DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3WST

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00669

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245585**

2.STATE VENDOR OR MEDICAID NO.
(L2) **145240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRAVERSE CARE CENTER**
(L4) **303 SEVENTH STREET SOUTH**
(L5) **WHEATON, MN** (L6) **56296**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2010**

6. DATE OF SURVEY **07/30/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supevisor 07/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/31/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245585

July 31, 2018

Ms. Calista Taffe, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Dear Ms. Taffe:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 25, 2018 the above facility is recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2018

Ms. Calista Taffe, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: Project Number S5585028

Dear Ms. Taffe:

On June 29, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 15, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 30, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 26, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 15, 2018, effective July 30, 2018 and therefore remedies outlined in our letter to you dated June 29, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3WST

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Facility ID: 00669

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(L3) **TRAVERSE CARE CENTER**
(L4) **303 SEVENTH STREET SOUTH**
(L5) **WHEATON, MN** (L6) **56296**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2010**

6. DATE OF SURVEY **06/15/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
LSC Surveyed as only one building

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 07/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 29, 2018

Ms. Calista Taffe, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: Project Number S5585028

Dear Ms. Taffe:

On June 15, 2018, a standard survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 25, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 25, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based

on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 December 15, 2018 (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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 12 through June 15, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 12 through June 15, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		7/25/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/06/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 655	Continued From page 1 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 655	Preparation, submission and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 655	Continued From page 2 failed to provide a summary of the baseline care plan, by completion of the comprehensive care plan to the resident or resident representative for 1 of 1 (R30) residents recently admitted. Findings include: R30's admission Minimum Data Set (MDS) dated 5/13/18, identified R30 was cognitively intact and had diagnoses which included non-pressure ulcers of right and left lower legs, depression and hypertension. R30's MDS also identified she required assistance with activities of daily living (ADL). R30's medical record lacked documentation of a baseline care plan, and had no indication a summary of the baseline care plan was provided to R30 or her representative. The facility verified and provided R30's current comprehensive care plan. On 6/12/18, R30 indicated the facility had never offered or given her a summary of her baseline care plan. On 6/15/18, at 10:51 a.m. MDS Coordinator (MDSC)-A indicated she had not offered or given R30 a summary of her baseline care plan. MDSC-A indicated she had never done this, and was not aware it was something she was supposed to do. MDSC-A indicated she kept the resident's base line care plans in her office once the comprehensive care plans were completed, and provided a copy of R30's baseline care plan to surveyor. On 6/15/18, at 11:25 a.m. director of nursing (DON) indicated she was not aware a summary	F 655	implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. • F655 Resident #30 and her representative have been given a copy of the baseline care plan. All other residents who admitted in the last quarter will be reviewed to ensure they have received the baseline care plan as required. Education on baseline care plans and resident and representative acknowledgement of receipt will be given to MDS/social worker and DON to ensure procedure is properly followed. DON/designee will audit weekly all new admissions to ensure they and their representative have explained and received a copy of the baseline care plan. DON/designee will audit weekly for 4 weeks and then monthly for 2 months and reviewed at QAPI to determine ongoing needs Deficient practice to be corrected by 7/25/2018	

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F 655	Continued From page 3 of the baseline care plan needed to be offered to the residents or resident representatives. The facility policy titled Baseline Resident Centered Care Plan, dated 9/22/17, identified a summary of the baseline care plan is shared with resident and/or resident's representative.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		7/25/18

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F 656	Continued From page 4 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for communication for 1 of 1 resident (R1) reviewed for communication. Findings include: R1's annual MDS dated 5/31/18, indicated R1 had moderate cognitive impairment and had diagnoses which included hypertension, heart failure and arthritis. The MDS indicated R1 required extensive assistance for all activities of daily living (ADLs) except eating, which R1 could complete independently. R1's MDS further indicated moderate difficulty hearing and no hearing aid or hearing appliance used. R1's Care Area Assessment (CAA) dated 6/13/18, indicated R1 was hard of hearing and that hearing may be contributing to a low score on cognitive testing. The CAA indicated R1 received new hearing aids recently and are not functioning properly. The facility was trying to find an audiologist to repair R1's current hearing aids.	F 656	• F656 Resident #1 care plan has been reviewed and updated for resident's communication needs. All residents care plans reviewed for presence of communication care plan if indicated. Social worker and MDS nurse will be educated on need for communication care plan as indicated by the MDS. Don/Designee audit weekly for 4 weeks and then monthly for 2 months and reviewed at QAPI to determine ongoing needs Deficient practice to be corrected by 7/25/2018	

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F 656	Continued From page 5 R1's CAA indicated communication would be addressed on the care plan with a goal to avoid complications. Review of R1's care plan revealed R1 preferred activites included playing cards with others, playing bingo and visiting with other residents or staff. However, R1's care plan lacked any information regarding R1's ability to hear, use of hearing devices or interventions to use to communicate with R1. On 6/12/18, at 6:56 p.m. R1 was seated in a wheelchair in the hallway outside their room. R1 stated to nursing assistant (NA)-D, I have to go to the bathroom. From approximately two feet away and standing up straight NA-D stated she would be right there to help her and walked away. R1 stated she could not hear NA-D and then stated "nevermind" as she shook her head left to right and dropped her hands in her lap. On 6/14/18, at 7:09 a.m. R1 was up and dressed and seated in wheelchair in the hall just outside of her room. Trained medication aide (TMA)-D approached R1 and from a standing position approximately three feet away asked R1 if she was ready for breakfast. R1 stated "I can't hear you" and TMA-D stated "I know, I know." TMA-D pushed R1 in her wheelchair back into her room. TMA-D hand wrote a note on a 4 inch by 6 inch note pad that read "do you want some coffee." R1 looked at the note with her glasses on and then looked up at TMA-D. TMA-D stated "can you read my writing" and R1 stated "no." TMA-D then bent down next to R1 and from a few inches away in a loud tone stated "it's breakfast time." R1 shrugged her shoulders and folded her hands into her lap. TMA-D then pushed R1 into the day	F 656		

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F 656	Continued From page 6 room outside of the dining area where other residents sat. R1 sat in the wheelchair and closed their eyes. On 6/15/18, at 10:01 a.m. TMA-D stated R1's hearing aids were sent to get fixed after getting broken a couple of weeks ago. TMA-D stated she felt bad for R1 due to not being able to hear anything. TMA-D stated R1 was worried about the hearing aids and asked about them often. She stated R1 could read her writing, and sometimes if you got really close to R1 and talked loud she could hear you. TMA-D was not aware if any other devices were tried with R1, and stated she had not received any education regarding communicating with R1. On 6/15/18, at 12:42 p.m. SSD-A stated she was unsure how long R1 had worn hearing aids, but R1 was hearing really well with them before they broke. SSD-A indicated a pocket talker was trailed with R1, but it did not seem to help her. SSD-A stated R1 was the most hearing impaired resident at the facility and would expect communication and ways to communicate with R1 to be on the care plan. SSD-A reviewed R1's care plan and confirmed communication was not on R1's care plan. On 6/15/18, at 1:09 p.m. MDS coordinator (MDSC)-A stated knowing R1's hearing and communication was a long-term concern and R1's hearing aids are broken at present. She stated she would expect to see communication and interventions on how to communicate with R1 on the care plan. On 6/15/18, at 2:59 p.m. director of nursing (DON) stated R1 could hear well with hearing	F 656		

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F 656	Continued From page 7 aids until the middle of May when the aids were sent to be fixed. DON stated she would expect to find hearing or communication on R1's care plan with interventions for staff to communicate effectively. A policy regarding communication and a policy regarding comprehensive care plans were requested, but not received from the facility.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		7/25/18

