Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2024

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: January 31, 2024

Dear Administrator:

On January 31, 2024, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 24, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 24, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 24, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 24, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Traverse Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 24, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 31, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
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 _____	C 01/31/2024

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 On 1/29/24 to 1/31/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006		2/16/24

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

Electronically Signed — 02/17/2024

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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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		

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E 006	Continued From page 2 facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain an emergency preparedness program that was reviewed and updated at least annually. This deficient practice had the potential to affect all 30 residents who currently resided in the facility. Findings include: Review of the emergency preparedness plan completed on 1/31/24 at 8:39 a.m., lacked evidence of an annual review and update of policies and procedures. The emergency preparedness policy most recent date documented was 5/17/19. On 1/31/2024 at 8:39 a.m. interim administrator, executive administrator, maintenance manager, and environmental services director consultant, reviewed the facility emergency preparedness plan, dated 5/17/19. Interim administrator confirmed the last documented review of the facility's emergency preparedness program and policies was 2019. Interim administrator indicated he had updated some of the employee names on 1/29/24, after survey began.	E 006	E006 Plan Based on All Hazards Risk Assessment Traverse Care Center has an emergency preparedness plan in place that has been updated and will be maintained as of 02/12/2024. This emergency preparedness plan includes a documented facility-based and community-based risk assessment, utilizes an all-hazards approach, including missing residents, while also including strategies for addressing emergency events identified in the risk management. Strategies for addressing emergency events that are identified by the risk management such as power failures, natural disasters, and other emergencies, are also included. The contents of the emergency preparedness plan will continue to be maintained and updated thoroughly by the maintenance director and administrator. Staff were educated 02/19/2024 during staff meeting. The administrator will keep an updated electronic and hard copy file of hazard risk assessments. Files will be updated accordingly, when required and when risk assessments have been changed. The facility will monitor by completing audits of the emergency preparedness plan. Audits will be completed by the administrator.	

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E 006	Continued From page 3	E 006	Audits will be done once a week and will continue for two months. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed. Facility will reach compliance 02/21/2024.	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030		2/15/24

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E 030	Continued From page 4 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 5 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's communication plan failed to include all required and updated information including names and contact information for the following: current staff, entities providing services under arrangement, and volunteers. This deficient practice had the potential to affect all 30 residents residing at the facility. Finding include: On 1/31/2024 at 8:29 a.m. interim administrator, executive administrator, maintenance manager, and environmental services director consultant, reviewed the facility emergency preparedness plan, dated 5/17/19. Interim administrator confirmed the above findings, and stated he had updated some of the employee names on 1/29/24, after survey began, however could not verify all contacts had been updated.	E 030	E030 Names and Contact Information Traverse Care Center has developed an emergency preparedness communication plan with updated names and contact information for current staff, entities providing services under arrangement, and volunteers as of 02/12/2024. The administrator will continue to maintain and update names and contact information annually. Updated names and contact information will be kept up and maintained electronically and hard copy format if network systems to retrieve electronic files are not accessible. The administrator will verify all contact information is updated continuously and as needed to assure there are no discrepancies in information for present and future use. The facility will monitor by completing	

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E 030	Continued From page 6	E 030	audits of the names and contact information. Audits will be completed by the administrator. Audits will be done once a week and will continue for two months. Staff were educated 02/19/2024 during staff meeting. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed. Facility reached compliance 02/21/2024.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.	E 031		2/15/24

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E 031	Continued From page 7 (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policy and procedure which included contact information for federal emergency staff and current ombudsman. This deficient practice had the potential to affect all 30 residents who currently resided in the facility. Findings include: On 1/31/2024 at 8:29 a.m. interim administrator, executive administrator, maintenance manager, and environmental services director consultant, reviewed the facility emergency preparedness plan, dated 5/17/19. The manual included various emergency contacts, however lacked a federal emergency contact and current ombudsman name and contact information. Interim administrator confirmed the above findings.	E 031	E031 Emergency Officials Contact Information Traverse Care Center has developed an emergency preparedness communication plan with updated contact information for federal, state, tribal, regional, and local emergency preparedness staff, as well as state licensing and certification agency, the office of the State Long-Term Care Ombudsman, and other sources of assistance as of 02/12/2024. The administrator will continue to maintain and update emergency officials contact information annually. Updated emergency officials contact information will be kept up and maintained electronically and hard copy format if network systems to retrieve electronic files are not accessible. The administrator will verify all contact information is updated continuously and as needed to assure there are no discrepancies in information for present and future use. The administrator will continue to maintain and update	

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(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 031	Continued From page 8	E 031	emergency officials contact information annually. The facility will monitor by completing audits of emergency officials contact information. Audits will be completed by the administrator. Audits will be done once a week and will continue for two months. Results will be shared with the QAPI/QAA Committee. Staff were educated 02/19/2024 during staff meeting. The Committee will determine if additional auditing is needed. Facility reached compliance 02/21/2024.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency	E 037		2/13/24

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 _____	C 01/31/2024

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E 037	Continued From page 9 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 10 expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 11 expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 037		

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E 037	Continued From page 12 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 6 of 6 employees, (housekeeping aide (HA)-A, activity aide (AA)-B, licensed practical nurse (LPN)-A, dietary aide (DA)-A, (DA)-B, and nursing assistant (NA)-A) had received new employee or annual training on the emergency preparedness plan. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include:	E 037	E037 EP Training Program Traverse Care Center will conduct monthly all staff meetings that includes training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. Emergency preparedness training will be documented and maintained by the	

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E 037	Continued From page 13 Review of the facility's Course Completion History logs identified HA-A, AA-B, LPN-A, DA-A, DA-B and NA-A had not completed emergency preparedness training. Review of the untitled facility staff listing identified the following: -HA-A was hired 11/29/23, -AA-B was hired 11/29/23, -LPN-A was hired 11/14/19, -DA-A was hired 2/7/23, -DA-B was hired 10/19/23, -NA-A was hired 3/31/23, On 1/31/2024 at 8:29 a.m., interim administrator, executive administrator, maintenance manager, and environmental services director consultant, reviewed the facility emergency preparedness plan, dated 5/17/19. During follow up interview on 1/31/24 at 3:40 p.m., interim administrator confirmed all staff had been recently assigned emergency preparedness training through Educare approximately two weeks ago. Interim administrator confirmed no employees had previously received annual or new employee emergency preparedness training prior to that and staff have not had time to complete the education that was recently assigned.	E 037	administrator. The facility will monitor by completing audits of the EP training program. Audits will be completed by the administrator. Audits will be done once a month and will continue for two months. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed. After the initial training has been conducted for staff, TCC will provide training on the emergency plan at least annually. Initial and subsequent training will be modified as needed and if TCC updates the policies and procedures to include but not limited to incorporating any lessons learned from the most recent exercises and real-life emergencies that occurred in and during the review of the facility's emergency program, TCC will demonstrate how we have updated the training as well, i.e., "new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's review. Staff were educated 02/19/2024 during all staff meeting. Compliance 02/21/2024.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	E 039		2/4/24

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E 039	Continued From page 14 *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and	E 039		

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E 039	Continued From page 15 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient	E 039		

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E 039	Continued From page 16 care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:	E 039		

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E 039	Continued From page 17 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 18 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 19 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of	E 039		

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E 039	Continued From page 20 the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the	E 039		

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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 039	Continued From page 21 emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 22 (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a second full-scale community based exercise, a facility based exercise, a table top, or a facility drill to test their emergency preparedness program at least twice per year. This deficient practice had the potential to affect all 30 residents who currently resided in the facility, along with staff who worked in the facility. Findings Include: On 1/31/2024 at 8:29 a.m., interim administrator, executive administrator, maintenance manager (MM)-A, and environmental services director consultant (ESD)-A, reviewed the facility emergency preparedness plan, dated 5/17/19.	E 039	E039 EP Testing Requirements Traverse Care Center will conduct exercises to test the emergency preparedness plan at least twice per year, including unannounced staff drills using the emergency preparedness procedures. This facility will participate in annual full-scale exercise that is community-based; but when community-based is not available, conducting an individual or facility-based functional exercise will be done. The director of maintenance will conduct drills and perform audits for drills monthly. TCC will continue to conduct exercises on an annual basis. TCC will conduct exercises	

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E 039	Continued From page 23 MM-A and ESD-A confirmed the facility had conducted a fire drill on 1/18/24, however had not completed any other annual exercises as required.	E 039	to test the emergency plan, which includes unannounced staff drills using the emergency procedures. Staff were educated 02/19/2024 during all staff meeting. The facility will monitor by completing audits of the EP testing requirements. Audits will be completed by the director of maintenance. Audits will be done once a month and will continue for two months. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed. Compliance 02/21/2024.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities	E 041		2/13/24

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E 041	Continued From page 24 Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records	E 041		

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E 041	Continued From page 25 Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain standards for the emergency and standby power system. This	E 041	E041 Hospital CAH and LTC Emergency Power	

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E 041	Continued From page 26 deficient practice had the potential to affect all 30 residents residing in the facility. Findings Include: On 1/31/2024 at 8:29 a.m., interim administrator, executive administrator, maintenance manager (MM)-A, and environmental services director consultant (ESD)-A, reviewed the facility emergency preparedness plan, dated 5/17/19. ESD-A confirmed the above findings. ESD-A indicated the facility had not completed a four hour load bank test of the generator within the last 36 months. 1. On 1/31/2024 between 9:45 a.m. and 12:00 p.m., it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. 2. On 1/31/2024 between 9:45 a.m. and 12:00 p.m., it was revealed by a review of available documentation that the facility failed to perform monthly generator inspections. 3. On 1/31/2024 between 9:45 a.m. and 12:00 p.m., it was revealed by a review of available documentation that the facility failed to perform weekly generator inspections. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	E 041	Traverse Care Center has resolved issues with emergency and standby power systems. Cummins has been notified 02/13/2024 to provide a 4-hour generator load bank test. The maintenance director will perform weekly and monthly generator inspections. The director of maintenance will schedule inspections in advance to secure a date for inspection of generator load test; this will assure compliance will be met. Staff were educated 02/19/2024 during staff meeting. The administrator will conduct audits for three months. The facility will monitor by completing audits of emergency power. Audits will be completed by the maintenance director. Audits will be done once a week and will continue for four months. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed. Compliance 02/21/2024.	
F 000	INITIAL COMMENTS On 1/29/24 to 1/31/24, a standard recertification survey was conducted at your facility. A complaint	F 000		

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F 000	Continued From page 27 investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed. The following complaints were reviewed. H55858919C (MN00099193) with a deficiency issued at F689 at a harm level. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral medications were administered safely for 1 of 1 resident (R4) who was observed to self administer medications left at the bedside and	F 554	F554 Traverse Care Center ensures that all residents have the right to self- administer medications and ensures that the practice	2/29/24

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F 554	Continued From page 28 had been assessed as not safe to self administer medications. Findings Include: R4's admission Minimum Data Set (MDS) dated 12/6/23, identified R4 was cognitively intact and had diagnoses which included: heart failure, diabetes, anxiety, depression and bipolar disorder (extreme mood changes). Identified R4 required partial/moderate assistance with lower body dressing, toileting hygiene, personal hygiene, and transfers chair/bed to chair. R4's care plan, dated 1/5/24, identified R4 had congestive heart disease, diabetes mellitus, and constipation related to use of narcotic medications. R4's care plan did not include instructions for self administration of medications. R4's Self-Administration Of Medications Review Tool dated 1/5/24, identified R4's vision impaired ability to self administer medications, and R4's significant other assisted at home. R4's tool identified: -Physician order to self-administer medications-No, -Approval to self-administer medications(s) granted-No, Review of R4's Order Summary Report signed 1/9/24, identified R4's orders did not include an order to self administer medication. During an observation on 1/29/24 at 12:14 p.m., family member was present in R4's room. R4 had a paper medication cup with pills in it on her bedside table. R4 took a drink of water, then leaned her head back, swallowed, leaned head	F 554	is clinically appropriate. Resident R4 will be reassessed for self-administer medications. R4 care plan will be revised to reflect if resident is appropriate or not appropriate to self-administer medications. Current residents will be reassessed for self-administration of medications. The residents care plan will be revised to reflect if the resident is appropriate or not appropriate to self-administer medications. New admissions to the facility will be assessed for self-administration of medications when admissions assessments/MDS are due to be completed. Current self-administration of medications policy & procedure updated. Licensed staff will be educated on the policy & procedure at the all staff meeting on 2/19/24. Audits will be conducted randomly x 3 weeks. Audits will be brought to the QA meeting for review and for further suggestions. Director of Nursing is responsible for audits. Complete date: 2/29/24	

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F 554	Continued From page 29 back again and swallowed again. No nurse was present in R4's room or hallway at that time. During an interview on 1/29/24 at 3:36 p.m., R4 indicated the nurses always left her medications in her room for her to take. R4 stated she informed the nurses later if she had taken them or not. On 1/30/24 at 9:36 a.m., R11 gave permission to review the resident council meeting minutes. Review of the minutes from 11/21/23 to 12/14/23, revealed the following: -11/21/23, medications were being left with residents unattended/unsupervised for them to take on their own. -12/14/23, morning medications being left on the table unattended/unsupervised by nursing staff still. During an interview on 1/30/24 at 10:49 a.m., licensed practical nurse (LPN)-A stated she had administered R4's morning medications yesterday. LPN-A confirmed she had left R4's medications in her room and did not observe R4 take the medications. LPN-A stated R4 could self administer medications after they were set up. LPN-A stated her usual practice was to administer R4's morning medications in the dining room while she remained in the dining room, so she could see if R4 took her medications however verified she would not stand and observe R4 to take them. LPN-A reviewed R4's electronic medical record and confirmed R4 did not have an order to self administer medications and R4's care plan did not identify R4 could self administer medications. In addition, LPN-A reviewed R4's Self-Administration Of Medications Review Tool dated 1/5/24, and confirmed R4	F 554		

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F 554	Continued From page 30 could not self administer medications. During an interview on 1/30/24 at 4:34 p.m., director of nursing (DON) indicated the facility's usual practice for self administration of medications included staff were to compete an assessment first to determine if the resident was safe to self administer their medications. DON stated she would expect it would be included on the resident's care plan if they were able to self administer medications. DON indicated she had not been aware it was discussed at multiple resident council meetings medications were being left unattended/unsupervised however someone had made her aware after the last resident council meeting. DON indicated it was important to not have residents self administer medications if not approved to do so due to safety concerns and to ensure the resident actually received the medications. Review of the facility policy titled Resident Self-Administration Of Medication, undated, identified a resident may only self-administer medications after the facility's interdisciplinary team had determined which medications may be self-administered safely. The policy identified the care plan must reflect the resident self-administration and storage arrangement for such medications.	F 554		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and	F 576		2/15/24

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F 576	Continued From page 31 use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 5 of 5 residents (R23, R6, R11, R16, R26) who voiced concerns with	F 576	F 576 Right to communication Residents R23, R6, R11, R16, and R26 had mail delivered to them in a timely	

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F 576	Continued From page 32 mail delivery. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: On 1/30/24 at 9:36 a.m. R11 gave permission for surveyor to review resident council meeting minutes. Review of resident council meeting minutes was completed. Minutes reviewed had no documentation related to mail delivery. On 1/30/24 at 11:00 a.m., a resident council meeting was held with 5 residents, R23, R6, R11, R16, R26. During the meeting all residents confirmed mail was delivered by activity staff, however mail was not delivered on Saturdays. During an interview on 1/30/24 at 1:46 p.m., activity assistant (AA)-A indicated mail was delivered by activity staff or administrative assistant (ADA)-A. AA-A stated mail was delivered before 4:30 p.m. Monday through Friday, however was not sure if mail was delivered on Saturdays, as no activity staff worked on the weekends. During an interview on 1/30/24 at 1:49 p.m., ADA-A indicated she assisted with mail delivery at times and worked Monday through Friday. ADA-A stated she thought mail was delivered by nursing staff on the weekends however was unsure. ADA-A confirmed at times mail was left on her desk from the weekend. During an interview on 1/30/24 at 1:53 p.m., assistant director of nursing (ADON)-A confirmed she worked weekends. ADON indicated mail was delivered at the front of building however did not	F 576	manner. Nursing staff delivered the mail on Saturday if activity staff were not available. The facility took that following actions to ensure residents receive mail in a timely manner. The policy was reviewed and is current. No changes are needed. All staff were trained in the resident right to receive mail in a timely manner, including on Saturdays. The schedule for activity staff was changed to allow more coverage on Saturdays. Activity staff will be responsible for mail delivery. Nursing staff will deliver mail if activity staff are not able. A notice was posted at the nursing station to remind staff. The facility will monitor by having the activity director, or designee, audit to ensure mail is delivered timely. Audits will be done weekly for 2 months, then monthly for 6 months. Audits will be reviewed with the QAA/QAPI committee. The QAPI/QAA will determine if additional auditing is needed. The date of correction is 2/15/24.	

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F 576	Continued From page 33 get picked up until Monday for delivery to residents. ADON-A stated mail delivery was not a task completed by nursing on the weekends. ADON stated it was important for mail to be delivered on Saturdays so residents received their mail on time. During an interview on 1/30/24 at 2:11 p.m., interim administrator indicated he was unaware of how mail was delivered in facility and thought activity staff delivered mail. Interim administrator indicated it was important for mail to be delivered on Saturdays so residents received their mail timely. During a follow-up interview on 1/30/24 at 2:28 p.m., interim administrator confirmed the facility did not have a policy for mail delivery in the facility.	F 576		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		2/23/24

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F 607	Continued From page 34 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure postage/signage of employee rights related to retaliation prohibition for reporting suspicions of a suspected crime were posted within the facility and included in the facility policy titled Vulnerable Adult-Minnesota. This deficient practice had the potential to affect all 30 residents currently residing in the facility. Findings include: During interview and observation on 1/31/24 at 10:35 a.m. executive administrator and surveyor completed observations of employee postings in the facility. Executive administrator confirmed the facility did not have the required posting in the facility. Executive administrator indicated that information was included in the employee handbook however was not posted as required. Review of the facility policy titled Abuse, Neglect, And Exploitation, revised 1/23, included definitions and procedures. The policy identified	F 607	F 607 Abuse Policies- The facility took the following action. A posting regarding an employee's right to file a complaint for retaliation was posted. The facility took the following corrective actions. The policy and procedure for abuse was reviewed and is adequate. No changes are needed. The administrator and other team members were educated about non-retaliation and that employees have a right to file a complaint. Education was provided to the posting is in a conspicuous place. All staff were informed that the facility does not retaliate for making a complaint. All staff were educated about their right to file a complaint and how to make a complaint. The facility will monitor by completing audits of facility posting to ensure it is available in a conspicuous location. Audits will be completed by the administrator or	

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F 607	Continued From page 35 staff would report their knowledge related to allegations without fear of reprisal. The policy had not been updated to reflect the current requirement regarding employee rights related to retaliation prohibition for reporting suspicions of a suspected crime or posting this information for employees in a conspicuous location.	F 607	designee. Audits will be done twice a week for two months, then once a month for 6 months. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed." The date of correction is 2/23/24.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 2 resident (R7) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: R7's quarterly Minimum Data Set (MDS), dated 11/2/23, identified R7 had diagnoses which	F 686	F 686 Traverse Care Center□s intent is to ensure that all residents are turned and repositioned in a timely manner to prevent the risk and/or development of pressure ulcers. Resident R7 will be reassessed for a turning and repositioning schedule to prevent the risk and/or develop further	2/29/24

