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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thorne Crest Retirement Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to notify a resident's representative of a change in condition for 1 of 3 residents (R3) reviewed for quality of care. Findings include:R1's quarterly minimum data set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation).R1's nursing progress note dated 9/4/25 at 1:00 p.m., identified acetaminophen 500 mg given due to complaint of right eye pain and soreness. At 1:20 p.m., an additional note indicated R1's right eye hurt some and was a little red and irritated.will continue to keep an eye on it for now.R1's nursing progress note dated 9/5/25 at 11:24 a.m., R1 again commented his eye was sore to the director of nursing (DON) who happened to look at it and let her know this started on 9/4/25. R1's eyebrow was a little swollen and now was pinkish red and warm to the touch, and the DON wondered if cellulitis was developing. Note identified that the DON would call nurse practitioner to get an order for something, and some eye drops also. Called and left a voicemail for the nurse practitioner. R1's Telemedicine Visit dated 9/5/25 at 2:37 p.m., identified nursing asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1's primary care provider started eye drops yesterday, unfortunately they have not arrived yet from the pharmacy. R1 reported 3 out of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, [NAME] feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 milligram (mg) per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics.R1's electronic health record was reviewed and does not identify R1's representative was notified of a change in condition with his right eye.During an interview on 9/17/25 at 2:24 p.m., assistant director of nursing (ADON) reviewed R1's electronic health record and stated it does not look like anyone notified R1's family of his change in condition with his right eye and they should have. ADON stated anytime a resident has a change in condition the resident representative should be notified immediately and should be documented in the resident's medical record. During an interview on 9/17/25 at 2:29 p.m., licensed practical nurse (LPN)-A indicated on 9/4/25, R1 had a change in condition when R1 was complaining of soreness in his right eye. LPN-A stated R1 had redness in his right eye and his eye lid that extended above his eyebrow. LPN-A further stated his eye worsened on 9/5/25 due to swelling and warmth. LPN-A stated she did not notify FM-B of R1's change in condition and should have.During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25. FM-B stated she was R1's resident representative and was upset the facility never contacted her about R1's eye infection. FM-B stated they should have called me when R1's eye first started getting red. FM-B stated she wanted to be notified of any changes R1 had. FM-B stated she didn't find out until she went to the facility to visit R1.During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 indicated when he has changes in his health, he would like the facility to notify FM-B.During an interview on 9/17/25 at 3:38 p.m., director of nursing (DON) reviewed R1's electronic medical record and stated there was no documentation that FM-B was notified of R1's change in condition of his right eye. DON indicated FM-B should have been notified immediately and should have been documented in R1's medical record. Facility policy regarding notification with a change in condition was requested and not received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to monitor for signs and symptoms of infection for 1 of 1 resident (R1) reviewed for change in condition. In addition, the facility failed to safely transport 1 of 1 resident (R1) to an outside appointment reviewed for resident safety. Findings include:Infection monitoring:R1's care plan dated 9/2/25, identified a focus that R1 was at risk for infection due to refusal of vaccinations. Interventions included to educate R1 and resident representative of techniques to prevent infections such as handwashing, adequate rest, nutrition, avoidance of crowds, to monitor for signs and symptoms of infection and staff to follow standard precautions including proper handwashing techniques to minimize microorganism growth.R1's quarterly minimum data set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation).R1's nursing progress note dated 9/4/25 at 1:00 p.m., identified acetaminophen 500 milligram (mg) given due to complaint that his right eye hurt and was sore. At 1:20 p.m., an additional note indicated R1's right eye hurt some and was a little red and irritated.will continue to keep an eye on it for now.R1's nursing progress note dated 9/5/25 at 11:24 a.m., R1 again commented his eye was sore to the director of nursing (DON) who happened to look at it and let her know this started on 9/4/25, noted his eyebrow was a little swollen and now was pinkish red and warm to the touch, was wondering if cellulitis was developing. Will call nurse practitioner to get an order for something and some eye drops also, called and left a voicemail for her. R1's Telemedicine Visit dated 9/5/25, at 2:37 p.m., identified nurse asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1 reported level 3 of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, [NAME] feeling) present. Assessment/Plan identified:1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 mg per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now.3. Monitor for spread outside the black markings placed today.4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics.Review of R1's electronic health record does not identify consistent daily comprehensive monitoring of eye infection from 9/5/25 through 9/16/25.During an interview on 9/17/25 at 2:29 