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F 657	Continued From page 8 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the comprehensive care plan was revised to include the use of transfer belts to promote safety with transfers for 1 of 1 resident (R3) reviewed for accidents. Findings include: R3's annual Minimum Data Set (MDS), dated 9/5/17, indicated R3 had moderately impaired cognition and diagnoses which included Alzheimer's disease, psychotic disorder and anxiety disorder. The MDS further indicated R3 required extensive assistance with transfers, bed mobility and walking, and had a fall since the last assessment. R3's quarterly MDS, dated 3/6/18, indicated R3 had severely impaired cognition and had diagnoses which included cerebrovascular accident (CVA), and had a fall since last assessment. The MDS further indicated, R3 was not steady and only stabilized with staff assistance when moved from a seated to a standing position, turned around and faced the opposite direction when walking, moved from on or off the toilet and when transferred from bed to chair or wheelchair. The MDS indicated R3 had a fall since the prior assessment. R3's Care Area Assessment (CAA) dated 9/15/17, indicated R3 had an actual problem with falls due to a history of falls and no sense of safety. The CAA indicated R3 had impaired balance during transitions, difficulty maintaining a	F 657	• F657 Resident #3 care plan has been reviewed and updated to reflect need for transfer belt with transfers. All residents care plans will be reviewed and revised to include transfer belts as indicated. Nursing staff educated on Policy and Procedure of use of transfer belts as indicated. DON/Designee will audit three times weekly for one month and then weekly for 2 months with review at QAPI to determine ongoing needs Deficient practice to be corrected by 7/25/2018	

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F 657	Continued From page 9 seated balance and did not know or understand what to do. R3's care plan printed 6/15/18, indicated R3 was a high fall risk due to history of transient ischemic attack (stroke), hypotension (low blood pressure), poor balance and poor communication/comprehension. In addition, R3's care plan indicated R3 required total staff assistance for activities of daily living which included transfers. However, R3's care plan lacked instructions for the use of a transfer belt for R3. R3's CNA [certified nursing assistant] Care Guide, last updated 6/15/18, indicated R3 was a fall risk and required assist of one staff for transfers. However, the Care Guide lacked direction for staff to utilize a transfer belt. During an observation on 6/14/18, at 7:50 a.m. R3 was lying in a low bed with a light colored, beveled edge fall mat at the base of the bed. Trained medication aide (TMA)-E approached R3, raised R3's bed to an approximate knee height and assisted R3 to a seated position, at the edge of the bed, with extensive assistance. R3 then laid back down and stated she was too tired and wanted to lay down longer. At 7:59 a.m. TMA-E positioned R3's wheelchair on top of the fall mat and locked the wheels, she then moved R3's positioning alarm (used to alert staff of self-transfer attempts) from R3's bed to R3's wheelchair. TMA-E then assisted R3 to a seated position with R3 utilizing the bedrail to assist in the transition. With R3's right hand on the bedrail, TMA-E approached R3 from the front, placed a hand under each of R3's underarms and extensively assisted R3 to stand. R3 stood up on	F 657		

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F 657	Continued From page 10	F 657		

top of the fall mat and before locking her knees R3's legs moved unsteadily and R3 sat back down on the edge of the bed. TMA-E encouraged R3 to try again and R3 stood again, with TMA-E holding onto R3's underarms and stood up. R3 pivoted her feet to the left as TMA-E held onto R3's underarms and assisted R3 to a seated position in the wheelchair. At 8:03 a.m. TMA-E pushed R3's wheelchair into the bathroom, positioned the wheelchair perpendicular to the toilet facing the wall and had R3 grab onto a hand bar attached to the bathroom wall. TMA-E stood in front of R3, again grabbed onto R3's underarms and told R3 to stand. R3 again required extensive assistance to stand and pivot onto the toilet. At 8:08 a.m. R3 stated they were done with the toilet. TMA-E asked R3 to grab onto the handrail and stand up. TMA-E stood to the right and behind R3 and placed two hands on the small of R3's back and pushed on R3's back as R3 pulled herself up with the handrail. TMA-E assisted R3 to pull up her incontinence brief and pants, then pivot her feet to the right and sat in the wheelchair.

On 6/15/18, at 10:04 a.m. TMA-D stated R3 required total assistance with cares, was getting over pneumonia and was very short of breath. TMA-D stated R3 transferred with one staff member utilizing a transfer belt and R3 would pivot her feet and sit down. TMA-D indicated a transfer belt was always used for transfers as R3 was a fall risk.

On 6/15/18, at 10:16 nursing assistant (NA)-E stated R3 was a fall risk and needed extensive assistance for pivot transfers. NA-E stated R3 would assist with the transfer by using the bedrail or grab bar in the bathroom, but NA-E always

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F 657	Continued From page 11 used a transfer belt due to R3's fall risk. On 6/15/18, at 1:54 p.m. licensed practical nurse (LPN)-A stated R3's ability to transfer was variable and due to their fall risk, LPN-A stated she always used a transfer belt when she transferred R3. LPN-A indicated staff should move R3's fall mat prior to transfers, so R3 had a solid surface to pivot her feet on. On 6/15/18, at 2:43 p.m. therapy site manager (TSM)-A stated nursing staff should always use a transfer belt when staff assistance was required for a transfer, especially if the resident was a fall risk. On 6/15/18, at 3:02 p.m. director of nursing (DON) stated R3 was a high fall risk, confirmed R3's care plan and care guide and stated she would expect staff to not transfer R3 on top of fall mats and use a transfer belt for every transfer. A policy regarding transfer belt use and comprehensive care plans was requested, however not provided by the facility.	F 657		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		7/25/18

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F 755	Continued From page 12 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a system to ensure controlled medication were promptly and accurately reconciled and secured while awaiting destruction to prevent potential loss or diversion. This practice had the potential to affect 4 of 4 residents (R30, R38, R96, R97) who had controlled medications awaiting destruction. In addition, the facility failed to implement a system to ensure expired medications were not adminsitered to residents for 1 of 1 resident (R94) who was administered expired medication. Findings include: On 6/15/18, at 10:30 a.m. a medication storage	F 755	• F755 Resident # 30, 38, 96, and 97 controlled medications have been destroyed in accordance with pharmacy guidelines. All other medications awaiting destruction have been destroyed in accordance with pharmacy guidelines. Nurses educated on the proper storage, including double locked expectation and the destruction of controlled medications. Resident #94 was immediately given a new mantoux with new tuberculin.	

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F 755	Continued From page 13 room tour was conducted with licensed practical nurse (LPN)-A. Above the counter of the medication storage room was a two door cabinet with a round silver lock with a key hole. Both doors of the cabinet opened without the use of a key. LPN-A identified the cabinet was used to store controlled medications awaiting destruction by the consultant pharmacist (CP). LPN-A stated when a controlled medication order was discontinued, or a resident with ordered controlled medication expired, the medication was double locked in this cabinet until the CP came monthly to destroy them. LPN-A stated the keys for the controlled medication cabinet was attached to the same key ring as the medication storage room key ring and each of the facilities two medication carts had these two keys. LPN-A indicated any licensed nurse or trained medication aide (TMA) would have access to these keys. LPN-A stated she was unaware when the last time the cabinet was accessed. The following medications were observed, with LPN-A, in the unlocked cabinet: -morphine sulfate 20 milligram (MG) per milliliter (ML), 46 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 46 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 47 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 22 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 17 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 2 individual prefilled syringes loose in the cabinet -tramadol 50 MG tablet, 24 tablets in 3 separate multi-dose plastic containers	F 755	Medications will be reviewed for expiration dates to ensure all are within the date to be use. Nursing staff will be educated on reviewing expiration dates before administering medication. Audits will be conducted three time weekly for one month and then weekly for 2 months with review at QAPI to determine ongoing needs Deficient practice to be corrected by 7/25/2018	

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F 755	Continued From page 14 -oxycodone/acetaminophen 5 MG/325 MG tablet, 5 tablets in a plastic multi-dose card -morphine sulfate extended release 15 MG tablet, 6 tablets in a plastic multi-dose card -lorazepam 0.5 MG tablet, 27 tablets in a plastic multi-dose card with one dose punched out of card and then taped back into place -lorazepam 0.5 MG tablet, 27 tablets in 6 separate multi-dose plastic containers LPN-A then closed and locked the cabinet with a key from her key ring and stated the cabinet should be locked at all times. On 6/15/18, at 10:54 a.m. during observation and interview with director of nursing (DON), the DON stated, when a controlled medication was discontinued or a resident with a supply of controlled medication expired, two staff count and reconcile the controlled medication, complete a Traverse Care Center Disposal of Medication form and document the discontinued date, medication/strength, prescription number, amount to be disposed of and the resident's name and place the form, along with the medication into the cabinet and lock the cabinet. Staff then fill out a Certificate of Inventory and Destruction of Controlled Substances Form 8-1, including the prescription number, drug name, strength, quantity and date it was placed in the cabinet. Staff then hang the form outside of the locked cabinet. The DON indicated this was the only time the medication was counted until it was destroyed by the CP monthly. When asked to observe the discontinued controlled medication in the medication storage room, the DON obtained a key ring from the top drawer of a locked medication cart, used a key to	F 755		