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F 686	Continued From page 36 included Alzheimer disease, dementia and anxiety. R7 required extensive assistance of two staff for bed mobility and transfers. R7 required extensive assistance of one staff to roll from left to right. Indicated R7 was a risk for pressure ulcers, currently had an unhealed pressure ulcer and infection in foot. R7's significant change Care Area Assessment (CAA), dated 5/3/23, identified R7 was at risk for skin breakdown and potential pressure ulcers due to needing extensive assistance with bed mobility. R7's care plan revised on 1/24/24, identified R7 had actual complications with impaired skin integrity related to the blister on heel. Indicated R7's heels were to be floated at all times when in bed and staff were to reposition every two hours. R7 was dependent on staff for all cares. R7's 1/26/24, weekly wound round documentation identified R7 was noted to have a right heel deep tissue injury acquired on 6/12/23. Indicated that R7 was to be repositioned, have soft boots on and to use the hoyer lift due to non weight bearing on feet. R7's treatment orders dated 12/5/23, identified R7 was to have: -heel protector boots on at all times. -pillows under calf and suspend right heel whenever in bed. Review of R7's progress notes dated 7/31/23 to 1/30/24, revealed the following: - 8/1/23, Provider saw on rounds. After discussion, assessment of patient, seeing heel blister referred to podiatry. - 8/8/23,seen by podiatrist, area on heel debrided,	F 686	pressure injuries. Resident□s care plan will be revised to reflect resident□s turning and repositioning schedule. Current residents turning and repositioning schedules will be reassessed. Resident care plans will be reviewed and/or revised to reflect the residents repositioning schedule. New admissions will be assessed for a turning and repositioning schedule upon completion of admission assessment/MDS. Current Pressure Injury Prevention and Management Policy reviewed. Created a new turning and repositioning policy. Nursing staff will be educated on policies & procedure on 2/19/24. Turning and repositioning audits will be conducted randomly on all shifts x3 weeks. DON is responsible for audits. Audits will be brought to the QA meeting for review and for further suggestions. Completion Date: 2/29/24	

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F 686	Continued From page 37 may redress with medi honey and gauze but more concerned about offloading. - 8/28/23 dressing change every Monday and Thursday to right heel. Wash with wound cleanser, apply medi honey to padded dressing over areas that are open - covered with blister, wrap with kerlix. Apply soft boots. Notify wound nurse of changes. -10/5/23, podiatrist here today and saw resident while in bed. Resident was seen while in bed - provider debrided edges - pink skin and small amount of bleeding. Podiatrist would like a lift boot ordered one for resident and an extra one if it gets dirty as it is foam. Provider ordered silver alginate dressing, telfa and kerlix to right heel daily. Continue off loading right heel and pillow under right calf and suspending right heel. -11/14/23, podiatry here today. Cut toenails and looked at wound right heel, treatment order changed to betadine swab daily and to continue with current contact layered dressing 4x4s and kerlix wrap. -1/9/24, podiatry visit, heel checked, no changes in current treatment protocol. During continuous observations on 1/30/24 from 8:56 a.m. to 11:09 a.m., revealed the following: - R7 was seated in the dining room being assisted with breakfast by licensed practical nurse (LPN)-A. R7 had heel protector boots on both feet and feet were rested on wheelchair foot pedals. - R7 resident continued to be in the same position. R7 was seated at the dining room table talking with her daughter. - R7's daughter pushed R7 from the dining room to the fireside dayroom. - R7 continued to sit in her wheelchair in the fireside day room.	F 686		

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F 686	Continued From page 38 - R7 continued to sit in her wheelchair in the same location in the fireside dayroom. - R7 continued to sit in her wheelchair in the same location in the fireside dayroom. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - At 11:09 a.m., ADON and LPN-A assisted R7 to lay down in bed. R7 was covered with a blanket. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 had not been repositioned for a total of two hours and 13 minutes during this observation. During an observation on 1/30/24 at 1:22 p.m., R7 was laying in bed covered with a sheet and pink comforter. R7 was laying on her left side facing the fall with a pillow behind her lower back. R7 was wearing both heel protecting boots with and had a wedge pillow between her knees. R7 did not have a pillow under her calf's, left heel/foot was laying to the left side. Right leg was bent at the knee and right heel and foot were flush on the bed. - At 3:10 p.m., R7 was laying in bed in the same position as above. - At 4:56 p.m., R7 was laying in bed in the same position as above. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 was unable to	F 686		

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F 686	Continued From page 39 reposition herself or place the pillow independently. R7 had not been repositioned for a total of three hours and 34 minutes.. During an interview on 1/30/24 at 3:34 p.m., nursing assistant (NA)-C identified staff completed all activities of daily living (ADLs) for R7. R7 was to be transferred with two people and the hoyer lift. NA-C stated R7 required extensive assistance with turning and repositioning. NA-C stated staff were expected to ensure the heel boots on at all times and R7 was to be repositioned from side to side. NA-C indicated she was unaware of the order to place a pillow under R7's calf's and to suspend heels off of the bed at all times. During an interview on 1/30/24 at 4:33 p.m., RN-A indicated staff were expected to reposition R7 every two hours. RN-A reviewed and confirmed the above orders for R7. RN-A explained R7 had a wound on her right heel that staff were to complete dressing changes and to monitor. RN-A entered R7's room and confirmed R7 was laying on her left side and did not have a pillow under her calf's suspending R7's heels. RN-A stated staff should have placed a pillow under her right leg no matter what position R7 was in. RN-A was not aware R7 had been laying in the same position since 1:22 p.m. RN-A placed a pillow under R7's calf's to suspend R7's heels. RN-A indicated her expectations were staff would reposition residents every two hours and were to follow the provider's orders along with resident's care plans. RN-A confirmed she had not repositioned R7 and was going to find another staff member to assist with repositioning R7. During a follow-up interview at 1/30/24 at 4:56	F 686		

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F 686	Continued From page 40 p.m., NA-C confirmed she had not repositioned R7 since she was laid down in bed at 1:22 p.m. NA-C explained she had been running around the building and had not been down R7's room yet. During an interview on 1/30/24 on 4:59 p.m., LPN-E confirmed she had not repositioned R7 since she arrived for her shift at 3:30 p.m. LPN-E indicated she had other tasks to complete and was beginning her medication pass. On 1/31/24 at 12:45 p.m., voicemail message left for podiatrist with no return phone call received. During an interview on 1/31/24 at 2:44 p.m., with director of nursing (DON) and executive administrator, DON was not aware R7 had not been repositioned within two hours. DON indicated staff had not informed her R7 had not been repositioned and provider orders for R7 had not been followed. DON confirmed the above findings and explained R7 should not have experienced prolonged sitting. DON indicated staff should have placed pillows under R7's calf and suspend her right heel whenever R7 was in bed. DON stated her expectations were staff would be following providers orders and if staff were unable to complete the orders they would inform the DON or charge nurse. Review of facility policy titled Pressure Injury Prevention and Management, unknown date, this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. After completing a thorough assessment/evaluation, the interdisciplinary team	F 686		

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F 686	Continued From page 41 would develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions would be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure injury present. Basic or routine care interventions could include, but were not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); Minimize exposure to moisture and keep skin clean, especially of fecal contamination; Provide appropriate, pressure-redistributing, support surfaces; Provide non-irritating surfaces; and Maintain or improve nutrition and hydration status, where feasible.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		2/29/24

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F 688	Continued From page 42 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services to prevent loss of function for 1 of 2 residents (R28) who required assistance with ambulation. In addition, the facility failed to provide range of motion services to prevent potential decrease in range of motion (ROM) for 1 of 1 residents (R24) reviewed whom required range of motion for restorative nursing exercises. Findings include: R28 R28's most recent diagnosis report dated 1/31/24, identified R28 had diagnoses of dementia, difficulty walking, muscle weakness and diabetes. R28's quarterly Minimum Data Set (MDS), dated 12/14/23, indicated R28 required extensive assistance with bed mobility, transfers and ambulation. R28 had mild cognitive impairment and at times had confusion that required additional cuing. R28's significant change Care Area Assessment (CAA) dated 9/14/23, identified R28 had potential for more independence with cuing and restorative nursing program to maintain current level of functioning. R28's care plan revised 1/3/24, indicated per	F 688	F 688 Traverse Care Center□s intent is to ensure that resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident□s clinical condition demonstrates that a reduction in range of motion is unavailable. MD orders obtained for Resident R28 to be evaluated and treated by physical and occupational therapy due to decline in ambulation status and transfer status. R24 orders were requested for PT and OT d/t decline in transferring and strength. PT and OT are on hold d/t resident has open areas on right foot diagnosis cellulitis. Resident currently is using a stand lift for transfers. Will resume PT and OT once cellulitis is resolved. All current residents that are on a ROM, exercise or walking program will be reassessed for any decline and will be referred to physical therapy and/or occupational therapy if needed. Decline in ROM or walking status will be assessed quarterly on all residents. Created a decline in ROM policy. Nursing staff will be educated on policy 2/19/24.	

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F 688	Continued From page 43 physical therapy (PT) R28 was to ambulate three times a day to or from meals. Required two to three assist with front wheeled walker (FWW) and follow with wheelchair. R28's care plan identified R28 was to follow PT recommendations as able/accepted. R28 was to be in a functional program: walking with FWW and one to two assist to all destinations with wheelchair following, initiated 9/3/23. Staff were to notify nurse manager and/or therapy of any barriers. In addition, staff were to notify PT of an increase or decrease in functional level. Review of R28's PT discharge summary dated 12/19/23, discharge recommendations: resident can complete stand pivot transfer on/off toilet with assist of two and use of grab bars on the wall, as long as he is able to follow appropriate cues. If unable to follow cues and is not standing appropriately he would need to complete transfer with hoyer. In and out of chair in lobby he needs to complete with hoyer lift and with assist of two. Continue to walk with resident with the use of the FWW and assist of two to three with wheel chair following to complete the distance safely. If he is not cooperative with walking at that time, attempt again later. This was important to continue with weight bearing on bilateral lower extremities (BLE) and to maintain strength. Review of R28's progress notes dated 7/1/23 to 1/30/24, revealed the following: - 9/5/23 at 10:29 a.m., PT recommends that we resume ambulation three times a day versus walking to all destinations with staff. Will continue to recommend one to two assist with FWW, 75 feet as tolerated. Will note change on walking list, he will be on walk list three times a day versus walking to all destinations. Staff have been	F 688	Audits will be conducted randomly x 3 weeks for residents that currently have a walking program or ROM. Audits will be done to check for completeness of the task. Director of Nursing is responsible for audits. Audits will be brought to the QA meeting for review and for further suggestions. Completion Date: 2/29/24	

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F 688	Continued From page 44 notified. - 9/11/23 at 12:45 p.m., minimum to moderate assist to come to standing from sitting on the bed. R28 walked from bed to toilet with gait belt and FWW. R28 walked with staff around the room door and 135 feet towards noon meal. - 9/14/23 at 2:52 a.m., walked with one assist to toilet. - 9/18/23 at 2:28 a.m., staff used the PAL (standing lift) for transfer out of the recliner to go to the bathroom and then staff walked resident back to recliner with FWW and gait belt. - 12/13/23 at 11:35 a.m., R28 is to be mechanical lift transfer due to a decrease in cognition and limited ability to follow cues to perform PAL lift transfer. Continue to walk with R28 with the use of the FWW and assist of two-to three with wheelchair following to complete the distance safely. If he is not cooperative with walking at this time, attempt again later with assist of two to continue weight bearing on BLE and maintain strength. During continuous observations on 1/30/24 from 8:47 a.m. to 1:19 p.m., R28 was wheeled to the dining room in his wheelchair by licensed practical nurse (LPN)-A and sat in the dining room for breakfast. After breakfast R28 self propelled around the dining room and dietary aid wheeled R28 out of the dining room. R28 wheeled himself down to fireside dayroom and sat in the doorway. R28 was wheeled to day room near dining room by activity assistant (AA)-A to participate in an activity. During the activity, R28 wheeled himself back to the fireside day room and sat in the doorway. Assistant director of nursing (ADON) asked R28 if he needed to use the bathroom and he stated "yeah, I have been waiting for 2 hours to go. No one has taken me".	F 688		

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(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 688	Continued From page 45 ADON wheeled resident into the bathroom next to the nurses' station and nursing assistant (NA)-C assisted ADON to toilet R28. R28 stood up next to the toilet and pivot transferred using the grab bars per therapy recommendations. R28 pivoted back into wheelchair and exited the bathroom. R28 was wheeled to the dayroom by the dining room by ADON. R28 wheeled himself back to the fireside dayroom. NA-C wheeled R28 from the fireside day room back to the dayroom near the dining room. (LPN)-A wheeled R28 into the dining room to his spot at the table. R28 was wheeled from dining room to fireside dayroom and placed at table to eat a sandwich. Staff were not observed to offer R28 to ambulate to or from breakfast and lunch meals per PT recommendations. During an observation on 1/31/24 at 10:53 a.m., occupational therapy (OT) and physical therapy assistant (PTA) attempted to stand and walk R28. R28 was sleeping in a recliner and OT woke R28. OT explained to R28 that OT and PTA were going to attempt R28 to stand and walk. OT asked R28 to put his feet down, applied gait belt and placed FWW in front of the chair. OT asked R28 to stand up with OT and PTA assisting on both sides. R28 attempted to stand and was not able. R28 refused to try and sat back in the recliner. OT talked with R28 and he agreed to try to stand one more time. R28 slid to the edge of the recliner and with the assistance of OT and PTA attempted to stand again. R28 was provided cues and placed hands on walker. R28 stated he could not stand and fell back into the recliner. R28 received explanation from OT and R28 stated that staff could not help him at this time. R28 did not attempt to stand on the third try. OT indicated the	F 688		

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F 688	Continued From page 46 recommendations for walking remained in place for R28 to help keep the strength he had up. OT confirmed R28 had a decline in his ability to stand with pivot transfers and ambulate the recommended distance three times daily. During an interview on 1/30/24 at 3:21 p.m., NA-C indicated R28 required a hoyer lift to transfer in and out of bed or recliner. NA-C stated R28 was not able to stand well even when he did have something in front of him to hold onto. NA-C indicated R28 had declined over the past couple months as staff used to be able to transfer him with a PAL lift however now required a hoyer lift to transfer at all times. NA-C stated staff were expected to ambulate R28 to and from meals however indicated ,"we were short staffed and unable to walk him as he needed". NA-C stated therapy staff provided recommendations staff were to follow for restorative nursing tasks. NA-C indicated the recommendations were expected to be communicated to staff during a meeting and a group of NA's would get together to complete the therapy recommendations. NA-C stated, "It is not too often that we get to do therapy things". During an interview on 1/31/24 at 10:31 a.m., OT stated PT and OT had worked with R28 and he had recently been discharged on 12/18/23, as he had reached a plateau. OT indicated the restorative nursing plan for R28 was for nursing staff to stand and pivot transfer with two staff for the bathroom and if he was not able to stand staff were expected to use the hoyer. OT revealed another part of the plan was for staff to walk R28 to meals. OT indicated recommendations were provided to the nurse manager/charge nurse and NA's were provided education. The recommendations were placed into the electronic	F 688		

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F 688	Continued From page 47 health record (EHR) orders and placed into a therapy binder. PT/OT notified the nurse manager, charge nurse or a NA of the new orders. OT indicated R28 had been discharged from therapy services and OT stated therapy staff had not been notified R28 had not been walked, or if staff had noted a decline in his functional status. OT indicated "at this time, about 75-100% of the residents would benefit from a functional maintenance program (MP). I do not think that staff have enough time to complete the recommendations from therapy". R24 R24's most recent diagnosis report, undated, identified R24 had diagnosis of congestive heart failure, chronic pain and diabetes. R24's quarterly MDS, dated 12/7/23, indicated R24 required extensive assistance with bed mobility, transfers and ambulation. R24's significant change CAA dated 9/8/23, identified the triggered worksheet activities of daily living (ADL) goals for consideration for rehab or decline prevention treatment had not been completed. Indicated R24's ADL functional/rehab potential would be addressed in the care plan to minimize risks. R24's care plan revised 1/3/24, indicated the staff were to use the PAL for all transfers except the following: recommended PAL bed to toilet, one-two assist from toilet sit to stand with pivot to toilet. Identified staff were to monitor/document any changes in ADL ability, reason for inability to perform ADL's, report to doctor any changes and to follow therapy recommendations as able.	F 688		

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F 688	Continued From page 48 Review of R24's Physical Therapy note dated 8/29/23, recommended: PAL lift from bed to toilet, two assist from toilet, sit to stand with pivot to toilet, and completion of toileting. Program for standing/exercises had been given to nursing staff and copy hung in bathroom. Standing tolerance at grab bars in bathroom 3 x 1 min each, standing weight shifts at grab bars in bathroom x 20 (side-side), standing marching at grab bars in bathroom x 20 each. This was important to continue to bear weight and maintain strength and mobility. Review of R24's progress notes dated 8/1/23 to 1/31/24, revealed the following: -8/2/23, R24 experiencing increased activity intolerance, has therapy orders. -8/29/23, program provided to nursing staff to be completed daily: standing tolerance at grab bars in bathroom 3 x 1 min each, standing weight shifts at grab bars in bathroom x 20 (side-side), standing marching at grab bars in bathroom x 20 each. -8/31/23, uses PAL for all transfers except for on and off toilet. -9/3/23, assist of one and stand up lift for all transfers and toileting. -9/7/23, transferring stand pivot transfer to and from toilet, rest of transfers require PAL used. -12/3/23, PAL used for all transfers not associated with toileting, encouraged to do stand pivot transfer on and off toilet. -12/18/23, at this time R24 is a standup lift transfer except in the bathroom. During an observation on 1/30/24 at 9:47 a.m., NA-C brought PAL lift into R24's room and assisted R24 into lift with sling, assisted R24 to a	F 688		

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F 688	Continued From page 49 standing position, wheeled PAL lift to bathroom, R24 sat onto toilet, gave R24 privacy in bathroom while R24 remained in PAL lift. NA-C returned to R24's room when R24 put call light on. NA-C raised PAL lift to standing position, proceeded to complete toileting cares and brought R24 to recliner, positioned and lowered R24 into chair. During an interview on 1/29/24 at 4:56 p.m., R24 stated he had no exercise program, would like to have one, had asked staff about getting therapy again with no response, would like to do some walking again and regain strength. During a follow-up interview on 1/31/24 at 10:34 a.m., R24 stated he recalled therapy providing instructions on exercises however was unsure where they were at now. R24 verified he had not performed exercises for a very long time. R24 indicated staff had not offered to do exercises. R24 stated he had lost strength due to not doing exercises and verified he would try to do exercises if staff had offered. During an interview on 1/30/24 at 9:47 a.m., NA-C stated the facility did not have a restorative program in place for residents and staff did not have time to do a restorative program even if there was one. During an interview on 1/31/24 at 11:56 a.m., NA-A stated R24 was not currently at the same physical level as when R24 moved in. NA-A indicated the staff now use the PAL lift for all transfers. NA-A stated R24 did not always use a PAL lift before. NA-A confirmed there was no restorative program in place for R24. NA-A stated staff were expected to encourage R24 to stand however indicated, "I am not that big and did not	F 688		

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F 688	Continued From page 50 feel safe doing that myself." During an interview on 1/31/24 at 10:26 a.m., occupational therapist OT verified the facility did not have a restorative program in place for the residents. OT stated 75% to 100% of residents in the facility would benefit from a restorative program. OT stated R24 would benefit from restorative program. OT stated she did not feel nursing staff had the time to perform a restorative program. During an interview on 1/31/24 at 2:08 p.m., the director of nursing (DON) verified the facility did not have a restorative program currently. DON stated residents would lose range of motion (ROM) and develop decreased strength. DON stated R24 did have exercises from therapy however was unable to verify if it had been done. During a follow-up interview on 1/31/24 at 2:44 p.m., DON and executive administrator (EA) stated they were not aware R28 had not been receiving restorative services per therapy recommendations. DON indicated she was not aware that R28 had experienced a decline in his standing/walking abilities. DON indicated her expectations were that staff were to follow the recommendations from therapy. DON stated she would expect staff to retry or use a different approach if residents were refusing. Requested policy on restorative therapy however one was not provided.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		2/29/24

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F 689	Continued From page 51 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify a root cause, develop and implement interventions to prevent or reduce risk of falls for 1 of 1 residents (R14) who had multiple falls in the facility. This deficient practice caused actual harm to R14 who had fallen and sustained a wedge fracture (collapsed bone in front of vertebrae-spine) of her T9-T12 vertebrae in her back after a fall on 12/11/23. Findings include: Review of R14's discharge chart revealed the following: R14's significant change Minimum Data Set (MDS) assessment dated 11/7/23, identified R14 had diagnoses which included Alzheimer's Disease, dementia, anxiety and depression. Indicated R14 required extensive assistance of staff for bed mobility, transfers and ambulation. Identified R14 utilized a wheelchair for mobility. Identified R14 had falls since admission and triggered the Care Area Assessment (CAA) for further interventions in the care plan. Indicated R14 had mild cognitive impairment with confusion at times.	F 689	F689 Traverse Care Center□s intent is to ensure that the resident□s environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident R14 was discharged from the facility prior to survey entrance. The nursing management team will review falls dated back to 1/1/24, to comprehensively assess and identify a root cause, develop, and implement interventions to reduce risk of falls for the resident. Going forward the nursing management team will review each incident report upon occurrence to comprehensively assess each fall and to implement interventions to reduce the risk including updating the care plan. Fall prevention program policy updated. Nursing staff will be educated on the policy 2/19/24. The DON or designee will complete random audits weekly x 6 consecutive weeks. Audits will consist of	