p.m., licensed practical nurse (LPN)-A indicated on 9/4/25 R1 had a change in condition when R1 developed redness to his right eye and eye lid that extended above his eyebrow and R1 said it was sore. LPN-A further stated his eye worsened on 9/5/25 due to swelling and warmth and she had nurse practitioner (NP)-A see R1 through a telehealth visit and NP -A ordered oral and eye antibiotics for orbital cellulitis to be started that day. NP-A also had us use a black marker to draw around R1's redness around his right eye and told us if the redness spreads beyond the black marker it would be ok to send him to the emergency department for intravenous (IV) antibiotics. LPN-A reviewed R1's electronic health record and verified there was no daily monitoring of signs and symptoms of infection for R1's right eye cellulitis from 9/5/25 to 9/16/25. LPN-A stated when she worked on 9/10/25, she noticed R1 had developed six to seven papules (small, red, solid bumps that quickly turn into fluid filled blisters with shingles) above his right eye. LPN-A stated she called the physician assistant (PA)-A on 9/10/25 and PA-A thought R1 could have shingles and gave orders to send R1 to the emergency department (ED) right away to have a maxillofacial cat scan (CT) to rule out infection spread, a herpes zoster swab to rule out shingles and some lab tests.During an interview on 9/17/25 at 2:52 p.m., assistant director of nursing (ADON) reviewed R1's electronic health record and verified there was no daily monitoring or comprehensive assessments for signs and symptoms of infection for R1's right eye cellulitis. ADON stated when R1 was put on antibiotics a

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R1) reviewed for quality of care.Findings include:R1's quarterly minimum data set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation).R1's Telemedicine Visit dated 9/5/25, at 2:37 p.m., identified nurse asked for an acute visit on the fly for acute evaluation of concerns for cellulitis (a common bacterial infection of the skin and underlying tissues that typically causes redness, swelling, pain, and warmth in the affected area) developing around R1's right eye. R1's primary care provider started eye drops yesterday unfortunately they have not arrived yet from the pharmacy. R1 reported level 3 of 10 pain. Nursing staff asked to mark the erythema (redness) surrounding his upper eye lid. Upper blepharitis (eye lid inflammation) with erythema, warmth and discharge present. R1 had conjunctivitis (when the white part of the eyeball becomes red and swollen that can cause irritation, itching, or a gritty, [NAME] feeling) present. Assessment/Plan identified: 1. Preseptal cellulitis (an infection of the eyelid and soft tissue on the outside of the eye's protective barrier, called the orbital septum)-amoxicillin-pot clavulanate (Augmentin)-(antibiotic) 875-125 milligram (mg) per tablet. Take 1 tablet by mouth two times a day for 5 days starting Friday 9/5/25, until Wednesday 9/10/25. 2. Start Polytrim antibiotic eye drops (a combination of Polymyxin B and trimethoprim used to treat eye infections, including acute bacterial conjunctivitis and blepharoconjunctivitis) as soon as possible when it arrives from the pharmacy. Check E-kit for supply, to be given now. 3. Monitor for spread outside the black markings placed today. 4. If spread occurs, consider the need for emergency department (ED) evaluation for intravenous (IV) antibiotics.R1's nurse practitioner (NP) verbal order on 9/4/25, regarding initiation of antibiotic eye drops was requested several times and not given.R1's medication administration record (MAR) dated September 2025, identified an order with a start date of 9/6/25, at 7:00 a.m., for amoxicillin-pot clavulanate to give one tablet by mouth two times a day for 5 days for early preseptal cellulitis. 9/5/25 identified an x was marked on morning and evening shift, indicating the medication was not started on 9/5/25, as per provider orders. An additional order with a start date of 9/5/25 at 2:30 p.m., for Polymyxin-B-Trimethoprim ophthalmic solution 100000-01 Units/milliliter (ML)-% to instill one eye drop four times a day for right eye conjunctivitis, discontinue when no longer needed. R1's evening and NOC (night shift) dose were left blank, indicating the dose was not started on 9/5/25 per provider orders.During a phone interview on 9/16/25 at 11:00 a.m., family member (FM)-A stated that FM-B was R1's resident representative and found out that R1's right eye was infected and was supposed to start antibiotics on 9/5/25, and they were not started until 9/6/25.During a phone interview on 9/18/25 at 8:31 a.m., FM-B stated R1 was seen by a virtual doctor for his infected right eye on 9/5/25 and was supposed to start antibiotics right away but R1 did not get them until the following day on 9/6/25. FM-B was concerned about the facility not starting the eye drops right away like the provider wanted because R1's right eye was so red, the redness was spreading to his eyelids and looked infected.During an observation and interview on 9/18/25 at 9:25 a.m., R1 was lying in bed eating breakfast. R1 stated one day a nurse came in with a monitor and a female doctor was on the monitor and had saw him for his right eye. R1 stated his right eye was red, painful and was itching and swollen. R1 stated the doctor prescribed him eye drops and antibiotics for his right eye infection and could not remember when exactly the medications were started. R1 stated he was never informed of a medication error.During a phone interview on 9/18/25 at 11:30 a.m., nurse practitioner (NP)-A stated she saw R1 through a telehealth visit on 9/5/25 and gave orders for the facility to start oral and eye drop antibiotics for concerns with right eye orbital cellulitis to start that day. During an interview on 9/18/25 at 1:01 p.m., licensed practical nurse (LPN)-A stated she was present on 9/5/25, and had assisted with the telehealth visit R1 had on 9/5/25. LPN-A stated the physician assistant (PA) that saw R1 had ordered oral and eye antibiotics on 9/5/25 and wanted them to start that day. LPN-A reviewed R1's electronic health record and verified the antibiotics were not started per the provider order on 9/5/25, rather were started on 9/6/25 and was unsure why. LPN-A stated this would be considered a medication error. LPN-A stated the process for a medication error was to fill out a paper medication error form and notify the resident, the director of nursing (DON) and

