterly MDS dated 9/19/24, indicated R7 had moderate cognitive impairment with diagnoses of dementia. R7 required moderate to	F 600		

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maximal assist of one staff with ADL's and used a wheelchair.

During an interview on 10/11/24 at 9:30 a.m., NA-B stated she did not know R1 was to not have female residents at his table.

During an interview on 10/11/24 at 12:21 a.m., cook-A explained there was not assigned seating in the dining room but residents usually sat in the same places during meal times. Cook-A had been informed earlier in the week R1 was not to have any females at his table. Cook-A was in the kitchen during breakfast and did not identify R1 had been sitting next to R7 at the table, but should have caught it.

During an observation on 10/11/24 at 12:45 p.m., R1 sat in his wheelchair in the common area. R4 sat on the couch. R1 moved himself towards the couch where R4 was sitting however, RN-A intervened by taking R1 to his room.

During an interview on 10/10/24 at 2:45 p.m., NA-K stated R1 was on 15-minute checks because R1 self-transferred and R1 liked to grope female residents in inappropriate ways. R1 had touched another female resident (R3) inappropriately in the past and that was when the 15-minute checks started. NA-K stated staff were supposed to keep R1 away from female residents and redirect him. NA-K did not think the 15 minute checks were adequate.

During an interview on 10/10/24 at 3:08 p.m., RN-E stated when R1 was admitted from another facility where he had been "handsy" with female residents and was asked to move out. When he was admitted here staff found out R1 knew R3.

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R1 would go up to R3 and put his hand on her thigh, that's when the 15-minute checks were implemented. RN-E indicated the incident happened in either June or July, but could not recall the exact date. RN-E stated R1 liked to go into other resident rooms, mainly female's rooms but was easily redirected out. In a subsequent interview on 10/15/24 at 3:57 p.m., RN-E was not able to articulate any protective/preventative measure put into place to protect female residents in facility aside from the 15-minute checks. RN-E did not think the 15-minute checks were adequate.

During an interview on 10/11/24 at 10:16 a.m., HSK-B stated has not been told to keep watch on any certain residents or certain residents should not be together.

During an interview on 10/11/24 at 12:34, MD-A stated he was both R1's and R2's primary care physician. MD-A was not made aware of the incident regarding R1 and R2. MD-A remembered starting the low dose paroxetine for R1's libido but had not heard of any incidents since the start of the medication in June and thought it was helping. It was his expectation the facility notify the physician and the protocol for abuse be followed to keep the residents free from abuse.

During an interview on 10/15/24 at 12:51 p.m., DON stated when she had first been notified of the incident between R1 and R2 on 10/6/24 via text message, she did not think too much of it because she was not aware of R1's sexual behaviors or his history until the incident with R2. Had she known the history she would have come into the facility after the incident to start the investigation and to ensure resident protections

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17 were implemented. DON stated she had not been aware of the incident in which R5 reported pertaining to R8. DON reviewed R1's record and indicated the documentation of R1's behaviors were not thorough, the documentation for 15-minute checks was not always completed and did not identify specific information on R1's whereabouts or what he was doing, and did not identify incidents as reported to surveyor by nursing staff and residents. DON would have expected more documentation on R1's behaviors and report all incidents or allegations of inappropriate sexual behaviors. DON further stated bringing in a resident with sexual behaviors is like brining in a resident with new medical condition. It takes training to learn how to prevent the incident from happening. DON did not think that the 15 minute checks were adequate and implemented that R1 not sit next to female residents in activities or the dining room after the incident occurred on 10/6/24. Review of facility ' s abuse policy titled Preventing Resident Abuse dated 12/19, did not address the protection of residents from abuse. The policy indicated: policy statement: Our facility will not condone any form of resident abuse and will continually monitor our facility ' s policies, procedures, training program, systems, ect., to assist in preventing resident abuse. j. assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict, or neglect. k. assessing with resident and symptoms of behavior problems and developing and implementing individualized care plans to address behavioral issues. The IJ was removed on 10/13/24 at 9:11 a.m.,	F 600		

