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	12/26/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - 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 beds were a safe distance away from a wall heater to prevent entrapment and burns for 1 of 1 resident (R1) who had severe cognitive impairment, and a history of self-transfers and falls reviewed for accidents. This resulted in actual harm when R1 rolled out of bed onto the heater which caused second degree burns to his left hip and back. The facility immediately implemented corrective action and the deficient practice was corrected on 12/19/25, prior to the start of the survey and was therefore issued as a past non-compliance (PNC). Findings include: R1's face sheet dated 12/18/25, identified diagnoses of neurocognitive disorder with Lewy Bodies dementia with anxiety, and history of falling. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had no issues with hearing or speech, had severe cognitive impairment, no behaviors; required some help with upper body dressing and was dependent on staff for lower body dressing. R1 was independent with rolling in bed and dependent on staff for transferring between surfaces. R1's care plan intervention dated 9/23/25, directed R1 to have bed in low position with safety mat in place. On 8/5/25, if R1 was sitting up at edge of bed, bring to day room and offer snack/drink. The care plan identified complete peri cares and to manipulate clothing as needed, dependent on assistance of two staff to use the toilet. Toilet upon waking up, before/after meals, when going to bed, and midnight. The care plan directed to aid with bed mobility as necessary; R1 was dependent on assistance of two staff for lying to sitting on side of bed, sitting to lying on bed, and rolling left and right. R1's progress note dated 12/18/25 at 8:07 a.m., identified at approximately 7:22 a.m., R1 was found between bed and heat register. R1 was moved safely away from the heat register and injuries noted on left rib cage, left hip, both knees, will be further assessed. R1's Hospice visit dated 12/18/25 at 8:40 a.m., identified R1was found on the floor and had fallen into the heater in his room. R1 had second degree burn on his left hip with three blistered areas. Burn measured 6.0 centimeters (cm) by (x) 6.5 cm. Three blistered areas one farthest left measured 1.1 cm x 0.5 cm, middle one 0.5 cm x 0.9 cm, third 0.2 cm x 0.2 cm. Burns to mid left back area top one measured 2.0 cm x 1.1 cm. lower to the left 5.5 cm x 2.0 cm and area to the right of this 3.5 x 0.8 cm. Right knee bruising 4.5 cm x 3.5 cm and left knee bruising 4.8 cm x 2.5 cm. Does not appear to be having increased pain and oxycodone was given post fall for comfort and ice applied to hip area. Bed has been moved away from heater to prevent further falls with burns. New wound care orders received. R1's physician order dated 12/18/25, directed staff to use Silvadene 1% cream to left hip blisters topically one time a day for burn wound. R1's post fall evaluation dated 12/18/25 identified R1's fall was not witnessed. R1 stated I was trying to get up but that didn't work out so well. Reason for fall was R1 attempted to self-transfer. Injuries included left hip redness and burn marks with three open blister areas, left rib cage reddened and burn marks, reddened knees. Room was rearranged with bed farther away from the heater and floor mats placed on each side of the bed, care plan reviewed and updated. R1's progress note dated 12/18/25 at 3:02 p.m., identified director of nursing (DON) completed measurements of injuries. R1's care plan was updated on 12/19/25, included fall mats to bilateral sides of low bed for injury prevention related to R1 crawling out of bed on knees frequently. R1 is impulsive and frequently crawls out of bed or a chair and crawls to destination. Bed to remain a minimum of 12 inches from wall radiator. Bed and floor mats never to be against radiator. R1's Hospice visit dated 12/19/25 at 8:25 a.m., identified R1's pain appeared to be worsening most likely related to fall with burns. The note indicated the doctor was notified and an order for scheduled oxycodone every six hours and continue with the as needed dose was received. During an interview on 12/23/25 at 2:59 p.m., maintenance director (M)-A stated on 12/18/25, as soon as he heard about the incident, he went online to look at different barriers to possibly install in replace of the existing barriers, if needed. M-A took his heat gun on 12/18/25, checked R1's radiator, and got 11 degrees Fahrenheit near the top, 104 degrees Fahrenheit in the middle, and 145-degrees Fahrenheit on the underside of the heater. DON reported to M-A she had found documentation that beds needed to be minimum 12 inches from radiator. M-A indicated during his research the temperatures of the radiators should be 159 degrees Fahrenheit or below, so on 12/19/25 he did a radiator temperature check on all the rooms in the facility and all were within limits. M-A explained when he started the director of maintenance position, he recalled doing a visual audit to ensure the beds were one foot away from the heater however did not document the results of the audit. M-A indicated he did not continue to audit and thought nursing would be routinely checking to make sure the beds were the one foot away from the heater. During an observation on