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	245585	A. BUILDING _____ B. WING _____	06/15/2018

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F 755	Continued From page 15 open the medication storage room door, then another key from the same key ring to unlock the controlled medication storage cabinet and opened the cabinet. Inside the cabinet were multiple loose papers titled Traverse Care Center Disposal of Medication and multiple medications awaiting destruction. The DON confirmed the medications that were observed with LPN-A. Review of the Traverse Care Center Disposal of Medication forms, with the DON, revealed the plastic multi-dose card with 27 lorazepam 0.5 MG tablets and the plastic multi-dose card containing 5 tablets of oxycodone/acetaminophen 5 MG/325 MG tablets from R96 and R30 had not been entered on to a form per regular procedure. Review of the Certificate of Inventory and Destruction of Controlled Substances Form 8-1, taped to the cabinet to the right of the controlled medication storage cabinet, with the DON, revealed the form lacked the addition of R96's plastic multi-dose card with 27 lorazepam 0.5 MG tablets. -At 11:00 a.m. DON stated she would not expect to find 2 loose prefilled morphine sulfate 20 MG per ML syringes in the cabinet not accompanied with a Traverse Care Center Disposal of Medication form. DON indicated the lot number and filled by date matched another plastic bag of morphine sulfate 20 MG per ML prefilled syringes and would presume they would belong with that bag, but the amount recorded for the bag of syringes were incorrect. DON stated the large amount of morphine sulfate prefilled syringes would be due to a few residents graduated off of hospice services. She indicated the amount of controlled medication the facility was receiving	F 755		

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F 755	Continued From page 16	F 755		

from the hospice agency was too much and she would be speaking to the hospice agency regarding the amount they were sending. The DON indicated she was unaware how long the controlled medication cabinet had been open or when it was last accessed. The DON stated her expectation for staff would be to enter all information on the Certificate of Inventory and Destruction of Controlled Substances Form 8-1 and Traverse Care Center Disposal of Medication with accurate medication counts and the controlled medication storage cabinet be locked at all times.

On 6/15/18, at 2:30 p.m. Consultant Pharmacist (CP)-A stated he would expect the second lock on the controlled medication cabinet in the medication storage room to be locked when not in use. CP-A stated part of his role was to ensure controlled medications were destroyed at each monthly visit, but indicated he did not destroy any controlled medication on his 6/1/18 visit. CP-A indicated the amount of controlled medication, along with inaccurate documentation and the cabinet being unlocked could add to the potential for controlled drug diversion.

Review of the Consultant Pharmacist Drug Regimen Review Summary dated 6/1/18 indicated medication storage spot checks were okay. Under the heading: Controlled Substance Destruction, it indicated none was completed due to "none prepared for destruction. RN [registered nurse] to make preparations for 7/2018."

Expired Meds:

On 6/15/18, at 10:30 a.m. during an observation and interview with LPN-A, a medication storage

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F 755	Continued From page 17 room tour was conducted. A medication storage refrigerator was observed stacked on top of another refrigerator that was used to store pop and drinks for residents. On a shelf of the refrigerator was a plastic tray where multiple vials of medications were stored. Two vials of tuberculin purified protein (an extract of Mycobacterium tuberculosis, the bacteria that cause tuberculosis in humans, used to test if a person had been exposed to tuberculin protein), were observed. One vial was opened, and the vial's box was dated as opened on 5/2/18. The side of the Tuberculin vial's box indicated to discard opened product after 30 days. LPN-A stated the tuberculin was used for new resident admissions and new staff. LPN-A verified the date opened on the vial of tuberculin was 5/2/18, and the product packaging indicated to discard after 30 days and placed the expired tuberculin back in the refrigerator. -At 10:44 a.m. a storage cabinet to the right of the refrigerators was observed to have a 12 ounce green plastic bottle of double strength antacid with an expiration date of 4/18. LPN-A stated the bottle was to be used as a stock medication, which meant any resident who utilized the standing order for antacid had the potential to use stock antacid. LPN-A confirmed the expiration date of 4/18, and indicated licensed nurses or TMAs were responsible for removing expired medication from the medication room. LPN-A removed the antacid from the medication storage room and indicated it was to be discarded. LPN-A stated there was no procedure in place to regularly go through the medication storage room to identify expired medications. On 6/15/18, at 10:54 a.m. during an observation	F 755		

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F 755	Continued From page 18 and interview of the medication storage room with the DON, the medication storage room refrigerator was observed. The DON verified the vial of tuberculin was dated as opened on 5/2/18, and the manufacture's product packaging indicated to discard open product 30 days after opening. DON stated the tuberculin vial dated 5/2/18, would be used for new admissions and new employees. DON indicated only one admission had occurred since the tuberculin expired which was R94 on 6/4/18. She stated the nurses should be discarding expired medications by the expiration dates. DON stated she thought the CP-A told the nurses the tuberculin was about to expire last time he was here on 6/1/18. On 6/15/18, at 2:30 p.m. CP-A stated his regular duties at the facility included a spot check of the medication storage room, but that he did not check each individual medication for expiration dates. CP-A stated his last time at the facility was on 6/1/18, and the medication storage spot check was okay. He indicated he did update nursing staff that a tuberculin vial had been used for administration was not dated when opened. He stated he would expect expired medications to be disposed, so residents do not have the potential for receiving expired medications. CP-A indicated if a resident received expired tuberculin, that the facility should administer new tuberculin as the original test may not be accurate. Review of the Consultant Pharmacist Drug Regimen Review Summary dated 6/1/18 indicated medication storage spot checks were okay. Under the heading: Labeling: it indicated in the refrigerator was a tuberculin test vial not dated.	F 755		

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F 755	Continued From page 19 On 6/15/18, at 2:53 p.m. DON confirmed R94 was the only resident to receive the expired tuberculin and no new staff had been hired. DON indicated R94 would receive a new tuberculin test due to receiving expired tuberculin. Review of facility provided policy titled Medications-Controlled, last revised 3/1/14, indicated controlled substances are kept under double lock either in the medication room or the medication cart. A count of controlled drugs are maintained by nurses of the off-going and oncoming shifts. When a resident was discharged or deceased, remove the drug from cart and medication book, verify count and complete the necessary records for discontinued/discharged medications and take the drug to DON or designee to be locked up until time for destruction in accordance with State Pharmacy Board.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		7/25/18

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F 880	Continued From page 20 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 21 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for proper disinfection of a multi -use glucometer was implemented to prevent the spread of infection. This had the potential to effect 5 of 5 residents (R5, R15, R34, R37, R42) who utilized the shared glucometer. In addition, the facility failed to ensure proper disinfection of a multi-use Hoyer lift (full body mechanical lift) was implemented to prevent the spread of infection for 2 of 2 residents (R20, R15,) observed to utilize the Hoyer lift. Findings include: Glucometers R5's Medication Review Report dated 5/28/18, included a diagnosis of type 2 diabetes mellitus. The report included an order to check blood glucose at 2:00 p.m. and 7:00 p.m. once weekly. R15's Medication Review Report dated 5/28/18, included a diagnosis of type 2 diabetes mellitus. The report included an order to check blood glucose four times a day. R34's Medication Review Report dated 5/25/18, included a diagnosis of type 2 diabetes mellitus.	F 880	• F880 Residents #5, 15, 34, 37 and 42 were provided their own glucometer for blood glucose monitoring. Nursing staff educated on proper disinfection of the glucometer. Residents #20 and 15 have had Hoyer lift disinfected between uses moving forward. Nursing staff educated on the proper disinfection of the lift machines between uses. Audits will be conducted by DON/Designee three times per week for one month hand then weekly for 2 months to ensure that proper disinfection is occurring. Deficient practice to be corrected by 7/25/2018	