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F 689	Continued From page 52 R14's significant change CAA dated 11/7/23, identified R14 had confusion, disorientation and forgetfulness. Indicated R14 had a decline in activities of daily living (ADLs), complications of mobility and muscle atrophy which had the potential for falls. Identified R14 had possible underlying problems that may affect falls related to function which included mood decline, increase in weakness, limited range of motion (ROM), poor coordination/balance and visual impairment. Review of R14's most recent care plan revised 1/3/24, revealed the following interventions related to history of falls: - initiated intervention on 8/31/22, assistive device (bathroom bars, call light, front wheeled walker, gripper socks, gait belt, electric recliner. - initiated intervention on 9/23/22, bring R14 to activities 15 minutes prior to activity start, wheelchair with auto lock breaks and cushion for mobility at night only to assist with bathroom transfer and will keep sign on walker "please call for help". - revised intervention on 7/24/23, educate/remind as needed about potential negative outcomes related to their choice; especially as R14 often self transfers and ambulates on own to get to Bingo, church and beautician. - revised intervention on 1/3/24, dressing assist of one. Review of R14's fall risk screening tool dated 12/11/23, identified R14 had three or more falls in the last six months. Had underlying diseases or conditions including psychiatric or cognitive conditions, cardiac diagnosis, and orthopedic/joint/arthritis related conditions. R14's medications included narcotics, psychotropic's and antihypertensives. R14's was and continued	F 689	reviewing all fall incident reports to ensure that a comprehensive assessment has been completed and interventions have been put into place to reduce the risk of falls. Audits will be brought to the QA meeting for review and for further suggestions. Completion Date: 2/29/24	

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F 689	Continued From page 53 to be at risk for falls due to cognition. Review of R14's incident reports dated 3/28/23 to 1/4/24, revealed the following: - 3/28/23 at 5:45 a.m., R14 had an unwitnessed fall in her room. Was found by nursing assistant (NA) laying on her left side in front of her recliner. Complaints of pain when rolling from side to side to place the sling underneath for transfer. Blood was observed on left ear and bruising was starting to appear on forehead. R14 transferred by ambulance to the emergency room (ER) for further evaluation. Predisposing situation factors indicated ambulating without assistance. No new interventions developed. - 4/19/23 at 8:45 p.m., R14 had an unwitnessed fall in her room. R14 was heard hollering out for help by nurse. R14 was found laying on the floor on her left side in the middle of the room. R14 sustained a two centimeter (cm) skin tear to the left outer elbow which was cleansed and dressing applied. Predisposing situation factors indicated ambulating without assistance and fall during a transfer. No new interventions developed. - 5/3/23 at 8:20 p.m., R14 had an unwitnessed fall in her room. R14 was found by NA during morning rounds. R14 was laying on her right side. R14 had complaints of pain to right shoulder with some redness noted to right shoulder, right side of scalp, right side of forehead, right thigh and right lower extremity lateral shin area. R14 assisted back to the recliner and activities of daily living (ADLs) completed. No predisposing situation factors indicated. Initiated intervention on 5/7/23, keep walker next to resident table by recliner as resident request. - 6/26/23 at 11:10 a.m., R14 had an unwitnessed fall in in her room. R14 was found in her room by therapy sitting next to her chair. R14 had a small	F 689		

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F 689	Continued From page 54 amount of blood on the back of her head, cleaned by nurse. No predisposing situation factors indicated. No new interventions developed. - 8/8/23 at 2:16 a.m., R14 had an unwitnessed fall in her room. R14 was found by nurse on the floor in a lateral recumbent position (left side) in her room. R14 noted to have a large bump on the left side of her head that was bleeding. R14 transferred via ambulance to the ER for further evaluation. Predisposing situation factors indicated using walker, disease process and psychosis-delusional/hallucinations. No new interventions developed - 8/25/23 at 4:07 a.m., R14 had an unwitnessed fall in her room. R14 was found by the nurse during morning rounds laying on her left side on the floor between her chair and rocking chair. R14 had a large bump to her left eye and left eyebrow area along with a laceration to her forehead. Pressure was applied to the bleeding site with gauze and Kerlix. R14 was transferred via ambulance to the ER for evaluation. Predisposing situation factors indicated using walker, disease process and ambulating without assistance. Initiated intervention on 8/25/23, frequent checks and toileting around 2:00 a.m. and 4:00 a.m. - 11/1/23 at 12:35 p.m., R14 had an assisted fall in the dining room. R14 was being assisted by NA to the salon for a hair appointment. R14 indicated she "was going down" and proceeded to lean over and go the the floor. NA assisted R14 to the floor and R14 had contact with her left side of her head on the wheel of another residents wheelchair. No predisposing situation factors indicated. Initiated intervention on 11/4/23, orthostatic checks from sit to stand for a few days. - 11/20/23 at 11:05 p.m., R14 had an unwitnessed	F 689		

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F 689	Continued From page 55 fall in her room. R14 was found on the floor by the nurse sitting up with the wall and next to the television stand by the wall. Predisposing situation factor indicated self-transferring when R14 had been told over and over, R14 was to call for help to assist her up and back to the recliner. Call light within reach. R14 did not utilize the call light for assistance. No new interventions developed. - 12/11/23 at 2:00 p.m., R14 had an unwitnessed fall in her room. Nurse went to get R14 for Bingo and R14 was found laying on the floor on her back with her walker on top of her legs. R14 was laying flat with feet facing the door and head towards the window. R14 had a 0.4 cm abrasion on the back of her head that was cleansed, pressure and ice pack applied. Predisposing situation factors indicated transferring without assistance. Initiated intervention on 12/14/23, Result of fall 12/11/23, R14 to be at fireside after lunch till 2:00 p.m., or 2:15 p.m., and then able to go back to room, toileted, and in her recliner till supper. -1/2/24 at 11:55 a.m., R14 had an assisted fall. R14 was ambulating with two staff when she became pale and limp. Staff assisted R14 to the floor for further and a registered nurse (RN) completed an assessment. Predisposing situation factors indicated ambulating with assistance. No new interventions developed. Review of R14's progress notes dated 7/4/23 through 1/28/24, revealed the following: - 8/25/25 at 8:17 a.m., R14 found laying on the floor during rounds on her left side between her chair and rocking chair. R14 had a bump to her left eye and eyebrow area. R14 had a laceration to her forehead that continued to bleed. R14 assessed and range of motion (ROM) completed	F 689		

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F 689	Continued From page 56 and R14 had difficulty with the right leg. R14 assisted off the floor with the mechanical lift and seated in chair. Pressure applied to the laceration with gauze and Kerlix. - 8/25/23 at 8:50 a.m., returned from the hospital ER, has fractured right ankle and is wearing a boot, scalp laceration with 3 staples. Orders received to wear a controlled ankle motion (CAM) boot to right ankle at all times, non-weight bearing (NWB) until evaluated by PT. - 8/25/23 at 3:50 p.m., PT re-evaluation completed today and will change plan of care (POC) to five times/week. Recommended to continue with NWB at this time and recommend hoyer over the weekend as she is unable to transfer maintaining NWB on right lower extremity (RLE). - 9/18/23 at 12:24 a.m., R14 was seen in the clinic on 9/15/23, progress note from provider said to advance to toe touch weight bearing (TTWB)/partial weight bearing (PWB) trial basis after discussion with therapy. Consult with provider this coming Thursday regarding use of boot. Provider said in note that x-ray shows evidence of healing on x-ray. - 9/19/23 at 10:25 a.m., R14 is alert and orientated to self and place, knows where her room is and is able to self-propel her wheelchair to her room. She does remain a fall risk as she will self-transfer, has fallen three or more times in the past three months one which resulted in an ankle fracture. - 10/3/23 at 10:38 a.m., resident is to resume walking to meals with staff members with use of four wheeled walker (FWW). Currently she has a CAM boot that she is to wear with walking until released from the doctor. She is able to weight bear as tolerated (WBAT). Tolerance to meals as tolerates. She does have rest areas available for	F 689		

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F 689	Continued From page 57 her to take a seated rest break as needed. - 10/19/23 at 1:12 p.m., returned from podiatry clinic visit, resident is WBAT without boot on, to continue with physical therapy (PT). - 11/18/23 at 6:10 a.m., staff reported that during transfer R14's right foot slid and staff assisted R14 to the floor. R14 was placed in the sitting position on the floor in front of her wheelchair. R14 assisted back to recliner. No incident report filed on assisted fall. - 12/11/23 at 2:00 p.m., staff went to get R14 for bingo and found her lying on the floor on her back with her walker on top of her legs. R14 was laying flat with her feet facing the door and head towards the window. R14's glasses were on the floor above her head. R14 did have gripper socks on. Room was well lit. Call light had been within reach of R14 when she was sitting in her recliner. Some blood on the floor by her head. Range of motion (ROM) assessed and within normal limits (WNL). Two person assist with mechanical lift to transfer from floor to recliner. Abrasion on back of head approximately 0.4 cm. Area cleansed. Ice pack and pressure applied. - 12/12/23 at 12:06 p.m., R14 walked part way to breakfast this am. After breakfast R14 complained of increased low back pain. - 12/12/23 at 6:48 p.m., called clinic to verify the x-ray results times two and the clinic did not call back prior to them leaving for the day. Will follow-up tomorrow. - 12/13/23 at 11:59 a.m., R14's daughter had been notified about the T9-T12 vertebrae wedge fractures from provider, appears new and would correlate with her fall and injury. - 12/21/23 at 6:52 p.m., resident was given Tylenol as scheduled. Writer asked how her pain was. Resident stated it was not good. Writer asked resident to rate the pain on a scale from	F 689		

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F 689	Continued From page 58 one to 10. Resident stated it was a seven. 45 minutes later resident rated the pain was at a six. -12/26/23 at 3:35 a.m., R14 had increased anxiety with transfer, toileting, and moving to fireside dayroom at 3:00 a.m. R14 was stirring in room. R14 kept saying oh no, oh no. -12/28/23 at 12:56 p.m., R14 had complaints of right leg pain. R14 had complaints of pain when ambulating to noon meal. Appointment was scheduled for R14 to go to clinic to get checked. - 12/28/23 at 3:29 p.m., R14 returned from the clinic. X-ray was negative. R14 received orders to begin prednisone (a medication used to reduce swelling) 5 mg two times a day (BID) for three days. - 12/29/23 at 4:33 a.m., physician's orders right hip pain on/off for three months. Achy pain worse when walking, standing, and laying on right side. Radiates at times to the knee. Right hip pain due to arthritis. X-ray negative for fracture. Orders: continue pain patch as before, Tylenol 1000 mg and prednisone 5 mg BID x three days. If not improving, follow up on next rounds. - 12/31/23 at 9:29 p.m., resident requested Tylenol due to complaints of pain rated nine out of 10. Review of R14's current orders signed 1/9/24, R14 received orders on 12/29/23, for Tylenol extra strength (a medication used to treat mild to moderate pain) 1,000 milligrams (mg) every 8 hours as needed (PRN) for pain and prednisone 5 mg two times a day (BID) for three days. R14 received orders on 8/25/23, apply antibiotic (ungt.) (triple antibiotic ointment) to scalp laceration daily, watch for signs of infection and update clinic if noted until healed, one time a day for scalp laceration.	F 689		

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F 689	Continued From page 59 Review of R14's provider notes dated 12/11/23 through 1/9/24, revealed the following: - 12/13/24 at 12:06 p.m., Advanced Practice Registered Nurse - Certified Nurse Practitioner (APRN-CNP), no rib fractures identified. There are new changes of wedge fractures to the T9-T12 vertebrae. These appear new and would correlate with her fall and injury. Monitor worsening pain or trouble with breathing, otherwise continue current plan of care if she remains stable. During an interview on 1/31/24 at 12:02 p.m., nursing assistant (NA)-A indicated R14 required assist of one staff with transfers and had a history of repeated falls. NA-A identified R14 was very anxious and did not want to miss certain activities such as bingo so R14 was brought early. NA-A stated he was unaware R14 had a fall with a major injury. NA-A indicated if a resident was found on the floor during a fall, NA-A would check if the resident was injured and would look for someone to assist NA-A with transferring the resident. During an interview on 1/31/24 at 12:50 p.m., assistant director of nursing (ADON) indicated R14 required assistance with transfers, ambulation and ADLs. ADON stated R14 had a history of multiple falls, would often self transfer in room and often self transferred to get to activities during the day. ADON indicated R14 had an unwitnessed fall on 12/11/23, that resulted in a major injury. ADON confirmed staff were not following the implemented care plan measure of bringing R14 to the dining room 15 minutes prior to the activity when R14 had the fall with major injury on 12/11/23. ADON further confirmed Bingo was scheduled 12/11/23 at 2:00 p.m. ADON	F 689		

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F 689	Continued From page 60 revealed R14 has had several falls over the past year due to self transferring and anxiety. ADON indicated when a resident had a fall, the floor nurse or charge nurse would assess the resident prior to staff assisting the resident up. The resident would then be assisted off the floor to a bed, wheelchair or recliner unless they needed immediate treatment. If immediate treatment was needed, the resident would be transferred to the emergency room. If no treatment was needed, they would complete the incident report and share during morning huddle and communicate to staff if there were any changes to the care plan. That was usually completed through orders being placed in the system and communication log. The staff would monitor for changes and inform the physician and family about the incident. During a follow-up interview on 1/31/24 at 2:08 p.m., ADON reviewed the incident report and revealed R14 was found in her room after an unwitnessed fall prior to bingo. ADON revealed R14's care plan indicated staff were to bring R14 to bingo 15 minutes prior because R14 would become anxious about missing bingo and would often self transfer herself to get to the activity. ADON confirmed she updated R14's care plan on 12/14/23, with a new fall intervention, verbally told staff about the update, updated R14's Kardex on 12/14/23 to reflect in the electronic health record (EHR) for NA's to review and documented it in the communication log. During an interview on 1/31/24 at 2:44 p.m., DON and executive administrator (EA), DON were not aware R14's care plan had not been followed which resulted in R14's fall with a major injury. DON indicated R14 had several falls over the past year and R14's care plan had some	F 689		

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F 689	Continued From page 61 interventions to help reduce the falls. DON confirmed the above findings and was unsure if R14's updated intervention on 12/14/23, had been communicated with staff. DON indicated changes to resident's care plans were discussed during shift huddle and placed into the communications binder. DON stated a registered nurse (RN), ADON or DON would update care plans to reflect new interventions and ensure the interventions were communicated with staff. DON explained her expectations were for staff to follow the care plans and interventions listed to reduce accidents and falls. EA indicated going forward, the facility would have an interdisciplinary team (IDT) review all accidents and falls. Although R14 had ten falls from March 2023 to January 2024, the facility had not completed a comprehensive assessment to determine a root cause of R14's fall so appropriate interventions could be implemented. R14 had eight falls in her room and two falls, when she was with staff and was suddenly "going down" or was pale and limp. There was no indication the facility reviewed R14's medications even though these medications have falls risk nor had they consistently completed orthostatic blood pressure monitoring. These was no indication the facility identified the majority of falls were in her room nor had they reviewed the falls interventions to determine if they were effective to reduce R14's the risk of falls. As a result, R14's become injured with a fracture, resulting in actual harm. Review of facility policy titled fall prevention program policy undated, each resident of Minnewaska Lutheran Home would be assessed for fall risk and would receive care and services in accordance with their individual level of risk to	F 689		

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F 689	Continued From page 62 minimize the likelihood of falls. The facility utilized a standardized risk assessment for determining a resident's fall risk. The risk assessment categorized residents according to low, moderate, or high risk. The nurse would indicate on the care plan the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. When a resident experienced a fall, the facility would assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of an emergency. Requested a copy of the communication logs however was not provided.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		2/23/24

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F 725	Continued From page 63 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to meet resident needs related to assistance of 1 of 1 residents (R28) reviewed for ambulation for restorative nursing services, 1 of 1 residents (R24) reviewed that required range of motion for restorative nursing and 1 of 1 residents (R7) reviewed for pressure ulcers. This deficient practice had the potential to affect all 30 residents who resided in the facility. Findings include: R28 R28's most recent diagnosis report dated 1/31/24, identified R28 had diagnoses of dementia, difficulty walking, muscle weakness and diabetes. R28's quarterly Minimum Data Set (MDS), dated 12/14/23, indicated R28 required extensive assistance with bed mobility, transfers and ambulation. R28 had mild cognitive impairment and at times had confusion that required additional cuing.	F 725	F725 Sufficient Nurse Staff Traverse Care Center has implemented a staffing ladder that takes into consideration, acuity, the facility's census, and diagnoses of the resident population, to accurately and efficiently staff the building. A¿staffing ladder affects the facility by ensuring TCC has enough staff who are adequately trained to provide high-quality care, offer timely assistance to residents, including help with daily activities, medication administration, and medical emergencies. The facility has a contract with a pool staff agency if staffing levels drop. The administrator, DON, and scheduling coordinator will work in tandem to create a schedule in which staff are made aware of possible openings in shifts a month in advance. This process will give the administrator, DON, and scheduling coordinator a clear view of potential needs by being proactive opposed to reactive in fully scheduling the building. The administrator and DON have worked with the travel staff in advance to fill needs in staffing. The goal is to now be	

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F 725	Continued From page 64 R28's significant change Care Area Assessment (CAA) dated 9/14/23, identified R28 had potential for more independence with cuing and restorative nursing program to maintain current level of functioning. R28's care plan revised 1/3/24, indicated per physical therapy (PT) R28 was to ambulate three times a day to or from meals. Required two to three assist with front wheeled walker (FWW) and follow with wheelchair. R28's care plan identified R28 was to follow PT recommendations as able/accepted. R28 was to be in a functional program: walking with FWW and one to two assist to all destinations with wheelchair following, initiated 9/3/23. Staff were to notify nurse manager and/or therapy of any barriers. In addition, staff were to notify PT of an increase or decrease in functional level. During continuous observations on 1/30/24 from 8:47 a.m. to 1:19 p.m., assistant director of nursing (ADON) asked R28 if he needed to use the bathroom and he stated "yeah, I have been waiting for 2 hours to go. No one has taken me". ADON wheeled resident into the bathroom next to the nurses' station and nursing assistant (NA)-C assisted ADON to toilet R28. R28 stood up next to the toilet and pivot transferred using the grab bars per therapy recommendations. R28 pivoted back into wheelchair and exited the bathroom. R28 was wheeled to the dayroom by the dining room by ADON. During an interview on 1/30/24 at 3:21 p.m., NA-C indicated R28 required a hoyer lift to transfer in and out of bed or recliner. NA-C stated R28 was not able to stand well even when he did have something in front of him to hold onto. NA-C	F 725	proactive in our approach and forecast the needs of the building to avoid a recurrence of poor staffing, Competencies through Educare, staff meetings, and orientation, will assist in assuring resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The administrator and DON will work jointly with the facilities scheduler to ensure the appropriate staffing levels daily. The administrator and DON will keep an open line of communication with the pool agency in advance regarding staffing needs and/or concerns with shared employees. In compliance 02/21/2024.	

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F 725	Continued From page 65 stated staff were expected to ambulate R28 to and from meals however indicated ,"we were short staffed and unable to walk him as he needed". NA-C stated, "It is not too often that we get to do therapy things". In a follow- up interview on 1/31/24 12:10 p.m., NA-C indicated when therapy recommendations were put into place staff were not available to complete the recommendations. "If we were fully staffed we would be able to walk residents as needed". NA-C further indicated the night shift often lacks enough staff and at times there has only been two people in the building, a nurse and an aid. NA-C stated residents have to wait a long time for assistance when they have used their call light". See F688 for additional information R7 R7's quarterly Minimum Data Set (MDS), dated 11/2/23, identified R7 had diagnoses which included Alzheimer Disease, dementia and anxiety. R7 required extensive assistance of two staff for bed mobility and transfers. R7 required extensive assistance of one staff to roll from left to right. Indicated R7 was a risk for pressure ulcers, currently had an unhealed pressure ulcer and infection in foot. R7's significant change Care Area Assessment (CAA), dated 5/3/23, identified R7 was at risk for skin breakdown and potential pressure ulcers due to needing extensive assistance with bed mobility. R7's care plan revised on 1/24/24, identified R7 had actual complications with impaired skin	F 725		

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F 725	Continued From page 66	F 725		

integrity related to the blister on heel. Indicated R7's heels were to be floated at all times when in bed and staff were to reposition every two hours. R7 was dependent on staff for all cares.