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	245425	A. BUILDING ______ B. WING ______	C 10/15/2024

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F 600	Continued From page 18 when it was verified, the facility completed the following actions: -The facility reviewed and updated their abuse policy and procedure pertaining to resident-to-resident sexual abuse - R1 ' s care plan was updated with 1:1 while awake to prevent him from having contact with vulnerable females related to his sexual inappropriate touching. -R1 will have a video monitor on while sleeping. -R1 is not to be left by any female residents at any time. -The facility provided education to all facility staff on the policy and on immediate implementation of individualized care plan and protection measures. -The facility completed trauma informed care assessments and care plan updated, on the residents affected by R1 ' s behaviors.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		11/6/24

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F 609 Continued From page 19

for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to timely report actual inappropriate unwanted touching and/or allegations of sexual abuse to the facility administrator/designee and to the State Agency (SA) for 6 of 6 residents (R2, R3, R4, R6, R7, R9) reviewed for abuse.

Finding include:

Review of facility reported incident #358192 dated 10/7/24 at 3:05 p.m., submitted by social worker (SW-A) indicated on 10/6/24 around 11:50 a.m., NA-A walked out to the day room and saw R1 had his right hand under R2's shirt and seemed to be doing a rubbing/grabbing in a circular motion on R2's chest area. NA-A ran over to R1, grabbed his hand, and said "no". NA-A stayed with R1 and R2 and called for LPN-A to come right away to the day room. LPN-A removed R2 to behind the nurse' station and NA-A took R1 to his room.

R1's progress note dated 10/7/24 at 11:39 a.m., indicated R1 was caught with his hands up a female resident (R2) shirt in the day room on 10/6/24 at 11:50 a.m. It was reported R1's right hand was under R2's shirt and R1 was rubbing,

F 609

Affected Residents
The incident for R-1 was reported to the Minnesota Department of Health on 10/7/2024.
Potential Affected Residents
All residents have the potential to be affected by the deficient practice.
Measure/Systematic Changes
· The Abuse Prevention Policy was reviewed and updated on 10.11.24 to include types of abuse including sexual abuse and the requirement to report any incidents or allegations immediately.
· The facility conducted education on The Abuse Prevention Policy with all staff prior to them working which includes the requirement to report any witnessed or alleged abuse to their supervisor, a nurse, the ADON, DON or Administrator immediately.
· The education was followed up with a quiz to ensure comprehension of the requirement to report immediately.
· All new staff on hire are educated on the new Abuse Prevention policy and the need to report immediately.

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F 609	Continued From page 20 grabbing, and making circular motions on R2 chest area. Staff immediately intervened by removing R1 back to his room. During an interview on 10/10/24 at 3:17 p.m., licensed practical nurse (LPN-A), called assistant director of nursing (ADON) to report the incident above around 11:50 a.m. on 10/6/24. LPN-A received a phone call back from ADON before she left her shift at 1:30 p.m. ADON stated she had called the DON and needed to have NA-A write a statement before she left for the day and the DON would be in later to do the report. During an interview on 10/10/24 at 4:25 p.m., ADON stated she was made aware of the incident around lunch time on 10/6/24. ADON then made DON aware and was told by DON that she was going to speak to R1 about the incident. ADON was able to articulate this was a reportable incident but not able to state the time frame in which the abuse needed to reported to the SA. ADON further stated she did not have reporting privileges to the SA, only Administrator, DON, and SW-A. During an interview on 10/10/24 at 4:39 p.m., SW-A stated she was made aware of incident on 10/7/24 around 9:00 a.m., during morning meeting. SW-A found out around 10:00 a.m., the incident had not been reported and was told by DON the incident was not a reportable incident. SW-A then contacted corporate who she reviewed incident with, they directed her to make the report to the SA and to report it to local law enforcement. SW-A reported to law enforcement and to SA. During an interviews on 10/10/24 at 4:15 p.m.	F 609	Monitoring: Social Services Director or designee will conduct audits of all grievances, complaints and self-reports weekly for 12 weeks to verify all allegations were reported as required. Audit review and analysis will be documented on an audit and will be brought to the facility Quality Assurance Committee meeting monthly to determine ongoing frequency and duration of audits. The Administrator is responsible for ensuring compliance.	