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F 880	Continued From page 22 The report included an order to check blood glucose two times a day. R37's Medication Review Report dated 5/25/18, included a diagnosis of type 2 diabetes mellitus. The report included an order to check blood glucose two times a week, every Monday and Friday. On 6/12/18, at 4:51 p.m. trained medical assistant (TMA)-A carried a white plastic bin which contained a glucometer, a bottle of glucose strips, lancets, and alcohol wipes to R15's room. TMA-A set the plastic bin on the top of the over the bed table. TMA-A washed her hands, donned gloves, and proceeded to obtain a blood sample from R15's finger to check blood sugar. When the results of the test were obtained, TMA-A removed the strip from the glucometer, set the glucometer into the bin without cleansing it. TMA-A carried the plastic bin to the nurse's cart with the same soiled gloves used for the blood glucose sampling. TMA-A placed the plastic bin into the top right hand drawer of the medication cart, removed her gloves and disposed of the refuse into the garbage receptacle on the side of the medication cart. The glucometer and plastic bin were not disinfected prior to placing it in to the cart. On 6/12/18, at 5:00 TMA-A verified the glucometer was used for all residents who needed a blood glucose level checked and indicated she had followed her usual practice for testing a resident's blood sugar level. TMA-A indicated she had previously checked another resident's blood glucose level at 4:00 p.m. the same day.	F 880		

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F 880	Continued From page 23 On 6/14/18, at 9:09 a.m. TMA-C applied hand sanitizer to her hands, retrieved a white plastic bin which contained glucometer supplies and a pair of rubber gloves. TMA-C carried the supplies to R15's room, placed the bin directly on the over the bed table and donned the gloves. After the results of the test were obtained, TMA-C returned the glucometer to the top of the over the bed table. TMA-C removed her gloves, wiped the glucometer with an alcohol wipe, placed glucometer into the plastic bin and returned the bin to the top right side drawer of the nurses cart. On 6/15/18, at 10:25 a.m. TMA-C verified the glucometer was used for all residents who required a blood glucose check. TMA-A identified the glucometer was disinfected between residents with a germicidal sani-wipe or with the alcohol wipe. TMA-C identified she used either the sani-wipe or the alcohol wipe, however; most often used the alcohol wipe because they were handy. On 6/15/18, at 10:29 a.m. licensed practical nurse (LPN)-A verified the glucometer should only be disinfected with the germicidal sani- wipe in the purple top container. On 6/15/18, at 3:22 p.m. the director of nursing (DON) verified the glucometers were multi-use and were to be disinfected between each resident. The DON identified an alcohol wipe was to be used to wipe the glucometer and then the germicidal sani-wipe was used as the disinfectant. The DON identified the glucometer was to remain wet with the disinfectant for two minutes. The DON indicated the staff had received education in the past regarding the disinfection of glucometers.	F 880		

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F 880	Continued From page 24 The facility policy titled Glucometer Infection Control Guidance dated March 2014, directed the following: It is the policy of this facility that glucometers that are shared between more than one resident are disinfected between each resident use and listed #4. Use an EPA-Registered disinfectant effective against HBV (hepatitis B), HCV(hepatitis C), and HIV(human immunodeficiency virus). Hoyer lift On 6/14/18, at 8:20 a.m. nursing assistant (NA)-B entered R20's room with the activity director (AD)/NA and a Hoyer lift . Both facility staff washed their hands and donned gloves. NA-B washed R20 with a wash cloth and a basin of soapy water. NA-B washed and dried R20's peri area. NA-B with the same dirty gloves used to provide peri care, grasped the lift by the part directly above the cradle (what the sling attaches to). NA-B moved the lift out of the way and continued to walk towards the bathroom. After R20 was washed and dressed, NA-B removed the lift from the room and placed it in the hall against a wall. The lift had a dark colored substance, approximately 4 centimeters (cm) by 2 cm observed on the area grasped by NA-B. NA-B did not clean or sanitize the lift and exited the area. On 6/14/18, at 9:22 a.m. NA-B and NA-C assisted R15 from bed into his wheel chair with the use of the hoyer lift. After R15 propelled himself from the room, NA-C pushed the lift from the room to the hall and placed it next to the wall. The lift was not disinfected and the dark substance remained visible on the lift.	F 880		

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F 880	Continued From page 25 On 6/15/18, at 3:22 p.m. the DON verified the lifts were multi-use and should be wiped down with a disinfectant after each use. The DON indicated she believed staff were not using the disinfectant wipes because they had not been easily accessible. The DON indicated in the future, the wipes would be more accessible and all staff re-educated. The facility policy titled Environment -Cleaning of equipment, dated April 1, 2008, directed all unit equipment (e.g., refrigerators, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and eternal equipment) is cleaned on a routine basis.	F 880		

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	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/14/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/06/2018

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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TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH** **WHEATON, MN 56296**

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K 000	Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building due to no 2 hour fire barrier between the construction types and considered as the least fire resistive construction as per 8.2.1.3 (3) and with the adoption of the 2012 LSC, they are now considered existing buildings. Wings 100, 200. were constructed in 1967 and was determined to be of Type II(111) construction. It is 1 story with partial basement and is fully protected with fire sprinklers with smoke detectors in the corridors and spaces open to the corridors. Wings 300, 400 and 500 were constructed in 2005 and was determined to be of Type V(111) construction. It is 1 story with no basement and is	K 000		

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	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/14/2018**

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K 000	Continued From page 2 fully protected with fire sprinkler with smoke detectors in the resident rooms and spaces open to the corridors. The facility is separated by one two hour fire barrier and 4 smoke barriers The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced	K 131		6/18/18

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K 131	Continued From page 3 by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 06/14/2018 observations revealed the two hour fire barrier separating the independent living facility has a 2 foot by 2 foot opening through the block that has been covered over by a wall that does not meet the 2 hour rating. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director	K 131	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. • K131 Environmental Services Director and Maintenance Assistant installed two layers of 5/8" UL rated sheetrock in the 2 foot by 2 foot opening to ensure the fire barrier meets the 2 hour rating between the skilled nursing home and independent living. All seams were sealed with fire retardant caulk. The remainder of the fire barrier wall separating the skilled nursing home and independent living was audited to ensure all other areas were in compliance with the two hour fire rating. Environmental Services Director was educated on the K131 regulation. Deficient practice was corrected on 6/18/2018.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		7/25/18

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K 321	Continued From page 4 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain Three hazardous storage rooms in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 34 of the 49 residents and an undetermined amount of staff and visitors.	K 321	• K321 The Environmental Services Director has ordered three 45 minute fire rated doors on 7/5/2018. These doors will be installed on clean storage room 517, clean storage room 512, and soiled utility room 314 upon their arrival. Environmental Services Director was educated on the K321 regulation.	

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K 321	Continued From page 5 Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/14/2018 observations revealed combustible storage room 517 and clean storage room 512 are over 100 sq ft and do not have 45 minute rated doors. The soiled utility room in wing 300 of the 2005 addition does not have a 45 minute rated door. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director	K 321	Environmental Services will audit all enclosed hazardous areas in the 2005 edition to ensure proper fire rated doors are installed. Environmental Services Director will report results to QAPI monthly for three months. Deficient practice to be corrected by 7/25/2018.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in	K 341	• K341 The Environmental Services Director	7/25/18

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K 341	Continued From page 6 accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/14/2018 observations revealed a smoke detector in the office support room was too close, within 36 inches, of an HVAC diffuser. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 341	ordered two deflectors for the HVAC vents on 6/15/2018. The Environmental Services Director and Maintenance Assistant installed a deflector on the HVAC vent in the front office room and laundry room to redirect air flow away from the smoke detector on 6/21/2018. Environmental Services Director was educated on the K341 regulation. All smoke detectors were checked by the Environmental Services Director in the facility to ensure that they were not installed within 36 inches of a HVAC vent. Environmental Services Director will audit smoke detectors to ensure they are not within 36 inches of a HVAC Vent monthly for three months. Environmental Services Director will report results to QAPI monthly for three months. Deficient practice to be corrected on by 7/25/18.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		7/25/18