During continuous observation on 1/30/24 from 8:56 a.m. to 11:09 a.m., R7 was seated in her wheelchair in the dining room being assisted for breakfast. R7's daughter requested someone to assist R7 to the restroom. R7's daughter spoke to the nurse at the nurses station for assistance, RN-A stated she would get someone to assist R7. R7 continued to be seated in her wheelchair in the fireside day room. ADON and LPN-A laid resident down and provided activities of daily living (ADLs) for R7.

R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 had not been repositioned for a total of two hours and 13 minutes during this observation.

During an observation on 1/30/24 at 1:22 p.m., R7 was laying in bed covered with a sheet and pink comforter covering her. R7 laid on her left side facing the fall with a pillow behind her lower back. R7 was wearing both heel protecting boots and had a wedge pillow between her knees. R7 did not have a pillow under her calf's, left heel/foot was laying to the left side. Right leg was bent at the knee and right heel and foot were flush on the bed.
- At 3:10 p.m., R7 was laying in bed in the same position as above.
- At 4:56 p.m., R7 was laying in bed in the same position as above.

R7 had not been offered to reposition every two

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F 725	Continued From page 67 hours or had a pillow suspending heels as directed by her care plan. R7 was unable to reposition herself or place the pillow independently. R7 had not been repositioned for a total of three hours and 34 minutes. During an interview on 1/30/24 4:56 p.m., NA-C confirmed she had not repositioned the R7 since she had been laid down at 1:22 p.m.. NA-C stated she had been" running around the building" and had not been able to return down that wing to reposition her. See F686 for additional information R24 Review of R24's quarterly MDS dated 12/7/23, identified R24 had diagnosis which included congestive heart failure, hypertension, atrial fibrillation, chronic pain and diabetes. Identified R24 was cognitively intact and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers and ambulation. Review of R24's physical therapy note dated 8/29/23, recommended: PAL lift from bed to toilet, two assist from toilet, sit to stand with pivot to toilet, and completion of toileting. Program for standing/exercises had been given to nursing staff and a copy hung in R24's bathroom: -standing tolerance at grab bars in bathroom 3x1 min each. -standing weight shifts at grab bars in bathroom	F 725		

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F 725	Continued From page 68 x20 (side-side). -standing marching at grab bars in bathroom x20 each. Review of R24's care plan revised 1/3/24, indicated transfers- PAL for all transfers except the following: recommended PAL bed to toilet, one-two assist from toilet sit to stand with pivot to toilet. R24's care plan further indicated staff were to monitor/document any changes in ADL ability, reason for inability to perform ADL's and report to doctor any changes. R24's care plan lacked information on therapy recommendations for standing/exercise program. Review of doctor's progress noted dated 11/13/23, stated R24 was very disappointed that he was not getting more walking help. During an interview on 1/29/24 at 4:56 p.m., R24 stated he had no exercise program, would like to have one, had asked staff about getting therapy again with no response and would like to do some walking again and regain strength. During an interview/observation on 1/30/24 at 9:47 a.m., NA-C brought PAL lift into R24's room and assisted R24 into lift with sling, assisted R24 to a standing position, wheeled PAL lift to bathroom, R24 sat onto toilet, gave R24 privacy in bathroom while R24 remained in PAL lift. NA-C returned to R24's room when R24 put call light on. NA-C raised PAL lift to standing position, proceeded to complete toileting cares and brought R24 to recliner, positioned and lowered R24 into chair. After above observation was completed asked NA-C to verify physical therapy recommendations posted on R24's bathroom wall. NA-C indicated she was not aware of the	F 725		

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F 725	Continued From page 69 transfer recommendations. NA-C verified the facility did not have a restorative program in place for residents and staff did not have time to do a restorative program even if there was one. During a follow-up interview on 1/31/24 at 10:34 a.m., R24 stated he recalled therapy provided instructions on exercises however was unsure where they were at now. R24 verified he had not completed exercises for a very long time and staff had not offered to do exercises. R24 stated he had lost strength due to not doing exercises and indicated he would try to do exercises if staff offered. During an interview on 1/31/24 at 11:56 a.m., NA-A stated R24 was not currently at the same physical level as when R24 moved to facility. NA-A confirmed they used the PAL lift for all transfers with R24 now and that they did not always use the PAL lift for transfers since R24 had been at the facility. NA-A confirmed there was no restorative program in place for R24. NA-A stated staff were expected to encourage R24 to stand however stated, "I am not that big and did not feel safe doing that myself." NA-A stated if there were enough staff they would be able to get restorative tasks completed and that sometimes it did not get done based on importance. During an interview on 1/31/24 at 10:26 a.m., OT verified the facility did not have a restorative program in place for the residents. OT verified R24 would benefit from restorative program. OT stated she did not feel nursing staff had the time to perform a restorative program. During an interview on 1/31/24 at 2:08 p.m.,	F 725		

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F 725	Continued From page 70 director of nursing (DON), verified the facility did not have a restorative program currently in place. DON stated residents would lose range of motion (ROM) and develop decreased strength. DON stated R24 did have exercises from therapy and was unable to verify if it was being done. DON confirmed she was aware there were times in the past when the restorative aid was removed from providing restorative services when the facility had a staff call in ill. During an interview on 1/31/24 3:11 p.m., DON and executive administrator (EA) confirmed the above findings and were aware of the staffing concerns. Both indicated it was a concern at the management level. EA revealed the current pool agencies being used had not always been dependable and the facility had recently replaced them with two different agencies. DON indicated that staff had called into work the past week causing very low staffing. DON stated her expectations were for staff to be to work on time as scheduled and follow the facility policy for staffing expectations. Review of facility policy titled Nursing Services and Sufficient Staff unknown date, it was the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population would be considered based on the facility assessment.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		2/29/24

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F 732	Continued From page 71 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 732		

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F 732	Continued From page 72 Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was accurately identified in the daily posting. This deficient practice had the potential to affect all 30 residents who resided in the facility and/or any visitors who may have wished to view the information. Findings include: During an observation on 1/29/24 at 3:38 p.m., a sheet of paper identified as Posted Nurse Staffing Information was posted on the bulletin board in the center of the building in between the day room and the 200 wing. -The posting was dated 1/29/24, and identified a census of 30 along with the following staffing information: -day hours- 6:30 a.m.-3:00 p.m. no registered nurses (RN) hours listed, licensed practical nurses (LPN) , trained medication aid (TMA), nursing assistant (NA)- each listed for eight hours - one staff. -pm hours- 2:30 p.m.-11:00 p.m. RN 4 hours - one staff, LPN - 12 hours - two staff, NA 24 hours - six staff. -overnight hours- 11:00 p.m.-7:00 a.m. - 8 hours - one staff, NA 16 hours - two staff. The posting lacked the actual and total number of hours worked per shift for RN's, LPN's TMA's and NA's. During an observation on 1/30/24 at 8:43 a.m., a sheet of paper identified as Posted Nurse Staffing Information was posted on the bulletin board in the center of the building in between the day room and the 200 wing. -The posting was dated 1/30/24, and identified a	F 732	F732 Traverse Care Center intent is to post a daily nurse staffing data in a prominent place and readily accessible to residents and visitors. A new daily nursing staffing posting form was created. Nurse staffing posting policy & procedure reviewed and updated. Nursing staff and nursing scheduler will be educated on the policy and procedure 2/19/24. Audits will be conducted randomly x 3 weeks for the posting of the daily nursing staffing scheduled and for accuracy of the posting. DON is responsible for audits. Audits will be brought to the QA meeting for review and for further suggestions. Completion Date: 2/29/24	

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F 732	Continued From page 73 census of 30 along with the following information: -day hours- 6:30 a.m.-3:00 p.m. no RN hours listed, LPN, NA each list eight hours - two staff. -pm hours- 2:30 p.m.-11:00 p.m. no RN hours listed, LPN, 16 hours - two staff, NA 21 hours - five staff. -overnight hours -11:00 p.m.-7:00 a.m. LPN - 8 hours - one staff, NA 16 hours - two staff. The posting lacked the actual and total number of hours worked per shift for RN's, LPN's TMA's and NA's. During an observation on 1/31/24 at 7:23 a.m., a sheet of paper identified as Posted Nurse Staffing Information was posted on the bulletin board in the center of the building in between the day room and the 200 wing. -The posting was dated 1/31/24, and identified a census of 30 along with the following information: -day hours- 6:30 a.m.-3:00 p.m. no RN hours listed, LPN, 24 hours - three staff, NA, 19 hours - three staff. -pm hours- 2:30 p.m.-11:00 p.m. no RN hours listed, LPN - 12 hours - two staff, NA 29 hours - four staff. -overnight hours- 11:00 p.m.-7:00 a.m. LPN - eight hours - one staff, NA 14 hours - two staff. The posting lacked the actual and total number of hours worked per shift for RN's, LPN's TMA's and NA's. During an observation on 1/31/24 at 7:40 a.m., the maintenance manager (MM) placed an updated the Posted Nurse Staffing Information sheet over the one mentioned above. The updated information revealed the following: -Staff Posting dated 1/29/23 identified the	F 732		

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F 732	Continued From page 74 following: -day hours- 6:30 a.m.-3:00 p.m. no RN hours listed, LPN, TMA, NA each list eight hours -one staff each. -pm hours- 2:30 p.m.-11:00 p.m. RN four hours - one staff, LPN - 12 hours - two staff, NA 24 hours - six staff. -overnight hours- 11:00 p.m.-7:00 a.m. LPN - eight hours - one staff, NA 16 hours - two staff. The posting lacked the actual and total number of hours worked per shift for RN's, LPN's TMA's and NA's. During an interview on 1/30/24 at 1:47 p.m., DON and the consultant confirmed the above findings and indicated they were unaware the posted nurse staffing was inaccurate. DON verified that the hours listed did not reflect the actual nurse staffing hours scheduled DON indicated the night nurse or the administrative assistant were responsible for updating the posting daily. DON stated her expectations were the correct staff hours would be reflected on the posted nurse staffing sheet and further education needed to be provided to ensure documentation was accurately recorded. During an interview on 1/30/24 at 2:33 p.m. interim administrator (IA) indicated he was unaware the posted nurse staffing sheets were inaccurate. IA indicated his expectations were the posted nurse staffing sheet needed to be completed by someone who understood the posting and how to correctly fill it out. IA stated further education was needed to ensure the documention was correct. Review of facility policy titled Nurse Staffing	F 732		

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F 732	Continued From page 75 Posting Information dated 2022, identified it was the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The Nurse Staffing Sheet would be posted on a daily basis and would contain the following information: facility name, the current date, facility's current resident census, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses/Licensed Vocational Nurses and Certified Nurse Aides.	F 732		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization	F 801		2/15/24

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F 801	Continued From page 76 recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or	F 801		

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F 801	Continued From page 77 (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a qualified director of food and nutrition services or a full-time qualified dietician was in place to oversee food preparation and kitchen function in the main production kitchen. This deficient practice had potential to affect all 30 residents, visitors, and staff who consumed food from the kitchen. Findings include: During an interview on 1/30/24 at 10:04 a.m., cook (C)-A stated food service supervisor (FSS)-A was their supervisor, however FSS-A was not certified as a dietary manager. C-A stated she had been employed at the facility since May 23, and the facility had not had a dietary manager since then. During an interview on 1/30/24 at 10:10 a.m., interim administrator confirmed the facility did not	F 801	F801 Qualified Dietary Staff Traverse Care Center has enrolled the dietary manager 02/15/2024 for her CDM. This is an online course through the University of North Dakota. The job description for dietary manager has been updated to avoid future confusion as well as to set a more thorough expectation for the position. Dietician and dietary manager were educated 02/19/2024 at staff meeting. Minnewaska Health Services has provided the facility with a dietician to work alongside the dietary manager while certification is in progress. Compliance date 02/21/2024	

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F 801	Continued From page 78 have a dietary manger, however FSS-A planned to become certified in the future. During an interview on 1/30/24 at 10:14 a.m. FSS-A verified the facility did not have a dietary manager since June or July of 2022. During a follow up interview on 1/30/24 at 10:24 a.m., FSS-A stated she had been in the role as supervisor since 1/1/24, and indicated the facility had not provided her with dietary manager training yet. FSS-A stated the facility had part time dieticians and they just hired new registered dietician (RD)-A in January 2024, FSS-A stated RD-A had been at the facility once. During a telephone interview on 1/30/24 at 4:09 p.m., RD-A confirmed she was the facility's dietician and had just recently started working with the facility. RD-A verified FSS-A was not certified and indicated she was going to assist FSS-A with training. RD-A confirmed the facility did not have a certified dietary manager. RD-A indicated she had been at the facility once last week, and intended to complete resident assessments, and assist FSS-A as necessary. RD-A stated she had assisted FSS-A with how to calculate and complete minimum data set (MDS) documentation, which the executive administrator had informed RD-A, FSS-A planned to complete. During an interview on 1/30/24 at 4:28 p.m., director of nursing (DON) confirmed the facility did not have a dietary manager and FSS-A was the kitchen supervisor. DON indicated she could not verify how long the facility had not had a dietary manager however it had been since at least March 2023. DON indicated FSS-A began her new role 1/1/24, and FSS-A had been	F 801		

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F 801	Continued From page 79 managing the kitchen staff.. DON indicated the only training FSS-A had so far was ServSafe training (food and beverage safety training), and FSS-A had not yet completed the test on it. A policy on dietary manager was requested, and on 1/30/24 at 4:50 p.m., DON verified the facility did not have a policy. The DON provided the following job descriptions. -Food Service Supervisor, undated, identified job summary to include management and scheduling of food service personnel, management of food supplies and kitchen equipment, food production and menu changes. The job description qualifications identified the food service supervisor would be willing and able to obtain dietary manager certification within eighteen months of employment, and was ServSafe certified. The job description indicated the food service supervisor would coordinate dietary activities with the consultant dietitian. -Food Services Director, undated identified job summary to include responsibility for leadership and oversight necessary to provide appetizing, appealing, and nourishing food to residents with a variety of dietary needs. The job description included qualifications as three years experience in food service, a minimum of one year in supervisory position and possession of certified dietary manager (CDM) credentials. The job description tasks included: completion of the MDS as delegated by the MDS coordinator, complete nutritional risk assessments, and participate in care conferences weekly.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/23/24

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F 812	Continued From page 80 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwasher temperatures were maintained according to manufacturer's guidelines to assure sanitization of dishware. This deficient practice had the potential to affect all 30 residents who received food from the kitchen. Findings include: During an observation on 1/29/24 at 11:07 a.m., dietary aide (DA)-A ran a rack of dishes through the dishwasher, the rinse cycle gauge did not move during observation. At 11:13 a.m., food service supervisor (FSS)-A ran the dishes back through the dishwasher and indicated the wash cycle obtained 180 degrees, and the rinse cycle	F 812	F812 Food Safety-Dish Sanitation The facility took the following actions to ensure sanitary dishware. Three compartment hand washing was implemented or use of disposable products until the dishwasher can be repaired or replaced. The facility reviewed policies and procedures for sanitation including dishwasher temperatures and three-compartment handwashing of dishes. Dietary staff were trained in policies and procedures. The dietary manager will implement use of hand-washing or disposable products	

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F 812	Continued From page 81 ran at 140 degrees. FSS-A stated the dishwasher was last serviced on 10/31/23, at which time dishwasher representative (DR)-A replaced the gauges, and informed them at that time the facility needed to replace the booster heater. FSS-A and surveyor reviewed the facility temp records, posted on the wall near the dishwasher, and FSS-A confirmed the wash cycle had not been reaching 150 as required, and the rinse cycle did not reach 180 degrees. FSS-A verified the dishwasher temps had been running low. FSS-A stated they used a plate thermometer that they ran through to test the temperatures, or used test strips to test dishwasher temperatures as needed. FSS-A indicated they had been able to get the temperatures up to 174 to 182 after running the machine multiple times, however confirmed the dishwasher had not consistently been reaching the required temperatures. FSS-A indicated the facility needed a new dishwasher. Review of the Dishwasher Record Log dated January, included three wash cycle-150 degrees columns, and three rinse cycle-180 degrees columns for each day entry. The log identified the following: Wash cycles recorded three times a day, January 1, through January 27, included: -120 degrees, one time. -130 degrees, twelve times. -135 degrees, two times. -140 degrees, thirty four times. -145 degrees, three times. -150 degrees, twenty nine times. Rinse cycles recorded three times a day, January 1, through January 27, included: -100 degrees, one time.	F 812	immediately if dishwasher temperatures are not adequate. A vendor was contacted to evaluate the dishwashing equipment and a new part was ordered. Handwashing in a three compartment sink or use of disposable products will continue until the dishwasher is in proper working order and temperatures are adequate. The facility will monitor by completing audits of dishware sanitation. Audits will be completed by the dietary department supervisor, or designee. Audits will be done 3 times a week for 2 months, then once a week for 6 months. Results will be shared with the QAPI/QAA Committee. The Committee will determine if additional auditing is needed. The date of correction is 2/23/24.	

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	245585	A. BUILDING _____ B. WING _____	C 01/31/2024

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F 812	Continued From page 82 -110 degrees, fifteen times. -115 degrees, one time. -120 degrees, forty eight times. -125 degrees, one time. -130 degrees, fourteen times. -150 degrees, one time. During a telephone interview on 1/30/24 at 4:09 p.m., registered dietician (RD)-A confirmed she was the facility dietician. RD-A indicated she was not aware the dishwasher was not heating at the required temperatures. RD-A stated it was important for the temperatures to be accurate or it would not kill everything on the dishes, and the dishes would not be clean. During a telephone interview on 1/30/24 at 1:22 p.m. DR-A indicated the dishwasher required work and a new booster heater since it was not reaching hot enough temperatures. DR-A stated he had informed the facility staff the last time he was at the facility. DR-A confirmed the dishwasher temperatures required the wash cycle to reach 150 degrees, and the rinse cycle to reach 180 degrees. DR-A stated if the temperatures were not reached, the dishes would not be sanitized. DR-A stated if the gauges were not working, the facility could run a plate thermometer or strips through the machine, and if they reached 160 degrees surface temperature, that would mean the machine reached 180 degrees. During an interview on 1/30/24 at 1:41 p.m., interim administrator stated he was informed of dishwasher temperature concerns yesterday. Interim administrator confirmed the dishwasher at the facility was a hot water temperature type, and indicated the facility had problems in the past with	F 812		

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F 812	Continued From page 83 the dishwasher. Interim administrator stated the dishwasher temperatures were important to be accurate to assure killing of bacteria and stated it was a sanitization issue. During a follow up interview on 1/30/24 at 2:03 p.m., FSS-A verified the facility did not have a manufacturer's instruction book. FSS-A stated they had problems with the dishwasher in the past and stated the low temperatures for the dishwasher began occurring again in January 24. The facility policy titled Dishwashing Machine Use, dated 3/10, identified the following: -dishwashers that used hot water to sanitize must maintain the following wash solution temperatures: -150 degrees for stationary rack, dual temperatures machines, or multi-tank, conveyor, multi-temperature machines -dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degrees , or less than: -165 degrees for stationary rack, single temperature machines -180 degrees for all other machines. The policy identified operator would check temperatures using the machine gauge with each dishwashing cycle, and record the results in a facility approved log. Inadequate temperatures would be reported to the supervisor and corrected immediately. The policy identified if the water temperatures did not meet the requirements, cease use of dishwasher machine immediately until temperatures were adjusted.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5)	F 851		2/15/24

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F 851	Continued From page 84 §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each	F 851		

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F 851	Continued From page 85 individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705 D identified the following dates triggered for review: 7/15/23, 7/16/23, 8/6/23, 8/11/23, 9/16/23, 9/17/23, 9/23/23, and	F 851	F851 SS=F Payroll Based Journal Individual that submits the PBJ has been educated on reported issues from the Minnesota Department of Health. Minnewaska Lutheran home staff will work in conjunction with our payroll system as well as the federal government to ensure compliant practices are occurring and accurate reports are being given through CMS. CFO/ HR will audit PBJ hours prior to submission each quarter. This will be audited prior to PBJ submission date quarterly and brought to the QAPI committee.	