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F 609	Continued From page 21	F 609		

and 10/11/24 at 10:03 a.m., NA-A stated she had witnessed the incident between R1 and R2 on 10/6/24 around 11:50 a.m. NA-A ran over to the residents and removed R1's hand from under R2's shirt and told R1 "No" and then yelled for LPN-A to come to day room. LPN-A removed R2, and NA-A took R1 to his room. NA-A was aware R1 had demonstrated sexually inappropriate behaviors toward three other female residents R3, R4, and R6. NA-A explained she went into R3 and R6's room, R6 was in the bathroom on the toilet with the door open, R1 was sitting in his wheelchair watching R6 while she was in the bathroom. NA-A recalled another time where she had seen R1 holding R4's hand in the day room, however could not remember the date. NA-A stated she did report the incidents with R3, R4, R6 to her nurse but because she worked with multiple nurses she could not recall which nurse she had reported to.

In review of R1's, R3's, R4's, and R6's records it did not address these encounters as NA-A described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.

During an interview on 10/11/24 at 9:44 a.m., R3 was sitting in her wheelchair in her room watching TV. R3 stated she knew R1 from the past. R1 on several occasions would roll up to her in his wheelchair, reach over and hold her hand. R3 was okay with this until R1 rolled into her room and told her "You and me" and pointed to her bed. R3 put on call light and staff came to remove R1 from R3's room. R3 recalled another incident where R1 was holding her hand and tried to move her had to his private area (penis). R3 stated that made her very uncomfortable. Staff saw what R1

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F 609	Continued From page 22 was doing so they removed him from her personal space. Staff have told both R1 and R3 they needed to stay 4 feet away from each other. R3 was not able to remember the dates of either incidents. R3 did not want to ever be close to R1 as she felt he was inappropriate with his actions. During an interview on 10/10/24 at 3:08 p.m., registered nurse (RN)-E stated R1 would go up to R3 and put his hand on her thigh. RN-E indicated the incident happened in either June or July, but could not recall the exact date. In review of R1's and R3's records it did not address these encounters as R3 described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified. During an interview on 10/11/24 at 12:40 p.m., RN-A stated she had witnessed R1 wheel over to R4 when she slept in her wheelchair in the day room. R1 reached over, held her hand and rubbed it. RN-A took R1 to his room. RN-A explained in another incident R9 had told her R1 was trying to hold her hand while R9 was waiting at the medication cart but R9 was able to move herself away. RN-A reviewed R1's record and reported the incidents were not documented. During a subsequent interview on 10/15/24 at 12:11 p.m. RN-A stated she did not report these incidents to her supervisors because she thought it was harmless hand holding and did not know of R1's history of inappropriate sexual behaviors. RN-A could not remember specific dates of either incident but recalled they both had been within the last month. During an interview on 10/15/24 at 12:51 p.m.,	F 609		

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F 609	Continued From page 23 DON stated she did not know of R1's background, otherwise would have come in on 10/16/24 and made report and started investigation. DON stated all abuse needs to be reported with in two-hour timeframe from time of incident. Review of facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 9/2022; indicated the following: 1.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 3.Immediately is defined as: a: within two hours of an allegation involving abuse or result in serious bodily harm; or b: within 24 hours of an allegation that does not involve abuse or result in serious bodily harm.	F 609		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 28, 2024

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

Re: Event ID: IE3811

Dear Administrator:

The above facility survey was completed on October 15, 2024 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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	00833	A. BUILDING: ________ B. WING ________	10/15/2024

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2 000	Initial Comments	2 000		

*****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 On 10/10/24, 10/11/24, 10/13/24, and 10/15/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaints were reviewed: H54259386 (MN00107282). No licensing orders

Minnesota Department of Health

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2 000	Continued From page 1 were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		