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K 345	Continued From page 7 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to verify the DACT signal as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.3 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, table 14.3.1. This deficient condition could delay alarm notification to emergency personnel in case of a failure and affect all 49 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 06/14/2018 review of the documents revealed transmission of the fire alarm signal was not sent the next day following an overnight fire drill. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 345	• K345 Fire drill was completed on 6/26/2018 at 13:10. Audible alarm signal was sent and received by Fire Alarm Company on 6/26/2018 at 13:20. Audits of alarms will be completed after each fire drill by the Director of Maintenance and reported to QAPI. Environmental Services Director was educated on the K345 regulation. Environmental Services Director or designee will complete monthly audits of each fire drill to ensure that a fire alarm signal will be sent to the monitoring company for twelve months. Environmental Services Director will report results to QAPI monthly for twelve months. Deficient practice to be corrected by 7/25/2018	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall	K 372		7/25/18

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K 372	Continued From page 8 be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of two smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 34 of the 49 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 06/14/2018 observations revealed penetrations in the following smoke barriers. 1. Above the ceiling in the telephone room, a 1 inch hole. 2. Inside the med room in wing 500 above the ceiling tile tile, a 1 1/2 inch by 3 inch hole. 3. Inside the treatment room of wing 300, an annular space around the sprinkler pipe. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 372	• K372 Environmental Services Director and Maintenance Assistant filled the following penetrations with fire retardant caulk on 6/18/2018. 1. Above ceiling in the telephone room, a 1 inch hole. 2. Inside the med room in wing 500 above the ceiling tile, a 1.5 inch by 3 inch hole. 3. Inside the treatment room of wing 300, an annular space around the sprinkler pipe. Environmental Services Director was educated on K372 regulation. Environmental Services Director completed an audit on 6/18/18 of entire building to ensure all fire walls are in compliance and all penetrations are properly sealed to adhere to fire code. The audit revealed that 13 areas needed correction. All 13 areas will filled with fire retardant caulk on 6/18/18. Environmental Services Director or	

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K 372	Continued From page 9	K 372	designee will audit all smoke barriers monthly for three months. Deficient practice to be corrected by 7/25/2018	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 49 of 49 residents as well as an undetermined number	K 914	• K914 Environmental Services Director ordered a pull tester from Grainger on 6/15/18. Environmental Services Director and Maintenance Assistant began an electrical	7/25/18

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K 914	Continued From page 10 of staff, and visitors to the facility. Findings include: On the facility tour between 8:30 am to 1:00 pm on 06/14/2018 documentation review revealed there was no record of receptacle inspections in the patient care areas in the last 12 months. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 914	receptacle inspection in all patient care areas on 7/4/18. Inspection is to be completed by 7/13/2018. Environmental Services Director is to complete the annual electrical receptacle inspection yearly in the month of July. The routine schedule has been entered into our online building maintenance platform, TELS. Environmental Services Director to report 2018 electrical receptacle audit results to QA. Executive Director will ensure compliance annually. Deficient practice to be corrected by 7/25/2018.	

Electronically delivered
June 29, 2018

Ms. Calista Taffe, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: State Nursing Home Licensing Orders - Project Number S5585028

Dear Ms. Taffe:

The above facility was surveyed on June 12, 2018 through June 15, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 12 through June 15, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 12 through June 15, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		7/25/18

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

Electronically Signed | 07/06/2018

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 655	Continued From page 1 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 655	Preparation, submission and	

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	245585	A. BUILDING _____ B. WING _____	06/15/2018

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F 655	Continued From page 2 failed to provide a summary of the baseline care plan, by completion of the comprehensive care plan to the resident or resident representative for 1 of 1 (R30) residents recently admitted. Findings include: R30's admission Minimum Data Set (MDS) dated 5/13/18, identified R30 was cognitively intact and had diagnoses which included non-pressure ulcers of right and left lower legs, depression and hypertension. R30's MDS also identified she required assistance with activities of daily living (ADL). R30's medical record lacked documentation of a baseline care plan, and had no indication a summary of the baseline care plan was provided to R30 or her representative. The facility verified and provided R30's current comprehensive care plan. On 6/12/18, R30 indicated the facility had never offered or given her a summary of her baseline care plan. On 6/15/18, at 10:51 a.m. MDS Coordinator (MDSC)-A indicated she had not offered or given R30 a summary of her baseline care plan. MDSC-A indicated she had never done this, and was not aware it was something she was supposed to do. MDSC-A indicated she kept the resident's base line care plans in her office once the comprehensive care plans were completed, and provided a copy of R30's baseline care plan to surveyor. On 6/15/18, at 11:25 a.m. director of nursing (DON) indicated she was not aware a summary	F 655	implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. • F655 Resident #30 and her representative have been given a copy of the baseline care plan. All other residents who admitted in the last quarter will be reviewed to ensure they have received the baseline care plan as required. All new admissions will be audited to ensure they receive their base line care plan. Education on baseline care plans and resident and representative acknowledgement of receipt will be given to all IDT and Nursing staff to ensure procedure is properly followed. DON/designee will audit weekly all new admissions to ensure they and their representative have explained and received a copy of the baseline care plan. DON/designee will audit weekly for 4 weeks and then monthly for 2 months and reviewed at QAPI to determine ongoing needs Deficient practice to be corrected by	

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F 655	Continued From page 3 of the baseline care plan needed to be offered to the residents or resident representatives. The facility policy titled Baseline Resident Centered Care Plan, dated 9/22/17, identified a summary of the baseline care plan is shared with resident and/or resident's representative.	F 655	7/25/2018	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		7/25/18

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F 656	Continued From page 4 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for communication for 1 of 1 resident (R1) reviewed for communication. Findings include: R1's annual MDS dated 5/31/18, indicated R1 had moderate cognitive impairment and had diagnoses which included hypertension, heart failure and arthritis. The MDS indicated R1 required extensive assistance for all activities of daily living (ADLs) except eating, which R1 could complete independently. R1's MDS further indicated moderate difficulty hearing and no hearing aid or hearing appliance used. R1's Care Area Assessment (CAA) dated 6/13/18, indicated R1 was hard of hearing and that hearing may be contributing to a low score on cognitive testing. The CAA indicated R1 received new hearing aids recently and are not functioning properly. The facility was trying to find an audiologist to repair R1's current hearing aids.	F 656	• F656 Resident #1 care plan has been reviewed and updated for resident's communication needs. All residents care plans will be audited for the presence of communication care plan if indicated, including new admissions to ensure that residents have a communication care plan if indicated. All licensed staff, Social Worker Designee and MDS nurse will be educated on need for communication care plan as indicated by the MDS and ongoing monitoring of the comprehensive care plan to ensure all areas are included, including communication. Don/Designee will audit communication care plans weekly for 4 weeks and then monthly for 2 months and reviewed at QAPI to determine ongoing needs Deficient practice to be corrected by	

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F 656	Continued From page 5 R1's CAA indicated communication would be addressed on the care plan with a goal to avoid complications. Review of R1's care plan revealed R1 preferred activites included playing cards with others, playing bingo and visiting with other residents or staff. However, R1's care plan lacked any information regarding R1's ability to hear, use of hearing devices or interventions to use to communicate with R1. On 6/12/18, at 6:56 p.m. R1 was seated in a wheelchair in the hallway outside their room. R1 stated to nursing assistant (NA)-D, I have to go to the bathroom. From approximately two feet away and standing up straight NA-D stated she would be right there to help her and walked away. R1 stated she could not hear NA-D and then stated "nevermind" as she shook her head left to right and dropped her hands in her lap. On 6/14/18, at 7:09 a.m. R1 was up and dressed and seated in wheelchair in the hall just outside of her room. Trained medication aide (TMA)-D approached R1 and from a standing position approximately three feet away asked R1 if she was ready for breakfast. R1 stated "I can't hear you" and TMA-D stated "I know, I know." TMA-D pushed R1 in her wheelchair back into her room. TMA-D hand wrote a note on a 4 inch by 6 inch note pad that read "do you want some coffee." R1 looked at the note with her glasses on and then looked up at TMA-D. TMA-D stated "can you read my writing" and R1 stated "no." TMA-D then bent down next to R1 and from a few inches away in a loud tone stated "it's breakfast time." R1 shrugged her shoulders and folded her hands into her lap. TMA-D then pushed R1 into the day	F 656	7/25/2018	

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F 656	Continued From page 6	F 656		

room outside of the dining area where other residents sat. R1 sat in the wheelchair and closed their eyes.