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F 851	Continued From page 86 9/24/23 for failure to have licensed nurse coverage 24 hours per day. In addition, excessively low weekend staffing also triggered for review. Review of staffing schedules from 7/14/23 thorough 9/24/23, identified the facility had seven staff identified to have worked: registered nurse (RN)-A, RN-B, Licensed Practical Nurse (LPN)-A, LPN-B, LPN-C, LPN-D and assistant director of nursing (ADON) on each of the above dates listed. In addition, review of staff's time cards from 7/14/23 through 9/24/23, on the above-mentioned dates identified licensed nursing staff had worked. Review of Casper Report 1702S staffing Summary Report from 7/1/23 thru 9/30/23 identified the facility had sufficient staffing coverage on the weekends. In addition, review of staff's time cards from 7/1/23 through 9/30/23 identified sufficient staff coverage for weekends. Review of the facility's staffing schedules and time cards identified a discrepancy with the PBJ report. During an interview on 1/31/24 at 3:11 p.m. director of nursing (DON) and executive administration (EA) confirmed the above findings and stated licensed staff had worked on the dates mentioned above. In addition, the DON confirmed sufficient weekend staffing had taken place between the use of current and contracted employees. EA indicated the PBJ report was inaccurate and was aware of the issues. Review of facility policy titled Payroll Based Journal undated, it was the policy of the facility to	F 851	Compliance date 02/15/2024	

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F 851	Continued From page 87 electronically submit timely to Centers for Medicare & Medicaid (CMS) complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. The facility would ensure all staffing data entered in the Payroll-Based Journal (PBJ) system was auditable and able to be verified through either payroll, invoices, and/or tied back to a contract. The facility would utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual. The Administrator, HR Director, and Director of Nursing were responsible for verifying accuracy of the staffing data that was submitted to CMS using various facility audit forms and/or payroll vendor reports. The Business Office Manager was responsible for verifying the accuracy of census data and collaborating with MDS Coordinator for any needed corrections.	F 851		
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	F 880		2/23/24

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F 880	Continued From page 88 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, 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.	F 880		

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F 880	Continued From page 89 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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 personal laundry was transported in a manner that prevented risk of contamination for 2 of 4 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 1/29/24 at 12:03 p.m., housekeeping aid (HA)-B was observed uncovering the laundry cart, removed laundry from the cart, placed the laundry in R22's closet, exited R22's room and returned to the uncovered cart. HA-B removed laundry from the uncovered cart, placed the laundry in R5's closet, exited R5's room, removed laundry from the uncovered cart,	F 880	F880 SS=E Infection Prevention and control ALL staff have been educated on the infection control policies and procedures as it relates to handling, storage and transportation of linen and clothing. ALL STAFF have also been educated in handwashing. EVS with the infection prevention team has presented hands on training with all staff that includes hand washing and sanitizing. These practices will be audited 3 times per week 3 weeks, 2 times per week for 3 weeks, and once per week for 2 weeks by the Administrator, Infection Preventionist, DON as well as EVS director. These Audits will be brought to QAPI to determine continued frequency and compliance quarterly and to determine if ongoing random audits are necessary.	

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F 880	Continued From page 90 placed in R2's closet, exited R2's room with empty hangers and hung the hangers in the cart. HA-B pushed the uncovered laundry cart to R24's room, removed laundry from cart, left uncovered in front of visitor passing by cart, knocked on door, hung up laundry in R24's closet and exited R24's room with empty hangers and hung the hangers in the cart. HA-B removed laundry from the uncovered cart, placed the laundry in R27's closet, exited R27's room. HA-B returned to the uncovered cart, removed laundry from cart, delivered laundry to R26's closet and exited R26's room. HA-B removed laundry from the uncovered cart, knocked on R16's door, delivered laundry and exited R16's room. HA-B pushed the uncovered cart down the hall, removed laundry from the cart, placed the laundry in R10's closet and exited R10's room. HA-B removed laundry from the uncovered cart, knocked on R28's door, placed laundry in R28's closet and exited R28's room. HA-B returned to the uncovered cart, removed laundry from the cart, dropped laundry on the floor in hallway, picked laundry up and delivered to R9's room while holding laundry against his body, placed laundry in R9's closet and exited R9's room. HA-B removed laundry from the uncovered cart, walked down the hall with the laundry, knocked on R14's door, placed the laundry in R14's closet, exited R14's room, closed R14's door and walked back down the hall to the laundry cart which remained uncovered. HA-B removed laundry from the cart, walked down the hall, knocked on R19's door, hung laundry in R19's closet and exited R19's room. HA-B walked back down the hall and pushed the empty laundry cart back to the laundry room. HA-B did not sanitize his hands and the laundry cart remained uncovered during the entire	F 880	Compliance Date: 02/23/2024	

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F 880	Continued From page 91 observation. During an observation on 1/29/24 at 3:29 p.m., nursing assistant (NA)-B pushed the covered laundry cart down the 300 hall to deliver clean laundry to residents. R18's two pairs of pants, one t-shirt, and two button up shirts were hanging on the outside of the cart. NA-B grabbed the laundry hanging from the cart, knocked on R18's door, placed clothing in R18's closet, exited R18's room with empty hangers and set hangers on the top of laundry cart. NA-B continued to deliver laundry down the hall. NA-B removed laundry from the uncovered cart, knocked on R22's door, opened door, delivered laundry, exited R22's room and returned to the uncovered laundry cart. NA-B removed laundry from cart, knocked on R2's door, pulled drawers open in R2's room, placed laundry in drawers, closed drawers and exited R2's room with empty hangers and set on top of cart. NA-B removed laundry from cart, knocked on R24's door, opened R24's bedside drawer, placed laundry in drawer, closed drawer and exited R24's room with empty hangers and set on top of cart. NA-B removed laundry from uncovered cart, knocked on R27's door, delivered laundry and exited R27's room. NA-B removed laundry from uncovered cart, delivered to R26's room and exited R26's room. NA-B pushed the uncovered laundry cart down the hall, removed laundry and delivered laundry to R16's room and exited R16's room. NA-B removed laundry from the uncovered cart, placed in R10's closet and exited R10's room. NA-B removed laundry from uncovered cart, placed in R28's closet and exited R28's room. NA-B pushed the uncovered cart down the hall, removed laundry, placed in R20's closet and exited R20's room. NA-B removed laundry from cart, knocked on	F 880		

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F 880	Continued From page 92 R14's door, placed laundry in dresser and in closet and exited R14's room. NA-B removed laundry from the uncovered cart, placed in R19's closet and exited R19's room. NA-B pushed the uncovered laundry cart down the hall, stopped and visited with resident in the lounge area by the nurses station and returned the cart to the laundry room. NA-B did not sanitize her hands and the laundry cart remained uncovered during the entire observation. During an interview on 1/30/24 at 10:50 a.m., HA-B verified he removed clothes from the uncovered cart, placed them in the residents' closets, took back any hangers to the uncovered cart and did not sanitize his hands. (HA)-B stated the purpose of keeping the cart covered and for completing hand hygiene was to prevent the spread of infection between residents. During an interview on 1/31/24 at 2:12 p.m., the director of nursing (DON) verified the expectation of staff delivering laundry was to keep the laundry cart covered during delivery and to complete hand hygiene in between. DON stated these practices were important to prevent contamination from the environment and cross contamination of surfaces. Review of a facility policy titled Infection Prevention and Control Manual Environmental Services/Housekeeping/Laundry undated, indicated laundry should be packaged, transported and stored in a manner that ensured cleanliness and protected the laundry from dust and soil. Clothing would be taken out of cart and covered again while unattended in the hallways.	F 880		

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F 880	Continued From page 93 Laundry staff would sanitize hands on the way out of the resident room.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the	F 883		2/29/24

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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 883	Continued From page 94 benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R2, R9, R26, R28, R29) were offered or received pneumococcal vaccinations based on shared clinical decision-making in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC recommendations 3/15/2023, revealed The Center for Disease Control and Prevention (CDC) identified Adults 65 years of age or older who had not previously received Pneumococcal 13-valent Conjugate Vaccine (PCV13) and who had previously received one or more doses of Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should	F 883	F883 Traverse Care Center intent that each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. Resident R2, R9, R26, R28, & R29 were offered the PVC – 20 immunization. Consent or declination forms were signed either by the resident or resident's responsible person. Physician orders obtained, and PVC-20 ordered from pharmacy. Administration and consent or declination will be charted in resident's chart.	

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F 883	Continued From page 95 receive a dose of Pneumococcal 15-valent Conjugate Vaccine (PCV15) or one dose of Pneumococcal 20-valent Conjugate Vaccine (PVC20). The dose of PCV15 or PCV20 should be administered at least one year after the most recent PPSV23 dose. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 was received at age 65 and older, based on shared clinical decision-making, one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R2's immunization report, R2, age 96, was admitted to the facility on 10/12/16. Review of R2's Minnesota Immunization Information Connection (MIIC) undated, identified R2 had received the PCV-13 vaccination on 5/9/17, and the PPSV23 vaccination on 10/8/96 and 3/24/15. R2's medical record lacked documentation R2 had been offered or received the PCV15 or PCV20 vaccines based on shared clinical decision-making with the provider. Review of R9's immunization report, R9, age 92, was admitted to the facility on 12/11/18. Review of R9's MIIC undated, identified R9 had received the PCV-13 vaccination on 7/20/15, and the pneumovax dose 1 vaccination on 8/15/16. R9's medical record lacked documentation R9 had been offered or received the PVC15 or PCV20 vaccines based on shared clinical decision-making with the provider. Review of R26's immunization report, R26, age 95, was admitted to the facility on 5/24/23. Review of R26's MIIC undated, identified R26 had received the PCV-13 vaccination on 1/24/17, and the PPSV23 vaccination on 5/10/19. R26's medical record lacked documentation R26 had	F 883	All current residents were offered the PVC – 20 immunization. Consent or declination forms were signed either by the resident or resident's responsible person. Physician orders obtained, and PVC-20 ordered from pharmacy. Administration and consent or declination will be charted in resident's chart. Pneumococcal Vaccine (Series) policy reviewed and updated. Licensed staff will be educated at all staff meeting 2/19/24. PVC - 20 immunization consent or declination forms will be added to admission packets so new admissions will be offered the PVC – 20 immunization. Licensed staff will use resources such as the PneumoRecs Vax Advisor APP. DON or Designee will complete audits on new admissions x 6 weeks to ensure PVC-20 was offered and given if consented. Audits will be brought to the QA meeting for review and for further suggestions. Completion Date: 2/29/24	

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F 883	Continued From page 96 been offered or received the PVC15 or PCV20 vaccines based on shared clinical decision-making with the provider. Review of R28's immunization report, R28, age 88, was admitted to the facility on 6/27/23. Review of R28's MIIC undated, identified R28 had received the PCV-13 vaccination on 9/23/16, and the PPSV23 vaccination on 10/24/05. R28's medical record lacked documentation R28 had been offered or received the PVC15 or PCV20 vaccines based on shared clinical decision-making with the provider. Review of R29's immunization report, R29, age 85, was admitted to the facility on 10/18/23. Review of R29's MIIC undated, identified R29 had received the PCV-13 vaccination on 4/9/15, and the PPSV23 vaccination on 4/10/23. R29's medical record lacked documentation R29 had been offered or received the PVC15 or PCV20 vaccines based on shared clinical decision-making with the provider. During an interview on 1/31/24 at 3:37 p.m., the director of nursing (DON) confirmed the updated pneumococcal guidelines issued by the CDC on 3/15/23. DON reviewed residents' immunization records and confirmed the medical records lacked documentation of the PVC20 vaccination. The DON stated her expectation were residents would be offered or receive pneumococcal vaccinations according to CDC guidelines upon admission and thereafter in accordance to the CDC recommendations. Review of facility policy titled, Pneumococcal Vaccine not dated, identified all residents would be offered pneumococcal vaccinations to aid in	F 883		

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F 883	Continued From page 97 prevention of pneumococcal infections. Upon admission, residents would be provided information on the pneumococcal vaccinations and would be offered pneumococcal vaccinations after reviewing the residents pneumococcal vaccination history. Administration of pneumococcal vaccinations or revaccination would be made in accordance to CDC recommendations at the time of the vaccine.	F 883		

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/31/2024. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/14/2024

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.and 300 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	K 000		

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K 000	Continued From page 2 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 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 entire building is considered type V (111) due to the fire barrier separating the two has 20 minute doors only. The facility has a capacity of 44 beds and had a census of 30 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an egress corridors and emergency egress door per NFPA 101 (2012 edition), Life Safety Code, section 7.1.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 211	K211 SS=D Means of Egress All staff have been educated on the proper place to store facility equipment including laundry carts, linen containers and tables and chairs ESD will round daily to ensure that facility	2/13/24

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K 211	Continued From page 3 1. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that the egress corridor in the 500 and 600 wings were blocked with clean linen carts, soiled linen containers, garbage containers, and a table and chair. 2. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that two large carts with clean linens were being stored in the egress corridor in the north end of the 600 wing by the laundry area. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211	equipment, laundry carts, linen containers and tables and chairs are in the proper location This will then be documented, brought to Safety and presented to QAPI The QAPI team will then decide when full compliance has been reached and when to discontinue Means of Egress rounding. Compliance Date: 02/13/2024	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the	K 291	K-291 SS=F Emergency lighting Preventative maintenance on the emergency lighting has been imputed into the preventative maintenance program. This is a web-based program that will notify staff when an inspection needs to be completed. Maintenance staff will then complete the 30 second test per month on the emergency lighting, as well as the 90 minute test annually. The task will then be signed off via the web based program as	2/9/24

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K 291	Continued From page 4 facility could not provide documentation showing that the monthly and annual testing for the battery-powered emergency lighting had been conducted. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 291	well as the the audit log. The facility reached full compliance 02/09/2024	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324		2/8/24

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K 324	Continued From page 5 by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9), and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a report for inspections being completed for the last two inspection frequencies. 2. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that the Ansul system in the facility kitchen had a red tag on it indicating that on August 16, 2023, the system needed to have hydrostatic testing completed and that the system had improper duct, plenum, and/or appliance coverage. 3. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that a stove in the Therapy room did not have a switch and timer, not exceeding 120 minutes, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	K-324 SS=F Cooking Facilities Summit has provided the semi annual inspection. The documentation is unavialible. The Traverse Care Center now has copies of documentation of all assessments and inspections that have been provided by Summit Fire protection. Inspections have also been entered into the preventative Maintenance program to notify Maintenance of inspection dates and to collect the documentation from Summit as it pertains to inspections. The Ansul system has been repaired and is in the preventative maintenance program to ensure proper functionality. The power cord has been removed from the stove in the therapy area and is out of use at this time. The stove will not be used until an electrician can install the timer. Electricians have been contacted to install a timer will move forward when quotes are provided. ESD will bring Documentation of inspection to Safety and present at QAPI to ensure standards are being met. Administrator will Audit the Preventative Maintenance program The facility reached full compliance 02/08/2024.	

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K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that the walk-in cooler and freezer in the kitchen are not sprinkler protected.	K 351	K351 SS=F Sprinkler System Installation The Traverse Care Center has been working closely with NOVA fire protection to replace all sprinkler heads. This was completed 02/08/24. The freezer is now fully sprinkler protected. Wires have been removed from the sprinkler pipe in the basement and electricians have been contacted to provide adequate power to the air compressor this will be completed 02/14/2024 Contracts have been signed with NOVA to ensure that regulatory compliance will be reached on an ongoing basis.	2/13/24

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K 351	Continued From page 7 2. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that there were several wires in contact with the sprinkler pipe in the basement storage room. 3. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that electrical power for the air compressor for the dry sprinkler system was wired into a switch in the sprinkler riser room. 4. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that there were several sprinkler heads not stored in a secure manner in the sprinkler cabinet in the sprinkler riser room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 351	ESD will place ongoing preventative maintenance such as sprinkler heads in the preventative maintenance program. Date of compliance: 02/13/2024	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers,	K 355	K355 SS=F Portable Fire Extinguishers All fire extinguishers will be checked on a monthly basis. This will be put into the preventative	2/13/24

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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
K 355	Continued From page 8 sections 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/31/2024 between 09:45 AM and 12:00 PM, it was revealed by observation and documentation that the fire extinguishers in the facility had not been inspected consistently on a monthly basis during 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	maintenance program. Administrator will Audit monthly and will bring results to Safety monthly and QAPI to determine significant compliance. Date of Compliance: 02/13/2024	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical wiring and equipment per NFPA 101 Life Safety Code(2012 edition), sections 19.5.1.1, and 9.1.2, and NFPA 70 National Electrical Code (2011 edition), section 230.62 (A). These deficient findings could have a	K 511	K511 SS=E Utilities Gas and Electric Electrical panels have been closed. ESD will audit once weekly to determine compliance and will bring results of Audits	2/2/24

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K 511	Continued From page 9 patterned impact on the residents within the facility. Findings include: On 01/31/2024 between 9:45 and 12:00 PM, it was revealed by oberservation, that two electrical panels in the basement area were not proplerly enclosed to prevent accidental contact with energized parts. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511	to Safety and QAPI to determine significant compliance. Compliance date 02/02/24	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6, 4.7.4, and 4.6.1.1. These deficient findings could have a widespread impact on the residents within the facility.	K 712	K712 SS=F Fire Drills Fire drills have been placed in the Preventative Maintenance program to be done at different times, different shifts and recorded on the fire drill logs and fire drill matrix in the preventative maintenance	2/13/24

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K 712	Continued From page 10 Findings include: 1. On 01/31/2024 between 09:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the second and third shifts during the first quarter of 2023. 2. On 01/31/2024 between 09:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the first and third shifts during the second quarter of 2023. 3. On 01/31/2024 between 09:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the second and third shifts during the third quarter of 2023. 4. On 01/31/2024 between 09:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the first, second, and third shifts during the fourth quarter of 2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712	program. Administrator will audit compliance with Fire Drills monthly, bring results to QAPI to determine Significant compliance The facility has reached full compliance as of 02/13/2024	
K 754 SS=E	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers	K 754		2/13/24

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K 754	Continued From page 11 Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain soiled linen and trash receptacles in accordance with NFPA 101, Life Safety Code, Section 19.7.5.7. These deficient findings could have a widespread impact on residents. Findings include: On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by observation that trash and soiled linen receptacles were being stored in the hallways of the 500 and 600 wings and not in a room protected as a hazardous area when not attended. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 754	K754 SS=E Soiled Linen and Trash Containers All staff have been educated on the proper place to store facility equipment including laundry carts, linen containers and tables and chairs ESD will round daily to ensure that facility equipment, laundry carts, linen containers and tables and chairs are in the proper location This will then be documented, brought to Safety and presented to QAPI The QAPI team will then decide when full compliance has been reached and when to discontinue rounding	

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K 754	Continued From page 12	K 754	Compliance Date: 02/13/2024	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, and NFPA 80 (2010 edition) Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that the facility could not provide documentation verifying the annual fire door inspections were completed in the last 12	K 761	K761 SS=F Maintenance inspection and testing- Doors Fire door inspections have been placed in the preventative maintenance program. Fire doors will be checked annually by maintenance staff. ESD will bring Door checks to QAPI to determine significant compliance. Facility compliance date 02/13/2024	2/13/24

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K 761	Continued From page 13 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761		
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 a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a	K 914	K-914 SS=F Electrical Systems-Maintenance and Testing Receptacle testing has been placed in the preventative maintenance program. Each room and receptacle has been labeled	2/16/24

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K 914	Continued From page 14 widespread impact on the residents within the facility. Findings include: On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the electrical receptacles in resident rooms had been inspected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	and will be tested annually. This will be in preventative maintenance program. Administrator will Audit ESD to ensure that all Receptacles are in working order and replaced when necessary. Administrator will bring audits to QAPI to determine significant compliance. Facility compliance Date: 02/16/2024	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		2/13/24

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K 918	Continued From page 15 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. 2. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that the facility failed to perform monthly generator inspections.	K 918	K-918 SS=F Essential Electric System Maintenance and Testing The generator is visually inspected every Friday and tested on the second Friday of the month. Monthly it will run with full facility load or minimum 30% of generator nameplate kilowatt rating for 30 minutes; battery specific gravity. Annually Run 90 minutes (starting with minimum 50% load for 30 minutes that 75% or full load for 60 minutes); fuel quality test on diesel engines in accordance with ASTM testing methods. Every 36 months- Run 4 hours continuous under load. The facility was in compliance 02/13/2024.	

