

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998</p> <p>Based on observation, interview, and document review the facility failed to maintain resident supervision and safety to prevent accidents for 1 of 1 residents (R1) who was an elopement risk left the facility unsupervised through an unlocked door during the night and found outside. This resulted in an immediate Jeopardy (IJ) situation for R1.</p> <p>The IJ began on 12/7/24 when R1 exited the building without staff awareness through an unlocked door to a courtyard between 11:15 p.m. and 3:30 a.m. (on 12/7/24) and found on the ground at approximately 4:10 a.m. with hypothermia and minor injuries. The administrator and chief operating officer (COO) were notified of the immediate jeopardy on 12/11/24 at 3:00 p.m. The facility had implemented immediate corrective action on 12/8/24 to prevent recurrence, so the IJ was issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's Admission Record identifies R1 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) was not completed due to R1's admitted [DATE].</p> <p>R1's Brief Interview for Mental Status dated 12/6/24, indicated R1 had severe cognitive impairment.</p> <p>R1's Elopement Evaluation dated 12/6/24, indicated R1 was at risk for elopement (did not identify risk level) due to expressions of desire to go home, recent admission, and not accepting of the situation [of facility placement]. The focus identified R1 was at risk for elopement. The goals of care included the resident would not leave facility unattended and safety would be maintained. No interventions were identified or implemented.</p> <p>R1's Fall Risk assessment dated [DATE], indicated R1 was at a high risk for fall related to intermittent confusion, 1-2 falls in the past 3 months, decreased muscular coordination, administered 1-2 that increase risk for falls, and had 1-2 diagnoses present that increase risk for falls.</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's document Individual Resident Baseline Care Plan dated 12/6/24, identified R1 was at risk for falls but did not identify safety measures. R1 required one staff assist with dressing, grooming, toileting, repositioning, and ambulation. R1 was alert and oriented to person with confusion and no behaviors. The baseline care plan noted, [R1] very upset at being here, not wanting to express any desires for food or anything. Just wanting to go home. This document did not address R1's risk for elopement or interventions to assure R1's safety.</p> <p>R1's Care plan dated 12/6/24 identified focus of Risk for Wandering/Elopement identified with corresponding goals that included, The resident will not leave the facility unattended and The resident's safety will be maintained. The care plan did not identify safety interventions to prevent or mitigate the risk of elopement. R1's care plan also identified the risk for falls related to a history of falls and recent hospitalization with the corresponding goal R1 will be free from falls throughout this next quarter. Fall interventions directed staff to complete fall risk evaluations, complete labs when ordered and report findings, monitor for medication side effects, and reinforce need to call for assistance. The care plan did not reference the note that was included in the Baseline Care Plan document pertaining to R1's voiced dislike of, and not wanting to be at the facility.</p> <p>R1's facility Progress Notes noted the following:</p> <p>12/6/24 at 11:23 p.m., indicated early in the shift R1 stated to staff and (FM-A) that she wanted to go home with her dog. R1 continued to be upset/confused about placement. Social worker was notified and talked to R1. R1 spent time watching [television] TV and did not transfer without assistance. Would continue to monitor.</p> <p>12/7/24 at 6:37 a.m., licensed practical nurse (LPN)-A identified R1 was in recliner at 1:45 a.m. rounds; on 3:45 a.m. rounds R1 was not in her room. Searched the building, checked outside, play park across the street, and in the courtyard. LPN-A notified the administrator, director of nursing (DON), family, police, and the medical director. R1 was found at 4:10 a.m. outside lying on the ground in the [facility] courtyard and ambulance was called immediately.</p> <p>12/7/24 at 2:22 p.m., was in ICU, Intensive Care Unit at that time.</p> <p>R1's emergency department and hospital records dated 12/7/24 at 6:09 am., Indicated R1 was seen for altered mental status, hypothermia (potentially dangerous drop in body temperature), and sepsis (life threatening complication of an infection) after R1 was found outside. Further identified R1 presented with cold extremities, multiple abrasions throughout bilateral upper extremities, core body temperature of 31.1 degree Celsius (87.98 degrees Fahrenheit). At 7:55 a.m. the record identified R1 was rewarmed with warm intravenous fluids and a BairHugger (forced air warming blanket), and would be admitted to the intensive care unit (ICU).</p> <p>According to the [NAME] Lea Weather Station -KMNALBER38 (reported or published online by Weather Underground) the temperature on 12/7/24 between 1:45 a.m. to 4:15 a.m., ranged from 26.6 degrees Fahrenheit (F) to 32.6 degrees F.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 12/10/24 at 11:30 a.m., R1 had intravenous (IV) access to the left hand, numerous scabs, abrasions, and bruises noted on both right and left hands and arms. R1 indicated the scabs and abrasions on her hands and arm were much better than they had been and got them when she wandered away from home and fell by the corner a couple of weeks ago when it was really cold. R1 stated she could not remember exactly what happened but remembered that she was outside for a while and was really, really cold. R1 further stated that she had some difficulty walking before that but has more difficulty walking after being outside for so long.</p> <p>During an interview on 12/11/24 at 10:50 a.m., family member (FM-A) indicated he received a call on 12/7/24 at 4:00 a.m., notifying him R1 was missing. Further identified he got to the facility right after they found R1 in the outside courtyard. R1 had fallen in the rocks, was very cold, and was all cut up. FM-A joined R1 in the emergency department and stated, was told if she (R1) had been out there another 30 minutes, she would have been dead. FM-A stated, it shouldn't have happened FM-A stated earlier that day, had been confused and also had told staff she wanted to go home. FM-A indicated R1 lived within walking distance from the facility and staff were aware.