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	05/20/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to comprehensively assess and evaluate care plan interventions for effectiveness, and develop individualized repositioning program to prevent pressure ulcer development and/or deterioration for 2 of 3 residents (R1, R2) reviewed for pressure ulcers.Findings include:Stage 2 pressure ulcer: partial-thickness loss of skin that presents as a shallow, open wound with a red or pink wound bed without exposure of fat or deeper tissues.Deep tissue injury: affects the deeper layers of tissue beneath the skin including muscles, subcutaneous fat, and sometimes bone which disrupt blood flow and oxygen delivery to the tissue.Braden Scale for Predicting Pressure Sore Risk is a standardized tool to assess the risk of developing pressure injuries. The scale evaluates six categories: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. Each category is scored from 1-4, except friction/shear which is scored 1-3. Scores are categorized as 19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, and 9 or less very high risk.R1R1's face sheet dated 5/19/26, identified diagnoses of unspecified fracture of lower end of left femur (upper leg bone), subsequent encounter for closed fracture with routine healing, hypertension, obesity, and chronic peripheral venous insufficiency (not enough blood flow to legs).R1's hospital discharge after visit summary dated 1/9/26, identified a Braden Scale score of 15.R1's facility Braden Scale with Skin Risk Evaluation dated 1/9/26, identified a score of 16. Skin Evaluation Risk included: acute condition, decreased range of motion, cast/brace/splint, limited mobility/bedfast. No ulcers were present on admission. Treatments included pressure-reducing device for chair and bed. R1 was to have an immobilizer on left leg at all times.R1's care plan dated 1/13/26, identified R1 was incontinent of bowel and bladder. R1 was dependent on staff for toileting, staff to offer toileting on wake up, after meals, and at bedtime.R1's care plan dated 1/21/26, identified R1 had potential for impaired skin integrity related to immobility due to femur fracture and urinary incontinence. Interventions included to apply moisture barrier as needed, Braden Scale on admission, every week for four weeks, quarterly, and with any significant change, nursing assistants (NA) to observe skin with morning and evening cares and report any abnormalities to the nurse, maintain good skin hygiene, moisturize dry skin as needed, observe for alteration in skin integrity and report to physician, skin inspected weekly per schedule, pressure reducing mattress on bed and cushion in wheelchair. On 2/9/26, every two-hour repositioning and blue pressure relieving boots to feet at all times for pressure relief were added.Although R1's care plan called for repositioning every two hours, there was no documentation of a comprehensive assessment supporting that interval or demonstrating that R1 could tolerate pressure for two-hour periods without increased risk of skin breakdown.R1's Hospice admission dated 2/3/26, identified R1 admitted to hospice services with decline in condition including 6.61% weight loss in the past 6 months, meal intake decline in the past 6 months typically only eating 0-25% of breakfast and nothing for lunch or supper, bedbound, incontinent of bladder, and sleeping 20-22 hours/day.R1's record identified R1 did not have a Braden Scale with Skin Risk Evaluation completed weekly between 1/9/26 and 2/4/26.R1's facility Braden Scale with Skin Risk Evaluation dated 2/5/26, indicated R1 had developed pressure ulcers since admission. The evaluation identified a score of 14 indicating R1 was at moderate risk for pressure ulcers (even (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	though R1 had developed two pressure ulcers). Skin Evaluation Risk included: chronic incontinence, cognitive impairment, decreased range of motion, muscle wasting, pale skin, cast/brace/splint, limited mobility/bedfast. R1 had one or more unhealed pressure ulcers/injuries, however did not identify how many ulcers R1 had or location. Treatment included pressure-reducing device for chair and bed, turning and repositioning program, pressure ulcer/injury care. Interventions included to elevate edematous (fluid retention)/affected extremities.Review of R1's record did not include a comprehensive assessment of the pressure ulcers that were noted on the Braden Scale Evaluation dated 2/5/26. Although R1's record identified developed pressure areas there was no indication the care plan interventions were evaluated for effectiveness, there was no change identified in the reposition program, and no new additional interventions were developed or implemented to prevent deterioration or new ulcer development.R1's progress note dated 2/7/26, identified R1 refused supper, was incontinent of urine once, and had a bed bath with no new skin issues identified.R1's progress note dated 2/9/26, identified R1 had been in bed all day and not been eating. Hospice registered nurse (HRN)-A and family was present. A deep tissue injury was noted on right heel. The area was closed, discolored and non-blanchable (redness or discoloration on skin does not turn white when gentle pressure applied). Pressure relieving boots applied and an air alternating mattress was ordered. A reddened line that measured 8 centimeters (cm) across R1's lower buttock was blanchable (turns white with gentle pressure applied) and appeared to have been caused by edge of R1's brief being rolled down. A small stage 2 pressure ulcer was noted on R1's coccyx in a V shape. HRN-A was increasing visits to daily due to R1's declining condition.R1's Client Coordination Notes Report from hospice dated 2/9/26, identified R1 was in bed upon visit arrival, minimally responsive with Cheyne-Stokes (abnormal breathing pattern) and 40 second apnea (no breathing). No mottling (blotchy, red, purple, bluish discoloration of skin) noted. Suspected deep tissue injury noted to right heel, HRN-A notified assistant director of nursing (ADON) and director of nursing (DON). Stage 2 pressure sore noted to coccyx, non-blanchable areas noted to upper right and left buttocks. Incontinence brief had been soiled with urine. R1 positioned on left side. Reviewed positioning frequency, floating heels, and pressure injury prevention with nurse and nursing assistant.R1's Client Coordination Notes Report from hospice dated 2/10/26, identified family was present and stated R1 had been repositioned