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure staff were following standard precautions by not performing hand hygiene before and after resident contact and failed to use personal protective equipment (PPE) for one of one resident (R1) that was on transmission-based precautions to reduce the risk of infection spread reviewed for quality of care. In addition, the facility failed to place the PPE cart directly outside R1's doorway to mitigate the risk for spread. Findings include:R1's quarterly minimum data set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of Cerebral palsy (a group of disorders caused by a non-progressive brain injury before, during, or shortly after birth that affects a person's movement, muscle control, posture, and balance) and elevated white blood count (a condition when you have too many white blood cells (WBCs) in your blood, which is your body's way of fighting off something, usually an infection or inflammation).R1's lab result dated 9/11/25, identified R1's test for varicella zoster virus (herpes virus that causes shingles that can be transmitted through contact with an infected persons fluid from the blisters. A person is contagious for a couple of days before the rash appears until all blisters have crusted over) was positive indicating R1 had active shingles (a viral infection that affects the nerves around the eye) to the right eye area. R1's nursing progress note dated 9/11/25 at 6:10 p.m., placed call to clinic/hospital ED, was informed of R1 being sent to the hospital for admission for right orbital cellulitis a common bacterial infection surrounding the tissues of the eye that typically causes redness, swelling, pain, and warmth in the affected area) with shingles.R1's nursing progress note dated 9/15/25 at 3:31 p.m., identified R1 arrived back to the facility by private transport service via wheelchair and identified a new skin issue to right eye, shingles area is pink, wound is new, has erythema/painful. Pain was sharp and intermittent. R1 was on Valtrex (antiviral medication used to treat shingles) for a diagnoses of herpes zoster (a viral infection that causes a painful rash of blisters on one side of the body). Pain concerns to watch for are herpes zoster to right eye.R1's nursing progress note dated 9/16/25 at 1:03 p.m., R1 was told he needed to stay in his room after he got up and proceeded to come out and then told he had to go back to his room. R1 refused breakfast and lunch.During an observation on 9/17/25 at 9:11 a.m., of R1 the door to his room had a yellow laminated sign on the door identified at the top of the sign in black bold letters, Contact Precautions. Below that in bold typed red letters was Everyone Must: To the left and right of these words was a picture of a red stop sign. Below this in smaller black bold letters was clean their hands, including before entering and when leaving the room. Below that in large bold red letters was Providers and Staff Must Also: below this in smaller black bold letter was put on gloves before room entry. To the left of this was a picture of a blue pair of gloves. Discard gloves before room exit. To the left of this was a picture of a blue gown. Below this put on gown before room entry, discard gown before room exit. In red bold letter, Do not wear the same gown and gloves for the care of more than one person. In black bold letters, use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. To the left of this was a picture of a blue stethoscope. At the bottom right-hand corner of the sign was a handwritten in red marker was an asterix followed by 9.2 and was underlined. There was no PPE cart outside of R1's room. Hospitality aide (HA)-A was carrying a breakfast tray and walked into R1's room to deliver the tray and set it on his tray table. HA-A did not perform hand hygiene prior to entering the room and did not follow the contact precaution sign on the door which indicated to don gowns and gloves. R1 stated he was not ready to eat breakfast yet and told HA-A to leave it on his tray table. HA-A walked back out of the room without performing hand hygiene.The contact precaution sign on the door indicated to don gloves and gown prior to entry to the room. During an interview on 9/17/25 at 9:14 a.m., HA-A stated she had no idea why there was a contact precautions sign on the door or for which resident it was for or what staff was supposed to do. HA-A stated she should have washed her hands prior to entering the room and after leaving the room and could not articulate the need for use of PPE as directed by the contact precaution sign on the door.During an interview on 9/17/25 at 9:18 a.m., licensed practical nurse (LPN)-A stated R1 was on contact precautions due to the shingles on his right eye. LPN-A stated he still has one blister that was open above his eye while rest of the blisters were crusted over. Staff should always wash their hands when entering and exiting a room with a resident who is on contact precautions, also gowns and gloves would be expected to be used.During an interview on 9/17/25 at 9:22 a.m., nursing assistant (NA)-A verified there was no PPE cart outside R1's room and indicated there was no room in the hall for the PPE cart so they keep it in R1's room. NA-A indicated R1