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K 918	Continued From page 16 3. On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed by a review of available documentation that the facility failed to perform weekly generator inspections. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 920	K920 SS=D Electrical Equipment Power	2/16/24

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K 920	Continued From page 17 facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/31/2024 between 9:45 AM and 12:00 PM, it was revealed observation there was a green extension cord plugged into a multi-plug adapter in the Maintenance Room being used to power the phone system for the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	Cords and Extension Cords Electricians have been contact and are placing receptacle units in place of the extension cords. ESD along with the Electrician will complete a walking round of facility to determine if any other receptacles are needed. No extension cords are being used at this time. ESD will do walking rounds to Audit use of extension cords and will bring Audits to QAPI to determine significant compliance. Compliance date: 02/16/2024	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2024

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: State Nursing Home Licensing Orders
Event ID: GYYZ11

Dear Administrator:

The above facility was surveyed on January 29, 2024 through January 31, 2024 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
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
	00669	A. BUILDING: _____ B. WING _____	C 01/31/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 1/29/24 to 1/31/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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(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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The following complaint was reviewed. H55858919C (MN00099193) with a licensing order issued at 0830. PLEASE DISREGARD THE HEADING OF THE	2 000		

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	00669	A. BUILDING: _____ B. WING _____	C 01/31/2024

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2 000	Continued From page 2 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		2/23/24

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 4 newly hired staff, housekeeping aid (HA)-C, dietary aid (DA)-B, activity aid (AA)-B and HA-A had completed the required Alzheimer's and dementia care training program. Findings include: HA-C personal file identified she was hired on 9/12/23. There was no indication that HA-C completed the facility mandatory training for Alzheimer and dementia care. DA-B personal file identified she was hired on 10/119/23. There was no indication that DA-B completed the facility mandatory training for Alzheimer and dementia care. AA-B personal file identified she was hired on 11/29/23. There was no indication that AA-B completed the facility mandatory training for Alzheimer and dementia care. HA-A personal file identified she was hired on 11/29/23. There was no indication that HA-A completed the facility mandatory training for Alzheimer and dementia care. During an interview on 1/31/24 at 3:20 p.m., director of nursing (DON) and executive administrator (EA) confirmed the above findings and indicated they were both aware staff did not receive the correct training upon hire. DON and EA indicated a new training program had been implemented and when staff were hired they would not be able to provide patient care until the	2 302	corrected	

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2 302	Continued From page 4 recommended training has been completed. All current staff would be required to complete the new training program as well. Requested a policy on new hires and education however one was not provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to meet resident needs related to assistance of 1 of 1 residents (R28) reviewed for ambulation for restorative nursing	2 800	CORRECTED	2/23/24

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2 800	Continued From page 5 services, 1 of 1 residents (R24) reviewed that required range of motion for restorative nursing and 1 of 1 residents (R7) reviewed for pressure ulcers. Findings include: R28 R28's most recent diagnosis report dated 1/31/24, identified R28 had diagnoses of dementia, difficulty walking, muscle weakness and diabetes. R28's quarterly Minimum Data Set (MDS), dated 12/14/23, indicated R28 required extensive assistance with bed mobility, transfers and ambulation. R28 had mild cognitive impairment and at times had confusion that required additional cuing. R28's significant change Care Area Assessment (CAA) dated 9/14/23, identified R28 had potential for more independence with cuing and restorative nursing program to maintain current level of functioning. R28's care plan revised 1/3/24, indicated per physical therapy (PT) R28 was to ambulate three times a day to or from meals. Required two to three assist with front wheeled walker (FWW) and follow with wheelchair. R28's care plan identified R28 was to follow PT recommendations as able/accepted. R28 was to be in a functional program: walking with FWW and one to two assist to all destinations with wheelchair following, initiated 9/3/23. Staff were to notify nurse manager and/or therapy of any barriers. In addition, staff were to notify PT of an increase or decrease in functional level.	2 800		

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2 800	Continued From page 6 During continuous observations on 1/30/24 from 8:47 a.m. to 1:19 p.m., assistant director of nursing (ADON) asked R28 if he needed to use the bathroom and he stated "yeah, I have been waiting for 2 hours to go. No one has taken me". ADON wheeled resident into the bathroom next to the nurses' station and nursing assistant (NA)-C assisted ADON to toilet R28. R28 stood up next to the toilet and pivot transferred using the grab bars per therapy recommendations. R28 pivoted back into wheelchair and exited the bathroom. R28 was wheeled to the dayroom by the dining room by ADON. During an interview on 1/30/24 at 3:21 p.m., NA-C indicated R28 required a hoyer lift to transfer in and out of bed or recliner. NA-C stated R28 was not able to stand well even when he did have something in front of him to hold onto. NA-C stated staff were expected to ambulate R28 to and from meals however indicated ,"we were short staffed and unable to walk him as he needed". NA-C stated, "It is not too often that we get to do therapy things". In a follow- up interview on 1/31/24 12:10 p.m., NA-C indicated when therapy recommendations were put into place staff were not available to complete the recommendations. "If we were fully staffed we would be able to walk residents as needed". NA-C further indicated the night shift often lacks enough staff and at times there has only been two people in the building, a nurse and an aid. NA-C stated residents have to wait a long time for assistance when they have used their call light". See F688 for additional information	2 800		

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2 800	Continued From page 7 R7 R7's quarterly Minimum Data Set (MDS), dated 11/2/23, identified R7 had diagnoses which included Alzheimer Disease, dementia and anxiety. R7 required extensive assistance of two staff for bed mobility and transfers. R7 required extensive assistance of one staff to roll from left to right. Indicated R7 was a risk for pressure ulcers, currently had an unhealed pressure ulcer and infection in foot. R7's significant change Care Area Assessment (CAA), dated 5/3/23, identified R7 was at risk for skin breakdown and potential pressure ulcers due to needing extensive assistance with bed mobility. R7's care plan revised on 1/24/24, identified R7 had actual complications with impaired skin integrity related to the blister on heel. Indicated R7's heels were to be floated at all times when in bed and staff were to reposition every two hours. R7 was dependent on staff for all cares. During continuous observation on 1/30/24 from 8:56 a.m. to 11:09 a.m., R7 was seated in her wheelchair in the dining room being assisted for breakfast. R7's daughter requested someone to assist R7 to the restroom. R7's daughter spoke to the nurse at the nurses station for assistance, RN-A stated she would get someone to assist R7. R7 continued to be seated in her wheelchair in the fireside day room. ADON and LPN-A laid resident down and provided activities of daily living (ADLs) for R7. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 had not been repositioned for a total of two hours and 13	2 800		

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2 800	Continued From page 8 minutes during this observation. During an observation on 1/30/24 at 1:22 p.m., R7 was laying in bed covered with a sheet and pink comforter covering her. R7 laid on her left side facing the fall with a pillow behind her lower back. R7 was wearing both heel protecting boots and had a wedge pillow between her knees. R7 did not have a pillow under her calf's, left heel/foot was laying to the left side. Right leg was bent at the knee and right heel and foot were flush on the bed. - At 3:10 p.m., R7 was laying in bed in the same position as above. - At 4:56 p.m., R7 was laying in bed in the same position as above. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 was unable to reposition herself or place the pillow independently. R7 had not been repositioned for a total of three hours and 34 minutes. During an interview on 1/30/24 4:56 p.m., NA-C confirmed she had not repositioned the R7 since she had been laid down at 1:22 p.m.. NA-C stated she had been" running around the building" and had not been able to return down that wing to reposition her. See F686 for additional information R24 Review of R24's quarterly MDS dated 12/7/23, identified R24 had diagnosis which included congestive heart failure, hypertension, atrial fibrillation, chronic pain and diabetes. Identified R24 was cognitively intact and required extensive	2 800		

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2 800	Continued From page 9 assistance with activities of daily living (ADL's) which included bed mobility, transfers and ambulation. Review of R24's physical therapy note dated 8/29/23, recommended: PAL lift from bed to toilet, two assist from toilet, sit to stand with pivot to toilet, and completion of toileting. Program for standing/exercises had been given to nursing staff and a copy hung in R24's bathroom: -standing tolerance at grab bars in bathroom 3x1 min each. -standing weight shifts at grab bars in bathroom x20 (side-side). -standing marching at grab bars in bathroom x20 each. Review of R24's care plan revised 1/3/24, indicated transfers- PAL for all transfers except the following: recommended PAL bed to toilet, one-two assist from toilet sit to stand with pivot to toilet. R24's care plan further indicated staff were to monitor/document any changes in ADL ability, reason for inability to perform ADL's and report to doctor any changes. R24's care plan lacked information on therapy recommendations for standing/exercise program. Review of doctor's progress noted dated 11/13/23, stated R24 was very disappointed that he was not getting more walking help. During an interview on 1/29/24 at 4:56 p.m., R24 stated he had no exercise program, would like to have one, had asked staff about getting therapy again with no response and would like to do some walking again and regain strength. During an interview/observation on 1/30/24 at 9:47 a.m., NA-C brought PAL lift into R24's room	2 800		

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2 800	Continued From page 10 and assisted R24 into lift with sling, assisted R24 to a standing position, wheeled PAL lift to bathroom, R24 sat onto toilet, gave R24 privacy in bathroom while R24 remained in PAL lift. NA-C returned to R24's room when R24 put call light on. NA-C raised PAL lift to standing position, proceeded to complete toileting cares and brought R24 to recliner, positioned and lowered R24 into chair. After above observation was completed asked NA-C to verify physical therapy recommendations posted on R24's bathroom wall. NA-C indicated she was not aware of the transfer recommendations. NA-C verified the facility did not have a restorative program in place for residents and staff did not have time to do a restorative program even if there was one. During a follow-up interview on 1/31/24 at 10:34 a.m., R24 stated he recalled therapy provided instructions on exercises however was unsure where they were at now. R24 verified he had not completed exercises for a very long time and staff had not offered to do exercises. R24 stated he had lost strength due to not doing exercises and indicated he would try to do exercises if staff offered. During an interview on 1/31/24 at 11:56 a.m., NA-A stated R24 was not currently at the same physical level as when R24 moved to facility. NA-A confirmed they used the PAL lift for all transfers with R24 now and that they did not always use the PAL lift for transfers since R24 had been at the facility. NA-A confirmed there was no restorative program in place for R24. NA-A stated staff were expected to encourage R24 to stand however stated, "I am not that big and did not feel safe doing that myself." NA-A stated if there were enough staff they would be able to get restorative tasks completed and that	2 800		

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2 800	Continued From page 11 sometimes it did not get done based on importance. During an interview on 1/31/24 at 10:26 a.m., OT verified the facility did not have a restorative program in place for the residents. OT verified R24 would benefit from restorative program. OT stated she did not feel nursing staff had the time to perform a restorative program. During an interview on 1/31/24 at 2:08 p.m., director of nursing (DON), verified the facility did not have a restorative program currently in place. DON stated residents would lose range of motion (ROM) and develop decreased strength. DON stated R24 did have exercises from therapy and was unable to verify if it was being done. DON confirmed she was aware there were times in the past when the restorative aid was removed from providing restorative services when the facility had a staff call in ill. During an interview on 1/31/24 3:11 p.m., DON and executive administrator (EA) confirmed the above findings and were aware of the staffing concerns. Both indicated it was a concern at the management level. EA revealed the current pool agencies being used had not always been dependable and the facility had recently replaced them with two different agencies. DON indicated that staff had called into work the past week causing very low staffing. DON stated her expectations were for staff to be to work on time as scheduled and follow the facility policy for staffing expectations. Review of facility policy titled Nursing Services and Sufficient Staff unknown date, it was the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure	2 800		

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2 800	Continued From page 12 resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population would be considered based on the facility assessment. SUGGESTED METHOD OF CORRECTION: Facility administration and the director of nursing could utilize employee, resident and family input to evaluate staffing patterns and identify times/ places where those staffing patterns could/should be adjusted and implement those adjustments in order to meet all resident needs in a timely manner. Facility policies and procedures for sufficient staffing could be reviewed/ revised. Pertinent employees could be retrained on those policies/ practices. Audit tools could be developed to observe for timely and complete care, meeting all resident needs as identified in their care plan. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		2/23/24

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2 830	Continued From page 13 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify a root cause, develop and implement interventions to prevent or reduce risk of falls for 1 of 1 residents (R14) who had multiple falls in the facility. Findings include: R14's significant change Minimum Data Set (MDS) assessment dated 11/7/23, identified R14 had diagnoses which included Alzheimer's Disease, dementia, anxiety and depression. Indicated R14 required extensive assistance of staff for bed mobility, transfers and ambulation. Identified R14 utilized a wheelchair for mobility. Identified R14 had falls since admission and triggered the Care Area Assessment (CAA) for further interventions in the care plan. Indicated R14 had mild cognitive impairment with confusion at times. R14's significant change CAA dated 11/7/23, identified R14 had confusion, disorientation and forgetfulness. Indicated R14 had a decline in activities of daily living (ADLs), complications of mobility and muscle atrophy which had the potential for falls. Identified R14 had possible underlying problems that may affect falls related to function which included mood decline, increase	2 830	CORRECTED	

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2 830	Continued From page 14 in weakness, limited range of motion (ROM), poor coordination/balance and visual impairment. Review of R14's most recent care plan revised 1/3/24, revealed the following interventions related to history of falls: - initiated intervention on 8/31/22, assistive device (bathroom bars, call light, front wheeled walker, gripper socks, gait belt, electric recliner. - initiated intervention on 9/23/22, bring R14 to activities 15 minutes prior to activity start, wheelchair with auto lock breaks and cushion for mobility at night only to assist with bathroom transfer and will keep sign on walker "please call for help". - revised intervention on 7/24/23, educate/remind as needed about potential negative outcomes related to their choice; especially as R14 often self transfers and ambulates on own to get to Bingo, church and beautician. - revised intervention on 1/3/24, dressing assist of one. Review of R14's fall risk screening tool dated 12/11/23, identified R14 had three or more falls in the last six months. Had underlying diseases or conditions including psychiatric or cognitive conditions, cardiac diagnosis, and orthopedic/joint/arthritis related conditions. R14's medications included narcotics, psychotropic's and antihypertensives. R14's was and continued to be at risk for falls due to cognition. Review of R14's incident reports dated 3/28/23 to 1/4/24, revealed the following: - 3/28/23 at 5:45 a.m., R14 had an unwitnessed fall in her room. Was found by nursing assistant (NA) laying on her left side in front of her recliner. Complaints of pain when rolling from side to side to place the sling underneath for transfer. Blood	2 830		

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2 830	Continued From page 15 was observed on left ear and bruising was starting to appear on forehead. R14 transferred by ambulance to the emergency room (ER) for further evaluation. Predisposing situation factors indicated ambulating without assistance. No new interventions developed. - 4/19/23 at 8:45 p.m., R14 had an unwitnessed fall in her room. R14 was heard hollering out for help by nurse. R14 was found laying on the floor on her left side in the middle of the room. R14 sustained a two centimeter (cm) skin tear to the left outer elbow which was cleansed and dressing applied. Predisposing situation factors indicated ambulating without assistance and fall during a transfer. No new interventions developed. - 5/3/23 at 8:20 p.m., R14 had an unwitnessed fall in her room. R14 was found by NA during morning rounds. R14 was laying on her right side. R14 had complaints of pain to right shoulder with some redness noted to right shoulder, right side of scalp, right side of forehead, right thigh and right lower extremity lateral shin area. R14 assisted back to the recliner and activities of daily living (ADLs) completed. No predisposing situation factors indicated. Initiated intervention on 5/7/23, keep walker next to resident table by recliner as resident request. - 6/26/23 at 11:10 a.m., R14 had an unwitnessed fall in in her room. R14 was found in her room by therapy sitting next to her chair. R14 had a small amount of blood on the back of her head, cleaned by nurse. No predisposing situation factors indicated. No new interventions developed. - 8/8/23 at 2:16 a.m., R14 had an unwitnessed fall in her room. R14 was found by nurse on the floor in a lateral recumbent position (left side) in her room. R14 noted to have a large bump on the left side of her head that was bleeding. R14 transferred via ambulance to the ER for further evaluation. Predisposing situation factors	2 830		

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2 830	Continued From page 16 indicated using walker, disease process and psychosis-delusional/hallucinations. No new interventions developed - 8/25/23 at 4:07 a.m., R14 had an unwitnessed fall in her room. R14 was found by the nurse during morning rounds laying on her left side on the floor between her chair and rocking chair. R14 had a large bump to her left eye and left eyebrow area along with a laceration to her forehead. Pressure was applied to the bleeding site with gauze and Kerlix. R14 was transferred via ambulance to the ER for evaluation. Predisposing situation factors indicated using walker, disease process and ambulating without assistance. Initiated intervention on 8/25/23, frequent checks and toileting around 2:00 a.m. and 4:00 a.m. - 11/1/23 at 12:35 p.m., R14 had an assisted fall in the dining room. R14 was being assisted by NA to the salon for a hair appointment. R14 indicated she "was going down" and proceeded to lean over and go the the floor. NA assisted R14 to the floor and R14 had contact with her left side of her head on the wheel of another residents wheelchair. No predisposing situation factors indicated. Initiated intervention on 11/4/23, orthostatic checks from sit to stand for a few days. - 11/20/23 at 11:05 p.m., R14 had an unwitnessed fall in her room. R14 was found on the floor by the nurse sitting up with the wall and next to the television stand by the wall. Predisposing situation factor indicated self-transferring when R14 had been told over and over, R14 was to call for help to assist her up and back to the recliner. Call light within reach. R14 did not utilize the call light for assistance. No new interventions developed. - 12/11/23 at 2:00 p.m., R14 had an unwitnessed fall in her room. Nurse went to get R14 for Bingo	2 830		

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2 830	Continued From page 17 and R14 was found laying on the floor on her back with her walker on top of her legs. R14 was laying flat with feet facing the door and head towards the window. R14 had a 0.4 cm abrasion on the back of her head that was cleansed, pressure and ice pack applied. Predisposing situation factors indicated transferring without assistance. Initiated intervention on 12/14/23, Result of fall 12/11/23, R14 to be at fireside after lunch till 2:00 p.m., or 2:15 p.m., and then able to go back to room, toileted, and in her recliner till supper. -1/2/24 at 11:55 a.m., R14 had an assisted fall. R14 was ambulating with two staff when she became pale and limp. Staff assisted R14 to the floor for further and a registered nurse (RN) completed an assessment. Predisposing situation factors indicated ambulating with assistance. No new interventions developed. Review of R14's progress notes dated 7/4/23 through 1/28/24, revealed the following: - 8/25/25 at 8:17 a.m., R14 found laying on the floor during rounds on her left side between her chair and rocking chair. R14 had a bump to her left eye and eyebrow area. R14 had a laceration to her forehead that continued to bleed. R14 assessed and range of motion (ROM) completed and R14 had difficulty with the right leg. R14 assisted off the floor with the mechanical lift and seated in chair. Pressure applied to the laceration with gauze and Kerlix. - 8/25/23 at 8:50 a.m., returned from the hospital ER, has fractured right ankle and is wearing a boot, scalp laceration with 3 staples. Orders received to wear a controlled ankle motion (CAM) boot to right ankle at all times, non-weight bearing (NWB) until evaluated by PT. - 8/25/23 at 3:50 p.m., PT re-evaluation completed today and will change plan of care	2 830		