every two hours and that R1 tolerated that well. Light mottling noted to lower extremities.Review of R1's record between 2/5/26 through 2/10/26 revealed no indication of a comprehensive pressure ulcer assessment was completed that would identify measurements, drainage, and pain. Further not evident of a comprehensive analysis that determined causal factors of pressure ulcer development so that appropriate interventions could be developed and implemented that would negate the risk of deterioration and/or new ulcer development.R1's Client Coordination Notes Report from hospice dated 2/11/26, identified HRN-A requested tasks be added for facility aides to reposition R1 every two hours.R1's Skin Issues progress note dated 2/11/26, identified left gluteus pressure ulcer acquired in-house, unknown how long the wound had been present. Measurement was 10.16 cm length by 1.27 cm width with intact surrounding tissue. No drainage, or odor present.R1's physician orders dated 2/11/26, identified pressure ulcer care to coccyx and deep tissue injury to right heel beginning 2/9/26. Blue pressure relieving boots to bilateral feet at all times beginning 2/9/26.During an interview on 5/19/26 at 3:13 p.m., registered nurse (RN)-A stated residents were at risk for pressure injuries if they laid in one position for extended periods or were unable to move by themselves. RN-A would not implement heel protectors unless a resident had boggy heels. If a resident had a pressure ulcer they should go on a more frequent turning and repositioning schedule such as every 2-3 hours. The NA's should just know by word of mouth to reposition residents every 2-3 hours if it was not in the care plan. R1 admitted to facility for therapy and planned to return to community when completed. Therapy was not progressing, and R1 initiated enrolling in hospice for personal reasons. R1 had started to decline around the time he started hospice and could not vocalize his needs as much. RN-A recalled working with R1 the weekend prior to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 5/20/26 at 10:16 a.m., staff pointed out where R2 slept in the main living room area. R2 slept on a recliner chair that had a cloth pad on the seat for incontinence and a tie blanket hanging over the arm of the chair. R2 was not in the chair at the time.During an interview on 5/19/26 at 3:08 p.m., NA-A stated all residents are repositioned every 2-3 hours. Bedbound residents would also be repositioned every 2-3 hours.During an interview on 5/20/26 at 8:47 a.m., NA-B stated she would put barrier cream on all incontinent residents to protect their skin. Incontinent residents should be on a two-hour toileting schedule and if bedbound they should also have two-hour turn/reposition schedule. R2 rarely uses her bed to sleep in and prefers the recliner. R2 does not have a pressure relieving device for the recliner chair.During an interview on 5/20/26 at 8:58 a.m., RN-B stated R2 usually slept in the recliner in the front room and the NA's use a pillow to offload her position. RN-B would expect R2 to have a pressure-relieving device in her chair.During a phone interview on 5/20/26 at 12:54 p.m., HRN-A stated she was the nurse who cared for R2 and recommended good peri care and reposition every two hours after she developed her stage 2 pressure ulcer. Turning and repositioning is very important to prevent pressure ulcers from occurring.During an interview on 5/20/26 at 1:28 p.m., assistant director of nursing (ADON) stated the Braden Scale provides a score and tells the risk of skin based off the assessment. Braden Scales are completed on admission, quarterly, annually, or if ADON visually saw a decline in a resident such as not getting out of bed or if the resident was on hospice. Bed bound residents should be repositioned every 2-3 hours. The facility does not do tissue tolerance assessments on residents. Nurses complete weekly skin checks on residents with baths and if reddened skin was reported, ADON would readjust plan of care. Residents would be provided with heel boots if facility noticed they were in bed more, not able to reposition themselves, and not mobile. If staff were also seeing redness that was not blanchable (skin would turn white when pressure applied and return to original color) on heels the facility may put heel boots on the resident. R1 should have been reassessed with a Braden Scale when he began declining as a decline would show signs his skin was at risk. R1's pressure injuries probably would have been avoidable. R2 sleeps in a recliner most of the time and does not have a pressure relieving device in the recliner. Facility does not put pressure relieving devices in recliners because of the risk of residents sliding off them. R2 was on a toileting schedule but would also alert staff when she needed to use the bathroom although she would already be incontinent.During an interview on 5/20/26 at 2:21 p.m., director of nursing (DON) stated the facility does not do tissue tolerance on residents. Braden Scale should be done on admission, quarterly, if a new ulcer appears, or with a change of condition. Braden Scale would kind of tell you if a resident needed to be on a turning/repositioning schedule but if someone had a stage one or two pressure ulcer they would automatically be placed on a two-hour repositioning schedule. NA's look at skin constantly and nurses observe skin weekly with baths and any skin issues would be identified through them. DON stated the facility did not have a policy for tissue tolerance or Braden Scales.The facility Wound Treatment Management dated 2/11/26, identified facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Treatment decisions will be based on: Etiology of the wound:Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage.Surgical.Incidental (i.e. skin tear, medical adhesive related skin injury).Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis).Characteristics of the wound:Pressure injury stage (or level of tissue destruction if not a pressure injury).Size - including shape, depth, and presence of tunneling and/or undermining.Volume and characteristics of exudate.Presence of pain.Presence of infection or need to address bacterial bioburden.Condition of the tissue in the wound bed.Condition of peri-wound skin.Location of the wound.Goals and preferences of the resident/representative. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include:Lack of progression towards healing.Changes in the characteristics of the wound (see above).Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.