On 6/15/18, at 10:01 a.m. TMA-D stated R1's hearing aids were sent to get fixed after getting broken a couple of weeks ago. TMA-D stated she felt bad for R1 due to not being able to hear anything. TMA-D stated R1 was worried about the hearing aids and asked about them often. She stated R1 could read her writing, and sometimes if you got really close to R1 and talked loud she could hear you. TMA-D was not aware if any other devices were tried with R1, and stated she had not received any education regarding communicating with R1.

On 6/15/18, at 12:42 p.m. SSD-A stated she was unsure how long R1 had worn hearing aids, but R1 was hearing really well with them before they broke. SSD-A indicated a pocket talker was trailed with R1, but it did not seem to help her. SSD-A stated R1 was the most hearing impaired resident at the facility and would expect communication and ways to communicate with R1 to be on the care plan. SSD-A reviewed R1's care plan and confirmed communication was not on R1's care plan.

On 6/15/18, at 1:09 p.m. MDS coordinator (MDSC)-A stated knowing R1's hearing and communication was a long-term concern and R1's hearing aids are broken at present. She stated she would expect to see communication and interventions on how to communicate with R1 on the care plan.

On 6/15/18, at 2:59 p.m. director of nursing (DON) stated R1 could hear well with hearing

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F 656	Continued From page 7 aids until the middle of May when the aids were sent to be fixed. DON stated she would expect to find hearing or communication on R1's care plan with interventions for staff to communicate effectively. A policy regarding communication and a policy regarding comprehensive care plans were requested, but not received from the facility.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		7/25/18

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F 657	Continued From page 8 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the comprehensive care plan was revised to include the use of transfer belts to promote safety with transfers for 1 of 1 resident (R3) reviewed for accidents. Findings include: R3's annual Minimum Data Set (MDS), dated 9/5/17, indicated R3 had moderately impaired cognition and diagnoses which included Alzheimer's disease, psychotic disorder and anxiety disorder. The MDS further indicated R3 required extensive assistance with transfers, bed mobility and walking, and had a fall since the last assessment. R3's quarterly MDS, dated 3/6/18, indicated R3 had severely impaired cognition and had diagnoses which included cerebrovascular accident (CVA), and had a fall since last assessment. The MDS further indicated, R3 was not steady and only stabilized with staff assistance when moved from a seated to a standing position, turned around and faced the opposite direction when walking, moved from on or off the toilet and when transferred from bed to chair or wheelchair. The MDS indicated R3 had a fall since the prior assessment. R3's Care Area Assessment (CAA) dated 9/15/17, indicated R3 had an actual problem with falls due to a history of falls and no sense of safety. The CAA indicated R3 had impaired balance during transitions, difficulty maintaining a	F 657	• F657 Resident #3 care plan has been reviewed and updated to reflect need for transfer belt with transfers. All residents care plans will be reviewed and revised to include transfer with gait belts as indicated. Nursing staff educated on Policy and Procedure of use of transfer belts as indicated. DON/Designee will audit transfers with gait belts three times weekly for one month and then weekly for 2 months with review at QAPI to determine ongoing needs Deficient practice to be corrected by 7/25/2018	

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F 657	Continued From page 9 seated balance and did not know or understand what to do. R3's care plan printed 6/15/18, indicated R3 was a high fall risk due to history of transient ischemic attack (stroke), hypotension (low blood pressure), poor balance and poor communication/comprehension. In addition, R3's care plan indicated R3 required total staff assistance for activities of daily living which included transfers. However, R3's care plan lacked instructions for the use of a transfer belt for R3. R3's CNA [certified nursing assistant] Care Guide, last updated 6/15/18, indicated R3 was a fall risk and required assist of one staff for transfers. However, the Care Guide lacked direction for staff to utilize a transfer belt. During an observation on 6/14/18, at 7:50 a.m. R3 was lying in a low bed with a light colored, beveled edge fall mat at the base of the bed. Trained medication aide (TMA)-E approached R3, raised R3's bed to an approximate knee height and assisted R3 to a seated position, at the edge of the bed, with extensive assistance. R3 then laid back down and stated she was too tired and wanted to lay down longer. At 7:59 a.m. TMA-E positioned R3's wheelchair on top of the fall mat and locked the wheels, she then moved R3's positioning alarm (used to alert staff of self-transfer attempts) from R3's bed to R3's wheelchair. TMA-E then assisted R3 to a seated position with R3 utilizing the bedrail to assist in the transition. With R3's right hand on the bedrail, TMA-E approached R3 from the front, placed a hand under each of R3's underarms and extensively assisted R3 to stand. R3 stood up on	F 657		

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F 657	Continued From page 10	F 657		

top of the fall mat and before locking her knees R3's legs moved unsteadily and R3 sat back down on the edge of the bed. TMA-E encouraged R3 to try again and R3 stood again, with TMA-E holding onto R3's underarms and stood up. R3 pivoted her feet to the left as TMA-E held onto R3's underarms and assisted R3 to a seated position in the wheelchair. At 8:03 a.m. TMA-E pushed R3's wheelchair into the bathroom, positioned the wheelchair perpendicular to the toilet facing the wall and had R3 grab onto a hand bar attached to the bathroom wall. TMA-E stood in front of R3, again grabbed onto R3's underarms and told R3 to stand. R3 again required extensive assistance to stand and pivot onto the toilet. At 8:08 a.m. R3 stated they were done with the toilet. TMA-E asked R3 to grab onto the handrail and stand up. TMA-E stood to the right and behind R3 and placed two hands on the small of R3's back and pushed on R3's back as R3 pulled herself up with the handrail. TMA-E assisted R3 to pull up her incontinence brief and pants, then pivot her feet to the right and sat in the wheelchair.

On 6/15/18, at 10:04 a.m. TMA-D stated R3 required total assistance with cares, was getting over pneumonia and was very short of breath. TMA-D stated R3 transferred with one staff member utilizing a transfer belt and R3 would pivot her feet and sit down. TMA-D indicated a transfer belt was always used for transfers as R3 was a fall risk.

On 6/15/18, at 10:16 nursing assistant (NA)-E stated R3 was a fall risk and needed extensive assistance for pivot transfers. NA-E stated R3 would assist with the transfer by using the bedrail or grab bar in the bathroom, but NA-E always

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F 657	Continued From page 11 used a transfer belt due to R3's fall risk. On 6/15/18, at 1:54 p.m. licensed practical nurse (LPN)-A stated R3's ability to transfer was variable and due to their fall risk, LPN-A stated she always used a transfer belt when she transferred R3. LPN-A indicated staff should move R3's fall mat prior to transfers, so R3 had a solid surface to pivot her feet on. On 6/15/18, at 2:43 p.m. therapy site manager (TSM)-A stated nursing staff should always use a transfer belt when staff assistance was required for a transfer, especially if the resident was a fall risk. On 6/15/18, at 3:02 p.m. director of nursing (DON) stated R3 was a high fall risk, confirmed R3's care plan and care guide and stated she would expect staff to not transfer R3 on top of fall mats and use a transfer belt for every transfer. A policy regarding transfer belt use and comprehensive care plans was requested, however not provided by the facility.	F 657		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		7/25/18

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F 755	Continued From page 12 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a system to ensure controlled medication were promptly and accurately reconciled and secured while awaiting destruction to prevent potential loss or diversion. This practice had the potential to affect 4 of 4 residents (R30, R38, R96, R97) who had controlled medications awaiting destruction. In addition, the facility failed to implement a system to ensure expired medications were not adminsitered to residents for 1 of 1 resident (R94) who was administered expired medication. Findings include: On 6/15/18, at 10:30 a.m. a medication storage	F 755	• F755 Resident # 30, 38, 96, and 97 controlled medications have been destroyed in accordance with pharmacy guidelines. All other medications awaiting destruction have been destroyed in accordance with pharmacy guidelines. Nurses educated on the proper storage, including double locked expectation and the destruction of controlled medications. Weekly audits will be done to ensure that medications are destroyed in a timely manner x's 3 months	