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2 830	Continued From page 18 (POC) to five times/week. Recommended to continue with NWB at this time and recommend hoyer over the weekend as she is unable to transfer maintaining NWB on right lower extremity (RLE). - 9/18/23 at 12:24 a.m., R14 was seen in the clinic on 9/15/23, progress note from provider said to advance to toe touch weight bearing (TTWB)/partial weight bearing (PWB) trial basis after discussion with therapy. Consult with provider this coming Thursday regarding use of boot. Provider said in note that x-ray shows evidence of healing on x-ray. - 9/19/23 at 10:25 a.m., R14 is alert and orientated to self and place, knows where her room is and is able to self-propel her wheelchair to her room. She does remain a fall risk as she will self-transfer, has fallen three or more times in the past three months one which resulted in an ankle fracture. - 10/3/23 at 10:38 a.m., resident is to resume walking to meals with staff members with use of four wheeled walker (FWW). Currently she has a CAM boot that she is to wear with walking until released from the doctor. She is able to weight bear as tolerated (WBAT). Tolerance to meals as tolerates. She does have rest areas available for her to take a seated rest break as needed. - 10/19/23 at 1:12 p.m., returned from podiatry clinic visit, resident is WBAT without boot on, to continue with physical therapy (PT). - 11/18/23 at 6:10 a.m., staff reported that during transfer R14's right foot slid and staff assisted R14 to the floor. R14 was placed in the sitting position on the floor in front of her wheelchair. R14 assisted back to recliner. No incident report filed on assisted fall. - 12/11/23 at 2:00 p.m., staff went to get R14 for bingo and found her lying on the floor on her back with her walker on top of her legs. R14 was laying	2 830		

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2 830	Continued From page 19 flat with her feet facing the door and head towards the window. R14's glasses were on the floor above her head. R14 did have gripper socks on. Room was well lit. Call light had been within reach of R14 when she was sitting in her recliner. Some blood on the floor by her head. Range of motion (ROM) assessed and within normal limits (WNL). Two person assist with mechanical lift to transfer from floor to recliner. Abrasion on back of head approximately 0.4 cm. Area cleansed. Ice pack and pressure applied. - 12/12/23 at 12:06 p.m., R14 walked part way to breakfast this am. After breakfast R14 complained of increased low back pain. - 12/12/23 at 6:48 p.m., called clinic to verify the x-ray results times two and the clinic did not call back prior to them leaving for the day. Will follow-up tomorrow. - 12/13/23 at 11:59 a.m., R14's daughter had been notified about the T9-T12 vertebrae wedge fractures from provider, appears new and would correlate with her fall and injury. - 12/21/23 at 6:52 p.m., resident was given Tylenol as scheduled. Writer asked how her pain was. Resident stated it was not good. Writer asked resident to rate the pain on a scale from one to 10. Resident stated it was a seven. 45 minutes later resident rated the pain was at a six. -12/26/23 at 3:35 a.m., R14 had increased anxiety with transfer, toileting, and moving to fireside dayroom at 3:00 a.m. R14 was stirring in room. R14 kept saying oh no, oh no. -12/28/23 at 12:56 p.m., R14 had complaints of right leg pain. R14 had complaints of pain when ambulating to noon meal. Appointment was scheduled for R14 to go to clinic to get checked. - 12/28/23 at 3:29 p.m., R14 returned from the clinic. X-ray was negative. R14 received orders to begin prednisone (a medication used to reduce swelling) 5 mg two times a day (BID) for three	2 830		

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2 830	Continued From page 20 days. - 12/29/23 at 4:33 a.m., physician's orders right hip pain on/off for three months. Achy pain worse when walking, standing, and laying on right side. Radiates at times to the knee. Right hip pain due to arthritis. X-ray negative for fracture. Orders: continue pain patch as before, Tylenol 1000 mg and prednisone 5 mg BID x three days. If not improving, follow up on next rounds. - 12/31/23 at 9:29 p.m., resident requested Tylenol due to complaints of pain rated nine out of 10. Review of R14's current orders signed 1/9/24, R14 received orders on 12/29/23, for Tylenol extra strength (a medication used to treat mild to moderate pain) 1,000 milligrams (mg) every 8 hours as needed (PRN) for pain and prednisone 5 mg two times a day (BID) for three days. R14 received orders on 8/25/23, apply antibiotic (ungt.) (triple antibiotic ointment) to scalp laceration daily, watch for signs of infection and update clinic if noted until healed, one time a day for scalp laceration. Review of R14's provider notes dated 12/11/23 through 1/9/24, revealed the following: - 12/13/24 at 12:06 p.m., Advanced Practice Registered Nurse - Certified Nurse Practitioner (APRN-CNP), no rib fractures identified. There are new changes of wedge fractures to the T9-T12 vertebrae. These appear new and would correlate with her fall and injury. Monitor worsening pain or trouble with breathing, otherwise continue current plan of care if she remains stable. During an interview on 1/31/24 at 12:02 p.m., nursing assistant (NA)-A indicated R14 required assist of one staff with transfers and had a history	2 830		

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2 830	Continued From page 21 of repeated falls. NA-A identified R14 was very anxious and did not want to miss certain activities such as bingo so R14 was brought early. NA-A stated he was unaware R14 had a fall with a major injury. NA-A indicated if a resident was found on the floor during a fall, NA-A would check if the resident was injured and would look for someone to assist NA-A with transferring the resident. During an interview on 1/31/24 at 12:50 p.m., assistant director of nursing (ADON) indicated R14 required assistance with transfers, ambulation and ADLs. ADON stated R14 had a history of multiple falls, would often self transfer in room and often self transferred to get to activities during the day. ADON indicated R14 had an unwitnessed fall on 12/11/23, that resulted in a major injury. ADON confirmed staff were not following the implemented care plan measure of bringing R14 to the dining room 15 minutes prior to the activity when R14 had the fall with major injury on 12/11/23. ADON further confirmed Bingo was scheduled 12/11/23 at 2:00 p.m. ADON revealed R14 has had several falls over the past year due to self transferring and anxiety. ADON indicated when a resident had a fall, the floor nurse or charge nurse would assess the resident prior to staff assisting the resident up. The resident would then be assisted off the floor to a bed, wheelchair or recliner unless they needed immediate treatment. If immediate treatment was needed, the resident would be transferred to the emergency room. If no treatment was needed, they would complete the incident report and share during morning huddle and communicate to staff if there were any changes to the care plan. That was usually completed through orders being placed in the system and communication log. The staff would monitor for changes and inform the	2 830		

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2 830	Continued From page 22 physician and family about the incident. During a follow-up interview on 1/31/24 at 2:08 p.m., ADON reviewed the incident report and revealed R14 was found in her room after an unwitnessed fall prior to bingo. ADON revealed R14's care plan indicated staff were to bring R14 to bingo 15 minutes prior because R14 would become anxious about missing bingo and would often self transfer herself to get to the activity. ADON confirmed she updated R14's care plan on 12/14/23, with a new fall intervention, verbally told staff about the update, updated R14's Kardex on 12/14/23 to reflect in the electronic health record (EHR) for NA's to review and documented it in the communication log. During an interview on 1/31/24 at 2:44 p.m., DON and executive administrator (EA), DON were not aware R14's care plan had not been followed which resulted in R14's fall with a major injury. DON indicated R14 had several falls over the past year and R14's care plan had some interventions to help reduce the falls. DON confirmed the above findings and was unsure if R14's updated intervention on 12/14/23, had been communicated with staff. DON indicated changes to resident's care plans were discussed during shift huddle and placed into the communications binder. DON stated a registered nurse (RN), ADON or DON would update care plans to reflect new interventions and ensure the interventions were communicated with staff. DON explained her expectations were for staff to follow the care plans and interventions listed to reduce accidents and falls. EA indicated going forward, the facility would have an interdisciplinary team (IDT) review all accidents and falls. Although R14 had ten falls from March 2023 to	2 830		

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2 830	Continued From page 23 January 2024, the facility had not completed a comprehensive assessment to determine a root cause of R14's fall so appropriate interventions could be implemented. R14 had eight falls in her room and two falls, when she was with staff and was suddenly "going down" or was pale and limp. There was no indication the facility reviewed R14's medications even though these medications have falls risk nor had they consistently completed orthostatic blood pressure monitoring. These was no indication the facility identified the majority of falls were in her room nor had they reviewed the falls interventions to determine if they were effective to reduce R14's the risk of falls. As a result, R14's become injured with a fracture Review of facility policy titled fall prevention program policy undated, each resident of Minnewaska Lutheran Home would be assessed for fall risk and would receive care and services in accordance with their individual level of risk to minimize the likelihood of falls. The facility utilized a standardized risk assessment for determining a resident's fall risk. The risk assessment categorized residents according to low, moderate, or high risk. The nurse would indicate on the care plan the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. When a resident experienced a fall, the facility would assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of an emergency. Requested a copy of the communication logs however was not provided.	2 830		

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2 830	Continued From page 24 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review care plan interventions with staff related to fall prevention, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 2 resident (R7) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: R7's quarterly Minimum Data Set (MDS), dated	2 895	CORRECTED	2/23/24

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2 895	Continued From page 25 11/2/23, identified R7 had diagnoses which included Alzheimer disease, dementia and anxiety. R7 required extensive assistance of two staff for bed mobility and transfers. R7 required extensive assistance of one staff to roll from left to right. Indicated R7 was a risk for pressure ulcers, currently had an unhealed pressure ulcer and infection in foot. R7's significant change Care Area Assessment (CAA), dated 5/3/23, identified R7 was at risk for skin breakdown and potential pressure ulcers due to needing extensive assistance with bed mobility. R7's care plan revised on 1/24/24, identified R7 had actual complications with impaired skin integrity related to the blister on heel. Indicated R7's heels were to be floated at all times when in bed and staff were to reposition every two hours. R7 was dependent on staff for all cares. R7's 1/26/24, weekly wound round documentation identified R7 was noted to have a right heel deep tissue injury acquired on 6/12/23. Indicated that R7 was to be repositioned, have soft boots on and to use the hoyer lift due to non weight bearing on feet. R7's treatment orders dated 12/5/23, identified R7 was to have: -heel protector boots on at all times. -pillows under calf and suspend right heel whenever in bed. Review of R7's progress notes dated 7/31/23 to 1/30/24, revealed the following: - 8/1/23, Provider saw on rounds. After discussion, assessment of patient, seeing heel blister referred to podiatry. - 8/8/23,seen by podiatrist, area on heel debrided,	2 895		

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2 895	Continued From page 26 may redress with medi honey and gauze but more concerned about offloading. - 8/28/23 dressing change every Monday and Thursday to right heel. Wash with wound cleanser, apply medi honey to padded dressing over areas that are open - covered with blister, wrap with kerlix. Apply soft boots. Notify wound nurse of changes. -10/5/23, podiatrist here today and saw resident while in bed. Resident was seen while in bed - provider debrided edges - pink skin and small amount of bleeding. Podiatrist would like a lift boot ordered one for resident and an extra one if it gets dirty as it is foam. Provider ordered silver alginate dressing, telfa and kerlix to right heel daily. Continue off loading right heel and pillow under right calf and suspending right heel. -11/14/23, podiatry here today. Cut toenails and looked at wound right heel, treatment order changed to betadine swab daily and to continue with current contact layered dressing 4x4s and kerlix wrap. -1/9/24, podiatry visit, heel checked, no changes in current treatment protocol. During continuous observations on 1/30/24 from 8:56 a.m. to 11:09 a.m., revealed the following: - R7 was seated in the dining room being assisted with breakfast by licensed practical nurse (LPN)-A. R7 had heel protector boots on both feet and feet were rested on wheelchair foot pedals. - R7 resident continued to be in the same position. R7 was seated at the dining room table talking with her daughter. - R7's daughter pushed R7 from the dining room to the fireside dayroom. - R7 continued to sit in her wheelchair in the fireside day room. - R7 continued to sit in her wheelchair in the	2 895		

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	00669	A. BUILDING: _____ B. WING _____	C 01/31/2024

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2 895	Continued From page 27 same location in the fireside dayroom. - R7 continued to sit in her wheelchair in the same location in the fireside dayroom. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - At 11:09 a.m., ADON and LPN-A assisted R7 to lay down in bed. R7 was covered with a blanket. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 had not been repositioned for a total of two hours and 13 minutes during this observation. During an observation on 1/30/24 at 1:22 p.m., R7 was laying in bed covered with a sheet and pink comforter. R7 was laying on her left side facing the fall with a pillow behind her lower back. R7 was wearing both heel protecting boots with and had a wedge pillow between her knees. R7 did not have a pillow under her calf's, left heel/foot was laying to the left side. Right leg was bent at the knee and right heel and foot were flush on the bed. - At 3:10 p.m., R7 was laying in bed in the same position as above. - At 4:56 p.m., R7 was laying in bed in the same position as above. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 was unable to reposition herself or place the pillow independently. R7 had not been repositioned for	2 895		

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2 895	Continued From page 28 a total of three hours and 34 minutes.. During an interview on 1/30/24 at 3:34 p.m., nursing assistant (NA)-C identified staff completed all activities of daily living (ADLs) for R7. R7 was to be transferred with two people and the hoyer lift. NA-C stated R7 required extensive assistance with turning and repositioning. NA-C stated staff were expected to ensure the heel boots on at all times and R7 was to be repositioned from side to side. NA-C indicated she was unaware of the order to place a pillow under R7's calf's and to suspend heels off of the bed at all times. During an interview on 1/30/24 at 4:33 p.m., RN-A indicated staff were expected to reposition R7 every two hours. RN-A reviewed and confirmed the above orders for R7. RN-A explained R7 had a wound on her right heel that staff were to complete dressing changes and to monitor. RN-A entered R7's room and confirmed R7 was laying on her left side and did not have a pillow under her calf's suspending R7's heels. RN-A stated staff should have placed a pillow under her right leg no matter what position R7 was in. RN-A was not aware R7 had been laying in the same position since 1:22 p.m. RN-A placed a pillow under R7's calf's to suspend R7's heels. RN-A indicated her expectations were staff would reposition residents every two hours and were to follow the provider's orders along with resident's care plans. RN-A confirmed she had not repositioned R7 and was going to find another staff member to assist with repositioning R7. During a follow-up interview at 1/30/24 at 4:56 p.m., NA-C confirmed she had not repositioned R7 since she was laid down in bed at 1:22 p.m. NA-C explained she had been running around the	2 895		

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2 895	Continued From page 29 building and had not been down R7's room yet. During an interview on 1/30/24 on 4:59 p.m., LPN-E confirmed she had not repositioned R7 since she arrived for her shift at 3:30 p.m. LPN-E indicated she had other tasks to complete and was beginning her medication pass. On 1/31/24 at 12:45 p.m., voicemail message left for podiatrist with no return phone call received. During an interview on 1/31/24 at 2:44 p.m., with director of nursing (DON) and executive administrator, DON was not aware R7 had not been repositioned within two hours. DON indicated staff had not informed her R7 had not been repositioned and provider orders for R7 had not been followed. DON confirmed the above findings and explained R7 should not have experienced prolonged sitting. DON indicated staff should have placed pillows under R7's calf and suspend her right heel whenever R7 was in bed. DON stated her expectations were staff would be following providers orders and if staff were unable to complete the orders they would inform the DON or charge nurse. Review of facility policy titled Pressure Injury Prevention and Management, unknown date, this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. After completing a thorough assessment/evaluation, the interdisciplinary team would develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions would be based on	2 895		

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2 895	Continued From page 30 specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure injury present. Basic or routine care interventions could include, but were not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); Minimize exposure to moisture and keep skin clean, especially of fecal contamination; Provide appropriate, pressure-redistributing, support surfaces; Provide non-irritating surfaces; and Maintain or improve nutrition and hydration status, where feasible. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide a resident restorative nursing program, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of the restorative nursing program to ensure the residents programs are completed consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two	2 905		2/23/24

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2 905	Continued From page 31 hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 2 resident (R7) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: R7's quarterly Minimum Data Set (MDS), dated 11/2/23, identified R7 had diagnoses which included Alzheimer disease, dementia and anxiety. R7 required extensive assistance of two staff for bed mobility and transfers. R7 required extensive assistance of one staff to roll from left to right. Indicated R7 was a risk for pressure ulcers, currently had an unhealed pressure ulcer and infection in foot. R7's significant change Care Area Assessment (CAA), dated 5/3/23, identified R7 was at risk for skin breakdown and potential pressure ulcers due to needing extensive assistance with bed mobility. R7's care plan revised on 1/24/24, identified R7 had actual complications with impaired skin integrity related to the blister on heel. Indicated R7's heels were to be floated at all times when in bed and staff were to reposition every two hours. R7 was dependent on staff for all cares. R7's 1/26/24, weekly wound round documentation identified R7 was noted to have a right heel deep tissue injury acquired on 6/12/23. Indicated that	2 905	CORRECTED	

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2 905	Continued From page 32 R7 was to be repositioned, have soft boots on and to use the hoyer lift due to non weight bearing on feet. R7's treatment orders dated 12/5/23, identified R7 was to have: -heel protector boots on at all times. -pillows under calf and suspend right heel whenever in bed. Review of R7's progress notes dated 7/31/23 to 1/30/24, revealed the following: - 8/1/23, Provider saw on rounds. After discussion, assessment of patient, seeing heel blister referred to podiatry. - 8/8/23,seen by podiatrist, area on heel debrided, may redress with medi honey and gauze but more concerned about offloading. - 8/28/23 dressing change every Monday and Thursday to right heel. Wash with wound cleanser, apply medi honey to padded dressing over areas that are open - covered with blister, wrap with kerlix. Apply soft boots. Notify wound nurse of changes. -10/5/23, podiatrist here today and saw resident while in bed. Resident was seen while in bed - provider debrided edges - pink skin and small amount of bleeding. Podiatrist would like a lift boot ordered one for resident and an extra one if it gets dirty as it is foam. Provider ordered silver alginate dressing, telfa and kerlix to right heel daily. Continue off loading right heel and pillow under right calf and suspending right heel. -11/14/23, podiatry here today. Cut toenails and looked at wound right heel, treatment order changed to betadine swab daily and to continue with current contact layered dressing 4x4s and kerlix wrap. -1/9/24, podiatry visit, heel checked, no changes in current treatment protocol.	2 905		

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2 905	Continued From page 33 During continuous observations on 1/30/24 from 8:56 a.m. to 11:09 a.m., revealed the following: - R7 was seated in the dining room being assisted with breakfast by licensed practical nurse (LPN)-A. R7 had heel protector boots on both feet and feet were rested on wheelchair foot pedals. - R7 resident continued to be in the same position. R7 was seated at the dining room table talking with her daughter. - R7's daughter pushed R7 from the dining room to the fireside dayroom. - R7 continued to sit in her wheelchair in the fireside day room. - R7 continued to sit in her wheelchair in the same location in the fireside dayroom. - R7 continued to sit in her wheelchair in the same location in the fireside dayroom. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - R7 continued the same position and located noted above. - At 11:09 a.m., ADON and LPN-A assisted R7 to lay down in bed. R7 was covered with a blanket. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 had not been repositioned for a total of two hours and 13 minutes during this observation. During an observation on 1/30/24 at 1:22 p.m., R7 was laying in bed covered with a sheet and pink comforter. R7 was laying on her left side facing the fall with a pillow behind her lower back.	2 905		

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2 905	Continued From page 34 R7 was wearing both heel protecting boots with and had a wedge pillow between her knees. R7 did not have a pillow under her calf's, left heel/foot was laying to the left side. Right leg was bent at the knee and right heel and foot were flush on the bed. - At 3:10 p.m., R7 was laying in bed in the same position as above. - At 4:56 p.m., R7 was laying in bed in the same position as above. R7 had not been offered to reposition every two hours or had a pillow suspending heels as directed by her care plan. R7 was unable to reposition herself or place the pillow independently. R7 had not been repositioned for a total of three hours and 34 minutes.. During an interview on 1/30/24 at 3:34 p.m., nursing assistant (NA)-C identified staff completed all activities of daily living (ADLs) for R7. R7 was to be transferred with two people and the hoyer lift. NA-C stated R7 required extensive assistance with turning and repositioning. NA-C stated staff were expected to ensure the heel boots on at all times and R7 was to be repositioned from side to side. NA-C indicated she was unaware of the order to place a pillow under R7's calf's and to suspend heels off of the bed at all times. During an interview on 1/30/24 at 4:33 p.m., RN-A indicated staff were expected to reposition R7 every two hours. RN-A reviewed and confirmed the above orders for R7. RN-A explained R7 had a wound on her right heel that staff were to complete dressing changes and to monitor. RN-A entered R7's room and confirmed R7 was laying on her left side and did not have a pillow under her calf's suspending R7's heels. RN-A stated	2 905		