</p> <p>During an interview on 12/10/24 at 4:15 p.m., LPN-B reported he was the day shift charge nurse on 12/6/24. LPN-B stated R1 had a urinary drainage bag and catheter so he did not think she could walk without assistance. LPN-A stated he had not been aware that R1 was at risk for elopement and for falls. LPN-B recalled on 12/6/24, R1 was upset about needing to be at the facility and wanted to go home. LPN-B reported R1's comments and behavior to the SW.</p> <p>During an interview on 12/10/24 at 4:05 p.m., social worker (SW) indicated she completed R1's initial cognitive assessment on 12/6/24, which identified R1 had severe cognitive impairment. Stated later that day the charge nurse notified her that R1 wanted to leave and was confused. SW visited with R1 and husband regarding R1's desire and ability to visit with their dog. SW thought R1's confusion was due to blood sugars so asked the charge nurse to check R1's blood sugar. The SW had no further contact with R1. SW did not communicate R1's confusion and/or desires to leave the facility nor developing/implementing safety interventions after becoming aware.</p> <p>During an interview on 12/11/24 at 12:00 p.m., registered nurse (RN)-A indicated she had worked day shift on 12/6/24, the day was very busy because there had been two admissions at the same time. RN-A completed R1's initial elopement assessment which identified she was at risk for elopement. Since FM-A had reported R1 did not have wandering behaviors, RN-A thought R1 was at low risk for elopement and did not apply a wanderguard or implement any safety interventions. RN-A was not aware R1's permanent home was in close proximity to the facility and not aware of R1's statements to other staff about wanting to go home, had RN-A been aware she would have implemented interventions and increased monitoring.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/11/24 at 8:25 a.m., nursing assistant (NA)-B indicated the doors going out to the courtyard were not locked on the night of 12/6/24 and did not think they were ever locked. NA-B indicated she worked the overnight shift on 12/6/24 into 12/7/24. R1 had been a new admission, was not told R1 required assistance nor made aware or had knowledge that R1 was an elopement risk and at risk for falls. Because NA-B did not know, she had not provided any assistance to R1. NA-B further explained on 12/6/24 at 11:15 p.m. she had physically observed R1 last at 11:15 p.m. (12/6/24). At approximately 2:00 a.m. (on 12/7/24) she had went to R1's room, did not see R1 in her room but saw R1's bathroom light on so assumed R1 was in the bathroom at that time. At approximately 4:00 a.m., LPN-A asked for NA-B for assistance in R1's room at which time notified R1 could not be found. Staff that were working began to search for R1. R1 was found at 4:15 a.m. in the facility courtyard lying on a bunch of tiny rocks next to a cement bird bath that was knocked over wearing only sweatpants, short sleeve shirt, and did not have on socks or shoes. R1 was very cold and confused.</p> <p>During an interview on 12/11/24 at 9:45 a.m., LPN-A reported working night shift (12/7/24) when R1 eloped from the facility. LPN-A reported during shift report, she was told R1 was a new admission on 12/6/24, was alert and oriented, and wanted to go home to her dog but the SW calmed her down. LPN-A stated she did not have any contact with R1 until she was found outside in the courtyard at approximately 4:15 a.m. LPN-A noted R1 was not in her room at approximately 3:30 a.m. while walking to another resident's room. LPN-A asked NA-A and NA-B when they last saw R1 and was told NA-B last checked on R1 at 1:45 a.m. but R1 had not been seen since. LPN-A indicated she alerted the police, administrator, and family and began searching. LPN-A reported R1 was found in an unlit area of the courtyard laying on rocks and described R1 as fidgety, confused, cold, pale, mumbling, and R1's catheter bag by her. LPN-A could not remember what R1 was wearing but thought she had a hospital gown and grippy socks on. LPN-A further identified the exit door to the courtyard was not locked and should have been. LPN-A also reported if R1 was identified as an elopement risk, it was the facility policy to put a wanderguard on and notify the oncoming staff. LPN-A stated if she would have known R1 was a fall and/or an elopement risk, she would have checked on R1 more frequently.</p> <p>During an interview on 12/11/24 at 2:00 p.m., the interim administrator indicated R1 was admitted the afternoon on Friday 12/6/24. The interdisciplinary (IDT) each had pieces of R1's admission, however, did not communicate amongst each other to determine actual risks and appropriate interventions. The administrator indicated the facility policy needed to be changed to identify protocol when risk of elopement was identified. Further, the courtyard door did not have a wanderguard system and the door was not locked.</p> <p>Facility policy titled, Elopements and Wandering Residents dated 10/2024, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Defines elopement as a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The policy also identifies the facility is equipped with door locks/alarms to help avoid elopements. The IDT will evaluate the unique factors contributing to risk in order to develop a person-centered care plan; interventions to increase staff awareness of the resident's risk, modify the resident's behavior or to minimize risks associated with hazards will be added to the resident care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements; charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. Any changes or new interventions will be communicated to relevant staff.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The past-noncompliance immediate jeopardy began on 12/7/24 and was removed on 12/8/24, when the facility implemented a systemic plan to ensure all residents were safe. The following actions were implemented prior to survey the facility locked the courtyard doors and placed all residents on 15-minute checks until all residents were re-assessed for elopement risk. When all residents were re-assessed, the residents at risk for elopement were placed on 15-minute checks until individualized interventions were developed and implemented. The facility reviewed all resident care plans, revised the elopement policy. On 12/8/24, the facility re-educated all staff on the elopement policy and on risk factors to watch for. On 12/10/24, upon R1's hospital return, the facility re-assessed R1 for elopement and fall risks and implemented interventions to mitigate the risks.</p>		