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TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 755	Continued From page 13 room tour was conducted with licensed practical nurse (LPN)-A. Above the counter of the medication storage room was a two door cabinet with a round silver lock with a key hole. Both doors of the cabinet opened without the use of a key. LPN-A identified the cabinet was used to store controlled medications awaiting destruction by the consultant pharmacist (CP). LPN-A stated when a controlled medication order was discontinued, or a resident with ordered controlled medication expired, the medication was double locked in this cabinet until the CP came monthly to destroy them. LPN-A stated the keys for the controlled medication cabinet was attached to the same key ring as the medication storage room key ring and each of the facilities two medication carts had these two keys. LPN-A indicated any licensed nurse or trained medication aide (TMA) would have access to these keys. LPN-A stated she was unaware when the last time the cabinet was accessed. The following medications were observed, with LPN-A, in the unlocked cabinet: -morphine sulfate 20 milligram (MG) per milliliter (ML), 46 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 46 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 47 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 22 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 17 individual prefilled syringes in a 1 gallon clear plastic bag -morphine sulfate 20 MG per ML, 2 individual prefilled syringes loose in the cabinet -tramadol 50 MG tablet, 24 tablets in 3 separate multi-dose plastic containers	F 755	Resident #94 was immediately given a new Mantoux with new tuberculin. Medications will be reviewed for expiration dates daily x's 3 months to ensure all are within the date to be used. Nursing staff will be educated on reviewing expiration dates before administering medication. Audits will be conducted three times weekly for one month and then weekly for 2 months with review at QAPI to determine ongoing needs to ensure the narcotic cupboard is double locked. Deficient practice to be corrected by 7/25/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH WHEATON, MN 56296**

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F 755	Continued From page 14 -oxycodone/acetaminophen 5 MG/325 MG tablet, 5 tablets in a plastic multi-dose card -morphine sulfate extended release 15 MG tablet, 6 tablets in a plastic multi-dose card -lorazepam 0.5 MG tablet, 27 tablets in a plastic multi-dose card with one dose punched out of card and then taped back into place -lorazepam 0.5 MG tablet, 27 tablets in 6 separate multi-dose plastic containers LPN-A then closed and locked the cabinet with a key from her key ring and stated the cabinet should be locked at all times. On 6/15/18, at 10:54 a.m. during observation and interview with director of nursing (DON), the DON stated, when a controlled medication was discontinued or a resident with a supply of controlled medication expired, two staff count and reconcile the controlled medication, complete a Traverse Care Center Disposal of Medication form and document the discontinued date, medication/strength, prescription number, amount to be disposed of and the resident's name and place the form, along with the medication into the cabinet and lock the cabinet. Staff then fill out a Certificate of Inventory and Destruction of Controlled Substances Form 8-1, including the prescription number, drug name, strength, quantity and date it was placed in the cabinet. Staff then hang the form outside of the locked cabinet. The DON indicated this was the only time the medication was counted until it was destroyed by the CP monthly. When asked to observe the discontinued controlled medication in the medication storage room, the DON obtained a key ring from the top drawer of a locked medication cart, used a key to	F 755		

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F 755	Continued From page 15	F 755		

open the medication storage room door, then another key from the same key ring to unlock the controlled medication storage cabinet and opened the cabinet. Inside the cabinet were multiple loose papers titled Traverse Care Center Disposal of Medication and multiple medications awaiting destruction. The DON confirmed the medications that were observed with LPN-A.

Review of the Traverse Care Center Disposal of Medication forms, with the DON, revealed the plastic multi-dose card with 27 lorazepam 0.5 MG tablets and the plastic multi-dose card containing 5 tablets of oxycodone/acetaminophen 5 MG/325 MG tablets from R96 and R30 had not been entered on to a form per regular procedure.

Review of the Certificate of Inventory and Destruction of Controlled Substances Form 8-1, taped to the cabinet to the right of the controlled medication storage cabinet, with the DON, revealed the form lacked the addition of R96's plastic multi-dose card with 27 lorazepam 0.5 MG tablets.

-At 11:00 a.m. DON stated she would not expect to find 2 loose prefilled morphine sulfate 20 MG per ML syringes in the cabinet not accompanied with a Traverse Care Center Disposal of Medication form. DON indicated the lot number and filled by date matched another plastic bag of morphine sulfate 20 MG per ML prefilled syringes and would presume they would belong with that bag, but the amount recorded for the bag of syringes were incorrect. DON stated the large amount of morphine sulfate prefilled syringes would be due to a few residents graduated off of hospice services. She indicated the amount of controlled medication the facility was receiving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 755	Continued From page 16	F 755		

from the hospice agency was too much and she would be speaking to the hospice agency regarding the amount they were sending. The DON indicated she was unaware how long the controlled medication cabinet had been open or when it was last accessed. The DON stated her expectation for staff would be to enter all information on the Certificate of Inventory and Destruction of Controlled Substances Form 8-1 and Traverse Care Center Disposal of Medication with accurate medication counts and the controlled medication storage cabinet be locked at all times.

On 6/15/18, at 2:30 p.m. Consultant Pharmacist (CP)-A stated he would expect the second lock on the controlled medication cabinet in the medication storage room to be locked when not in use. CP-A stated part of his role was to ensure controlled medications were destroyed at each monthly visit, but indicated he did not destroy any controlled medication on his 6/1/18 visit. CP-A indicated the amount of controlled medication, along with inaccurate documentation and the cabinet being unlocked could add to the potential for controlled drug diversion.

Review of the Consultant Pharmacist Drug Regimen Review Summary dated 6/1/18 indicated medication storage spot checks were okay. Under the heading: Controlled Substance Destruction, it indicated none was completed due to "none prepared for destruction. RN [registered nurse] to make preparations for 7/2018."

Expired Meds:

On 6/15/18, at 10:30 a.m. during an observation and interview with LPN-A, a medication storage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 17	F 755		

room tour was conducted. A medication storage refrigerator was observed stacked on top of another refrigerator that was used to store pop and drinks for residents. On a shelf of the refrigerator was a plastic tray where multiple vials of medications were stored. Two vials of tuberculin purified protein (an extract of Mycobacterium tuberculosis, the bacteria that cause tuberculosis in humans, used to test if a person had been exposed to tuberculin protein), were observed. One vial was opened, and the vial's box was dated as opened on 5/2/18. The side of the Tuberculin vial's box indicated to discard opened product after 30 days. LPN-A stated the tuberculin was used for new resident admissions and new staff. LPN-A verified the date opened on the vial of tuberculin was 5/2/18, and the product packaging indicated to discard after 30 days and placed the expired tuberculin back in the refrigerator.

-At 10:44 a.m. a storage cabinet to the right of the refrigerators was observed to have a 12 ounce green plastic bottle of double strength antacid with an expiration date of 4/18. LPN-A stated the bottle was to be used as a stock medication, which meant any resident who utilized the standing order for antacid had the potential to use stock antacid. LPN-A confirmed the expiration date of 4/18, and indicated licensed nurses or TMAs were responsible for removing expired medication from the medication room. LPN-A removed the antacid from the medication storage room and indicated it was to be discarded. LPN-A stated there was no procedure in place to regularly go through the medication storage room to identify expired medications.

On 6/15/18, at 10:54 a.m. during an observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 755	Continued From page 18	F 755		

and interview of the medication storage room with the DON, the medication storage room refrigerator was observed. The DON verified the vial of tuberculin was dated as opened on 5/2/18, and the manufacture's product packaging indicated to discard open product 30 days after opening. DON stated the tuberculin vial dated 5/2/18, would be used for new admissions and new employees. DON indicated only one admission had occurred since the tuberculin expired which was R94 on 6/4/18. She stated the nurses should be discarding expired medications by the expiration dates. DON stated she thought the CP-A told the nurses the tuberculin was about to expire last time he was here on 6/1/18.