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2 905	Continued From page 35 staff should have placed a pillow under her right leg no matter what position R7 was in. RN-A was not aware R7 had been laying in the same position since 1:22 p.m. RN-A placed a pillow under R7's calf's to suspend R7's heels. RN-A indicated her expectations were staff would reposition residents every two hours and were to follow the provider's orders along with resident's care plans. RN-A confirmed she had not repositioned R7 and was going to find another staff member to assist with repositioning R7. During a follow-up interview at 1/30/24 at 4:56 p.m., NA-C confirmed she had not repositioned R7 since she was laid down in bed at 1:22 p.m. NA-C explained she had been running around the building and had not been down R7's room yet. During an interview on 1/30/24 on 4:59 p.m., LPN-E confirmed she had not repositioned R7 since she arrived for her shift at 3:30 p.m. LPN-E indicated she had other tasks to complete and was beginning her medication pass. On 1/31/24 at 12:45 p.m., voicemail message left for podiatrist with no return phone call received. During an interview on 1/31/24 at 2:44 p.m., with director of nursing (DON) and executive administrator, DON was not aware R7 had not been repositioned within two hours. DON indicated staff had not informed her R7 had not been repositioned and provider orders for R7 had not been followed. DON confirmed the above findings and explained R7 should not have experienced prolonged sitting. DON indicated staff should have placed pillows under R7's calf and suspend her right heel whenever R7 was in bed. DON stated her expectations were staff would be following providers orders and if staff	2 905		

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2 905	Continued From page 36 were unable to complete the orders they would inform the DON or charge nurse. Review of facility policy titled Pressure Injury Prevention and Management, unknown date, this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. After completing a thorough assessment/evaluation, the interdisciplinary team would develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions would be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure injury present. Basic or routine care interventions could include, but were not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); Minimize exposure to moisture and keep skin clean, especially of fecal contamination; Provide appropriate, pressure-redistributing, support surfaces; Provide non-irritating surfaces; and Maintain or improve nutrition and hydration status, where feasible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff on ensuring each resident received turning and repositioning assistance according to their assessed need. The DON or designee could then perform observational audits to determine	2 905		

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2 905	Continued From page 37 compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a qualified director of food and nutrition services or a full-time qualified dietician was in place to oversee food preparation and kitchen function in the main production kitchen. Findings include: During an interview on 1/30/24 at 10:04 a.m., cook (C)-A stated food service supervisor (FSS)-A was their supervisor, however FSS-A was not certified as a dietary manager. C-A stated she had been employed at the facility since May 23, and the facility had not had a dietary manager since then.	2 980	CORRECTED	2/23/24

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2 980	Continued From page 38 During an interview on 1/30/24 at 10:10 a.m., interim administrator confirmed the facility did not have a dietary manger, however FSS-A planned to become certified in the future. During an interview on 1/30/24 at 10:14 a.m. FSS-A verified the facility did not have a dietary manager since June or July of 2022. During a follow up interview on 1/30/24 at 10:24 a.m., FSS-A stated she had been in the role as supervisor since 1/1/24, and indicated the facility had not provided her with dietary manager training yet. FSS-A stated the facility had part time dieticians and they just hired new registered dietician (RD)-A in January 2024, FSS-A stated RD-A had been at the facility once. During a telephone interview on 1/30/24 at 4:09 p.m., RD-A confirmed she was the facility's dietician and had just recently started working with the facility. RD-A verified FSS-A was not certified and indicated she was going to assist FSS-A with training. RD-A confirmed the facility did not have a certified dietary manager. RD-A indicated she had been at the facility once last week, and intended to complete resident assessments, and assist FSS-A as necessary. RD-A stated she had assisted FSS-A with how to calculate and complete minimum data set (MDS) documentation, which the executive administrator had informed RD-A, FSS-A planned to complete. During an interview on 1/30/24 at 4:28 p.m., director of nursing (DON) confirmed the facility did not have a dietary manager and FSS-A was the kitchen supervisor. DON indicated she could not verify how long the facility had not had a dietary manager however it had been since at	2 980		

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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) COMPLETE DATE
2 980	Continued From page 39 least March 2023. DON indicated FSS-A began her new role 1/1/24, and FSS-A had been managing the kitchen staff.. DON indicated the only training FSS-A had so far was ServSafe training (food and beverage safety training), and FSS-A had not yet completed the test on it. A policy on dietary manager was requested, and on 1/30/24 at 4:50 p.m., DON verified the facility did not have a policy. The DON provided the following job descriptions. -Food Service Supervisor, undated, identified job summary to include management and scheduling of food service personnel, management of food supplies and kitchen equipment, food production and menu changes. The job description qualifications identified the food service supervisor would be willing and able to obtain dietary manager certification within eighteen months of employment, and was ServSafe certified. The job description indicated the food service supervisor would coordinate dietary activities with the consultant dietitian. -Food Services Director, undated identified job summary to include responsibility for leadership and oversight necessary to provide appetizing, appealing, and nourishing food to residents with a variety of dietary needs. The job description included qualifications as three years experience in food service, a minimum of one year in supervisory position and possession of certified dietary manager (CDM) credentials. The job description tasks included: completion of the MDS as delegated by the MDS coordinator, complete nutritional risk assessments, and participate in care conferences weekly. SUGGESTED METHOD OF CORRECTION:	2 980		

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2 980	Continued From page 40 The Administrator or designee could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position. The Administrator or designee could educate all appropriate staff on the policies and procedures. The Administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwasher temperatures were maintained according to manufacturer's guidelines to assure sanitization of dishware. This deficient practice had the potential to affect all 30 residents who received food from the kitchen. Findings include: During an observation on 1/29/24 at 11:07 a.m., dietary aide (DA)-A ran a rack of dishes through the dishwasher, the rinse cycle gauge did not move during observation. At 11:13 a.m., food service supervisor (FSS)-A ran the dishes back through the dishwasher and indicated the wash	21015	CORRECTED	2/23/24

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21015	Continued From page 41 cycle obtained 180 degrees, and the rinse cycle ran at 140 degrees. FSS-A stated the dishwasher was last serviced on 10/31/23, at which time dishwasher representative (DR)-A replaced the gauges, and informed them at that time the facility needed to replace the booster heater. FSS-A and surveyor reviewed the facility temp records, posted on the wall near the dishwasher, and FSS-A confirmed the wash cycle had not been reaching 150 as required, and the rinse cycle did not reach 180 degrees. FSS-A verified the dishwasher temps had been running low. FSS-A stated they used a plate thermometer that they ran through to test the temperatures, or used test strips to test dishwasher temperatures as needed. FSS-A indicated they had been able to get the temperatures up to 174 to 182 after running the machine multiple times, however confirmed the dishwasher had not consistently been reaching the required temperatures. FSS-A indicated the facility needed a new dishwasher. Review of the Dishwasher Record Log dated January, included three wash cycle-150 degrees columns, and three rinse cycle-180 degrees columns for each day entry. The log identified the following: Wash cycles recorded three times a day, January 1, through January 27, included: -120 degrees, one time. -130 degrees, twelve times. -135 degrees, two times. -140 degrees, thirty four times. -145 degrees, three times. -150 degrees, twenty nine times. Rinse cycles recorded three times a day, January 1, through January 27, included: -100 degrees, one time.	21015		

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21015	Continued From page 42 -110 degrees, fifteen times. -115 degrees, one time. -120 degrees, forty eight times. -125 degrees, one time. -130 degrees, fourteen times. -150 degrees, one time. During a telephone interview on 1/30/24 at 4:09 p.m., registered dietician (RD)-A confirmed she was the facility dietician. RD-A indicated she was not aware the dishwasher was not heating at the required temperatures. RD-A stated it was important for the temperatures to be accurate or it would not kill everything on the dishes, and the dishes would not be clean. During a telephone interview on 1/30/24 at 1:22 p.m. DR-A indicated the dishwasher required work and a new booster heater since it was not reaching hot enough temperatures. DR-A stated he had informed the facility staff the last time he was at the facility. DR-A confirmed the dishwasher temperatures required the wash cycle to reach 150 degrees, and the rinse cycle to reach 180 degrees. DR-A stated if the temperatures were not reached, the dishes would not be sanitized. DR-A stated if the gauges were not working, the facility could run a plate thermometer or strips through the machine, and if they reached 160 degrees surface temperature, that would mean the machine reached 180 degrees. During an interview on 1/30/24 at 1:41 p.m., interim administrator stated he was informed of dishwasher temperature concerns yesterday. Interim administrator confirmed the dishwasher at the facility was a hot water temperature type, and indicated the facility had problems in the past with the dishwasher. Interim administrator stated the	21015		

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21015	Continued From page 43 dishwasher temperatures were important to be accurate to assure killing of bacteria and stated it was a sanitization issue. During a follow up interview on 1/30/24 at 2:03 p.m., FSS-A verified the facility did not have a manufacturer's instruction book. FSS-A stated they had problems with the dishwasher in the past and stated the low temperatures for the dishwasher began occurring again in January 24. The facility policy titled Dishwashing Machine Use, dated 3/10, identified the following: -dishwashers that used hot water to sanitize must maintain the following wash solution temperatures: -150 degrees for stationary rack, dual temperatures machines, or multi-tank, conveyor, multi-temperature machines -dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degrees , or less than: -165 degrees for stationary rack, single temperature machines -180 degrees for all other machines. The policy identified operator would check temperatures using the machine gauge with each dishwashing cycle, and record the results in a facility approved log. Inadequate temperatures would be reported to the supervisor and corrected immediately. The policy identified if the water temperatures did not meet the requirements, cease use of dishwasher machine immediately until temperatures were adjusted. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation for the dishwashing	21015		

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21015	Continued From page 44 machine. The director of dietary services or designee (s) could provide training for all appropriate staff on these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral medications were administered safely for 1 of 1 resident (R4) who was observed to self administer medications left at the bedside and had been assessed as not safe to self administer medications. Findings Include: R4's admission Minimum Data Set (MDS) dated 12/6/23, identified R4 was cognitively intact and had diagnoses which included: heart failure, diabetes, anxiety, depression and bipolar disorder (extreme mood changes). Identified R4 required partial/moderate assistance with lower body dressing, toileting hygiene, personal hygiene, and transfers chair/bed to chair.	21565	CORRECTED	2/23/24

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21565	Continued From page 45 R4's care plan, dated 1/5/24, identified R4 had congestive heart disease, diabetes mellitus, and constipation related to use of narcotic medications. R4's care plan did not include instructions for self administration of medications. R4's Self-Administration Of Medications Review Tool dated 1/5/24, identified R4's vision impaired ability to self administer medications, and R4's significant other assisted at home. R4's tool identified: -Physician order to self-administer medications-No, -Approval to self-administer medications(s) granted-No, Review of R4's Order Summary Report signed 1/9/24, identified R4's orders did not include an order to self administer medication. During an observation on 1/29/24 at 12:14 p.m., family member was present in R4's room. R4 had a paper medication cup with pills in it on her bedside table. R4 took a drink of water, then leaned her head back, swallowed, leaned head back again and swallowed again. No nurse was present in R4's room or hallway at that time. During an interview on 1/29/24 at 3:36 p.m., R4 indicated the nurses always left her medications in her room for her to take. R4 stated she informed the nurses later if she had taken them or not. On 1/30/24 at 9:36 a.m., R11 gave permission to review the resident council meeting minutes. Review of the minutes from 11/21/23 to 12/14/23, revealed the following: -11/21/23, medications were being left with residents unattended/unsupervised for them to	21565		

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21565	Continued From page 46 take on their own. -12/14/23, morning medications being left on the table unattended/unsupervised by nursing staff still. During an interview on 1/30/24 at 10:49 a.m., licensed practical nurse (LPN)-A stated she had administered R4's morning medications yesterday. LPN-A confirmed she had left R4's medications in her room and did not observe R4 take the medications. LPN-A stated R4 could self administer medications after they were set up. LPN-A stated her usual practice was to administer R4's morning medications in the dining room while she remained in the dining room, so she could see if R4 took her medications however verified she would not stand and observe R4 to take them. LPN-A reviewed R4's electronic medical record and confirmed R4 did not have an order to self administer medications and R4's care plan did not identify R4 could self administer medications. In addition, LPN-A reviewed R4's Self-Administration Of Medications Review Tool dated 1/5/24, and confirmed R4 could not self administer medications. During an interview on 1/30/24 at 4:34 p.m., director of nursing (DON) indicated the facility's usual practice for self administration of medications included staff were to compete an assessment first to determine if the resident was safe to self administer their medications. DON stated she would expect it would be included on the resident's care plan if they were able to self administer medications. DON indicated she had not been aware it was discussed at multiple resident council meetings medications were being left unattended/unsupervised however someone had made her aware after the last resident council meeting. DON indicated it was important	21565		

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21565	Continued From page 47 to not have residents self administer medications if not approved to do so due to safety concerns and to ensure the resident actually received the medications. Review of the facility policy titled Resident Self-Administration Of Medication, undated, identified a resident may only self-administer medications after the facility's interdisciplinary team had determined which medications may be self-administered safely. The policy identified the care plan must reflect the resident self-administration and storage arrangement for such medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review with staff current policies to ensure residents who are self administering medication had been assessed and were appropriate to administer their own medication, along with a physicians order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time,	21675		2/23/24

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21675	Continued From page 48 temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 2 of 4 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 1/29/24 at 12:03 p.m., housekeeping aid (HA)-B was observed uncovering the laundry cart, removed laundry from the cart, placed the laundry in R22's closet, exited R22's room and returned to the uncovered cart. HA-B removed laundry from the uncovered cart, placed the laundry in R5's closet, exited R5's room, removed laundry from the uncovered cart, placed in R2's closet, exited R2's room with empty hangers and hung the hangers in the cart. HA-B pushed the uncovered laundry cart to R24's room, removed laundry from cart, left uncovered in front of visitor passing by cart, knocked on door, hung up laundry in R24's closet and exited R24's room with empty hangers and hung the hangers in the cart. HA-B removed laundry from the uncovered cart, placed the laundry in R27's closet, exited R27's room. HA-B returned to the	21675	CORRECTED	

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21675	Continued From page 49 uncovered cart, removed laundry from cart, delivered laundry to R26's closet and exited R26's room. HA-B removed laundry from the uncovered cart, knocked on R16's door, delivered laundry and exited R16's room. HA-B pushed the uncovered cart down the hall, removed laundry from the cart, placed the laundry in R10's closet and exited R10's room. HA-B removed laundry from the uncovered cart, knocked on R28's door, placed laundry in R28's closet and exited R28's room. HA-B returned to the uncovered cart, removed laundry from the cart, dropped laundry on the floor in hallway, picked laundry up and delivered to R9's room while holding laundry against his body, placed laundry in R9's closet and exited R9's room. HA-B removed laundry from the uncovered cart, walked down the hall with the laundry, knocked on R14's door, placed the laundry in R14's closet, exited R14's room, closed R14's door and walked back down the hall to the laundry cart which remained uncovered. HA-B removed laundry from the cart, walked down the hall, knocked on R19's door, hung laundry in R19's closet and exited R19's room. HA-B walked back down the hall and pushed the empty laundry cart back to the laundry room. HA-B did not sanitize his hands and the laundry cart remained uncovered during the entire observation. During an observation on 1/29/24 at 3:29 p.m., nursing assistant (NA)-B pushed the covered laundry cart down the 300 hall to deliver clean laundry to residents. R18's two pairs of pants, one t-shirt, and two button up shirts were hanging on the outside of the cart. NA-B grabbed the laundry hanging from the cart, knocked on R18's door, placed clothing in R18's closet, exited R18's room with empty hangers and set hangers on the	21675		

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21675	Continued From page 50 top of laundry cart. NA-B continued to deliver laundry down the hall. NA-B removed laundry from the uncovered cart, knocked on R22's door, opened door, delivered laundry, exited R22's room and returned to the uncovered laundry cart. NA-B removed laundry from cart, knocked on R2's door, pulled drawers open in R2's room, placed laundry in drawers, closed drawers and exited R2's room with empty hangers and set on top of cart. NA-B removed laundry from cart, knocked on R24's door, opened R24's bedside drawer, placed laundry in drawer, closed drawer and exited R24's room with empty hangers and set on top of cart. NA-B removed laundry from uncovered cart, knocked on R27's door, delivered laundry and exited R27's room. NA-B removed laundry from uncovered cart, delivered to R26's room and exited R26's room. NA-B pushed the uncovered laundry cart down the hall, removed laundry and delivered laundry to R16's room and exited R16's room. NA-B removed laundry from the uncovered cart, placed in R10's closet and exited R10's room. NA-B removed laundry from uncovered cart, placed in R28's closet and exited R28's room. NA-B pushed the uncovered cart down the hall, removed laundry, placed in R20's closet and exited R20's room. NA-B removed laundry from cart, knocked on R14's door, placed laundry in dresser and in closet and exited R14's room. NA-B removed laundry from the uncovered cart, placed in R19's closet and exited R19's room. NA-B pushed the uncovered laundry cart down the hall, stopped and visited with resident in the lounge area by the nurses station and returned the cart to the laundry room. NA-B did not sanitize her hands and the laundry cart remained uncovered during the entire observation.	21675		

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21675	Continued From page 51 During an interview on 1/30/24 at 10:50 a.m., HA-B verified he removed clothes from the uncovered cart, placed them in the residents' closets, took back any hangers to the uncovered cart and did not sanitize his hands. (HA)-B stated the purpose of keeping the cart covered and for completing hand hygiene was to prevent the spread of infection between residents. During an interview on 1/31/24 at 2:12 p.m., the director of nursing (DON) verified the expectation of staff delivering laundry was to keep the laundry cart covered during delivery and to complete hand hygiene in between. DON stated these practices were important to prevent contamination from the environment and cross contamination of surfaces. Review of a facility policy titled Infection Prevention and Control Manual Environmental Services/Housekeeping/Laundry undated, indicated laundry should be packaged, transported and stored in a manner that ensured cleanliness and protected the laundry from dust and soil. Clothing would be taken out of cart and covered again while unattended in the hallways. Laundry staff would sanitize hands on the way out of the resident room. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures for proper infection control measures were implemented for linen handling and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21675		

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21675	Continued From page 52 (21) days.	21675		
21885	MN St. Statute 144.651 Subd. 21 Patients & Residents Of HC Fac.Bill of Rights Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.) This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 5 of 5 residents (R23, R6, R11, R16, R26) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: On 1/30/24 at 9:36 a.m. R11 gave permission for surveyor to review resident council meeting minutes. Review of resident council meeting minutes was completed. Minutes reviewed had no documentation related to mail delivery. On 1/30/24 at 11:00 a.m., a resident council meeting was held with 5 residents, R23, R6, R11,	21885	CORRECTED	2/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00669	A. BUILDING: _____ B. WING _____	C 01/31/2024

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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21885	Continued From page 53 R16, R26. During the meeting all residents confirmed mail was delivered by activity staff, however mail was not delivered on Saturdays. During an interview on 1/30/24 at 1:46 p.m., activity assistant (AA)-A indicated mail was delivered by activity staff or administrative assistant (ADA)-A. AA-A stated mail was delivered before 4:30 p.m. Monday through Friday, however was not sure if mail was delivered on Saturdays, as no activity staff worked on the weekends. During an interview on 1/30/24 at 1:49 p.m., ADA-A indicated she assisted with mail delivery at times and worked Monday through Friday. ADA-A stated she thought mail was delivered by nursing staff on the weekends however was unsure. ADA-A confirmed at times mail was left on her desk from the weekend. During an interview on 1/30/24 at 1:53 p.m., assistant director of nursing (ADON)-A confirmed she worked weekends. ADON indicated mail was delivered at the front of building however did not get picked up until Monday for delivery to residents. ADON-A stated mail delivery was not a task completed by nursing on the weekends. ADON stated it was important for mail to be delivered on Saturdays so residents received their mail on time. During an interview on 1/30/24 at 2:11 p.m., interim administrator indicated he was unaware of how mail was delivered in facility and thought activity staff delivered mail. Interim administrator indicated it was important for mail to be delivered on Saturdays so residents received their mail timely.	21885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21885	Continued From page 54 During a follow-up interview on 1/30/24 at 2:28 p.m., interim administrator confirmed the facility did not have a policy for mail delivery in the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure residents have a means to send and receive mail on Saturdays. The facility could work with the postal service to ensure a secure method of mail delivery. The administrator or designee could revise policies and procedures, educate staff on these changes, and audit periodically to ensure resident are receiving mail on Saturdays. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21885		