On 6/15/18, at 2:30 p.m. CP-A stated his regular duties at the facility included a spot check of the medication storage room, but that he did not check each individual medication for expiration dates. CP-A stated his last time at the facility was on 6/1/18, and the medication storage spot check was okay. He indicated he did update nursing staff that a tuberculin vial had been used for administration was not dated when opened. He stated he would expect expired medications to be disposed, so residents do not have the potential for receiving expired medications. CP-A indicated if a resident received expired tuberculin, that the facility should administer new tuberculin as the original test may not be accurate.

Review of the Consultant Pharmacist Drug Regimen Review Summary dated 6/1/18 indicated medication storage spot checks were okay. Under the heading: Labeling: it indicated in the refrigerator was a tuberculin test vial not dated.

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F 755	Continued From page 19 On 6/15/18, at 2:53 p.m. DON confirmed R94 was the only resident to receive the expired tuberculin and no new staff had been hired. DON indicated R94 would receive a new tuberculin test due to receiving expired tuberculin. Review of facility provided policy titled Medications-Controlled, last revised 3/1/14, indicated controlled substances are kept under double lock either in the medication room or the medication cart. A count of controlled drugs are maintained by nurses of the off-going and oncoming shifts. When a resident was discharged or deceased, remove the drug from cart and medication book, verify count and complete the necessary records for discontinued/discharged medications and take the drug to DON or designee to be locked up until time for destruction in accordance with State Pharmacy Board.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		7/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 880	Continued From page 20 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 21 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for proper disinfection of a multi -use glucometer was implemented to prevent the spread of infection. This had the potential to effect 5 of 5 residents (R5, R15, R34, R37, R42) who utilized the shared glucometer. In addition, the facility failed to ensure proper disinfection of a multi-use Hoyer lift (full body mechanical lift) was implemented to prevent the spread of infection for 2 of 2 residents (R20, R15,) observed to utilize the Hoyer lift. Findings include: Glucometers R5's Medication Review Report dated 5/28/18, included a diagnosis of type 2 diabetes mellitus. The report included an order to check blood glucose at 2:00 p.m. and 7:00 p.m. once weekly. R15's Medication Review Report dated 5/28/18, included a diagnosis of type 2 diabetes mellitus. The report included an order to check blood glucose four times a day. R34's Medication Review Report dated 5/25/18, included a diagnosis of type 2 diabetes mellitus.	F 880	• F880 Residents #5, 15, 34, 37, 42, and all residents that require blood glucose monitoring, were provided their own glucometer for blood glucose monitoring. Reviewed Policy and Procedure for Glucometer and Infection Control guidance. Residents will be provided their own individual glucometer and will be disinfected between each use. All nursing staff educated on proper disinfection of the glucometer. Audits will be conducted by DON/Designee three times per week for one month and then weekly for 2 months to ensure proper disinfection of glucometers is occurring. Results will be reviewed through QAPI to determine ongoing needs. Residents #20 and 15 have had Hoyer lift disinfected between uses moving forward. All nursing staff educated on the proper	

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	245585	A. BUILDING _____ B. WING _____	06/15/2018

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TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 880	Continued From page 22 The report included an order to check blood glucose two times a day. R37's Medication Review Report dated 5/25/18, included a diagnosis of type 2 diabetes mellitus. The report included an order to check blood glucose two times a week, every Monday and Friday. On 6/12/18, at 4:51 p.m. trained medical assistant (TMA)-A carried a white plastic bin which contained a glucometer, a bottle of glucose strips, lancets, and alcohol wipes to R15's room. TMA-A set the plastic bin on the top of the over the bed table. TMA-A washed her hands, donned gloves, and proceeded to obtain a blood sample from R15's finger to check blood sugar. When the results of the test were obtained, TMA-A removed the strip from the glucometer, set the glucometer into the bin without cleansing it. TMA-A carried the plastic bin to the nurse's cart with the same soiled gloves used for the blood glucose sampling. TMA-A placed the plastic bin into the top right hand drawer of the medication cart, removed her gloves and disposed of the refuse into the garbage receptacle on the side of the medication cart. The glucometer and plastic bin were not disinfected prior to placing it in to the cart. On 6/12/18, at 5:00 TMA-A verified the glucometer was used for all residents who needed a blood glucose level checked and indicated she had followed her usual practice for testing a resident's blood sugar level. TMA-A indicated she had previously checked another resident's blood glucose level at 4:00 p.m. the same day.	F 880	disinfection of the lift machines between uses. Audits will be conducted by DON/Designee three times per week for one month and then weekly for 2 months to ensure proper disinfection of disinfection of the lifts is occurring. Results will be reviewed through QAPI to determine ongoing needs. Deficient practice to be corrected by 7/25/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH WHEATON, MN 56296**

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F 880	Continued From page 23 On 6/14/18, at 9:09 a.m. TMA-C applied hand sanitizer to her hands, retrieved a white plastic bin which contained glucometer supplies and a pair of rubber gloves. TMA-C carried the supplies to R15's room, placed the bin directly on the over the bed table and donned the gloves. After the results of the test were obtained, TMA-C returned the glucometer to the top of the over the bed table. TMA-C removed her gloves, wiped the glucometer with an alcohol wipe, placed glucometer into the plastic bin and returned the bin to the top right side drawer of the nurses cart. On 6/15/18, at 10:25 a.m. TMA-C verified the glucometer was used for all residents who required a blood glucose check. TMA-A identified the glucometer was disinfected between residents with a germicidal sani-wipe or with the alcohol wipe. TMA-C identified she used either the sani-wipe or the alcohol wipe, however; most often used the alcohol wipe because they were handy. On 6/15/18, at 10:29 a.m. licensed practical nurse (LPN)-A verified the glucometer should only be disinfected with the germicidal sani- wipe in the purple top container. On 6/15/18, at 3:22 p.m. the director of nursing (DON) verified the glucometers were multi-use and were to be disinfected between each resident. The DON identified an alcohol wipe was to be used to wipe the glucometer and then the germicidal sani-wipe was used as the disinfectant. The DON identified the glucometer was to remain wet with the disinfectant for two minutes. The DON indicated the staff had received education in the past regarding the disinfection of glucometers.	F 880		

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	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 24	F 880		

The facility policy titled Glucometer Infection Control Guidance dated March 2014, directed the following: It is the policy of this facility that glucometers that are shared between more than one resident are disinfected between each resident use and listed #4. Use an EPA-Registered disinfectant effective against HBV (hepatitis B), HCV(hepatitis C), and HIV(human immunodeficiency virus).

Hoyer lift

On 6/14/18, at 8:20 a.m. nursing assistant (NA)-B entered R20's room with the activity director (AD)/NA and a Hoyer lift . Both facility staff washed their hands and donned gloves. NA-B washed R20 with a wash cloth and a basin of soapy water. NA-B washed and dried R20's peri area. NA-B with the same dirty gloves used to provide peri care, grasped the lift by the part directly above the cradle (what the sling attaches to). NA-B moved the lift out of the way and continued to walk towards the bathroom. After R20 was washed and dressed, NA-B removed the lift from the room and placed it in the hall against a wall. The lift had a dark colored substance, approximately 4 centimeters (cm) by 2 cm observed on the area grasped by NA-B. NA-B did not clean or sanitize the lift and exited the area.

On 6/14/18, at 9:22 a.m. NA-B and NA-C assisted R15 from bed into his wheel chair with the use of the hoyer lift. After R15 propelled himself from the room, NA-C pushed the lift from the room to the hall and placed it next to the wall. The lift was not disinfected and the dark substance remained visible on the lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH WHEATON, MN 56296**

(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 880	Continued From page 25 On 6/15/18, at 3:22 p.m. the DON verified the lifts were multi-use and should be wiped down with a disinfectant after each use. The DON indicated she believed staff were not using the disinfectant wipes because they had not been easily accessible. The DON indicated in the future, the wipes would be more accessible and all staff re-educated. The facility policy titled Environment -Cleaning of equipment, dated April 1, 2008, directed all unit equipment (e.g., refrigerators, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and eternal equipment) is cleaned on a routine basis.	F 880		