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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KIW1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00669

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

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

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

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

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

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

6. DATE OF SURVEY **04/11/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Pam Kerrsen, APM — 04/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/22/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/14/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245585

April 14, 2015

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, Minnesota 56296

Dear Ms. Stattleman:

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

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

Effective April 8, 2015 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 13, 2015

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, Minnesota 56296

RE: Project Number S5585025

Dear Ms. Stattleman:

On March 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 8, 2015 and therefore remedies outlined in our letter to you dated March 20, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5585r15

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245585	A. Building B. Wing	4/11/2015

Name of Facility	Street Address, City, State, Zip Code
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/08/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/08/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/14/2015	10679	04/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/5/2015			

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

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(L1) **245585**

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(L2) **145240100**

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

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

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

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

6. DATE OF SURVEY **03/05/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Patrici Bernstetter, HFE NEII 04/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7303

March 20, 2015

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: Project Number S5585025

Dear Ms. Stattleman:

On March 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: pam.kerssen@state.mn.us

Telephone: (218) 308-2129
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 5, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5585s15

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 _____ RECEIVED APR 06 2015	03/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based upon interview and document review, the facility failed to ensure the residents received their personal mail on Saturdays for 3 out of 3 residents (R23, R35, R15). This deficient practice had the potential to affect all 42 residents in the facility. Findings: During an interview on 3/5/15, at 1:52 p.m. R23 stated the facility does not deliver mail on Saturdays. The annual Minimum Data Set (MDS) dated 1/2/15, indicated there was no cognitive deficit.	F 170	F170 • Local post office was contacted and will re-start Saturday mail delivery to the facility. • Activity aides have been educated to deliver mail to residents on Saturdays. • Charge nurse, or designee, will conduct weekly audits to assure mail has been delivered on Saturday for 3 months. • QAA will review audits for three months to ensure compliance. • Completion date by: 4/8/2015 4-9-15 of c added JK	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4-1-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	03/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 170	Continued From page 1 During an interview on 3/5/15, at 2:24 p.m. R35 stated the facility does not deliver mail on Saturdays. The quarterly MDS dated 12/8/14, indicated there was no cognitive deficit. During an interview on 3/5/15, at 2:45 p.m. R15 stated the facility does not deliver mail on Saturdays. The quarterly MDS dated 11/14/14, indicated there was no cognitive deficit. During an interview on 3/5/15, at 2:45 p.m. the activities director (AD) stated the mail does not get delivered on Saturdays it is delivered on Mondays. During an interview on 3/5/15, at 3:03 p.m. the administrator stated the activities staff delivers the mail and there are activities staff working on the weekend. She stated she was not aware of the mail not being passed on Saturdays. During an interview on 3/05/15, at 3:20 p.m. with the activities coordinator (AC) she stated the post office was opened on Saturdays and they delivered mail to the facility's mailbox. The AC stated there was not a list of job duties for the p.m. activities aide but she would add it to the check list. The AC stated she didn't know it was an issue. Review of the p.m. activities aide check list with no print date on it, it did not include to pass mail to the residents on Saturdays. The resident Mail policy with a revision date of April 2009, indicated all mail is to be delivered promptly and unopened.	F 170		

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	245585	A. BUILDING _____ B. WING _____	03/05/2015

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

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F 176 F 176 SS=D	Continued From page 2 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, care plan, and obtain physician orders for self administration of medication for 1 of 1 resident (R46) whom was observed during medication administration. Findings include: R46's Medication Administration Record (MAR) of 3/2/15, indicated licensed practical nurse (LPN)-A had administered Amiodarone HCL 100 mg, aspirin 81 mg, vitamin D 2000 units, Colace 100 mg, Nephrocaps 1 mg, Coreg 6.25 mg, Lasix 40 mg and Senna S 8.6 mg-2 tablets for a.m. medications. R46 was observed on 3/2/15, at 7:35 a.m. sitting in an upright position in his bed with his bed side table in front of him eating breakfast independently. At this time LPN-A bought R46's medication in a white paper medication cup and sat them on his bed side table in front of him and stated to R46 "here is your medication." LPN-A then proceeded to administer R46's humalog insulin 18 units subcutaneous in his left upper arm, then left the room with R46's medications still on the bed side table.	F 176 F 176	F176 • R46 has been assessed for self administration of medication. • Nurses have been re-educated on self administration of medication policy. • All residents have been reviewed to ensure a self administration assessment has been completed for residents who are appropriate for self administration. • Nurse Managers have been educated that self administration assessments must be completed upon admission, with change of condition, and on an annual basis. • DON, or designee, will conduct audits three times per week for three months to assure that residents only are given meds to self administer if that resident has a current self administration assessment. • QAA will review audits to ensure compliance. • Completion date by: 4/8/2015	

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F 176	Continued From page 3 At approximately 7:38 a.m. LPN-A was asked if R46 had a physician order for self administration of medication. LPN-A stated "yes he does" and she proceeded to look at R46's MAR. No physician order was found on the MAR, nor on the standing house orders, or the care plan. At approximately 7:45 a.m. LPN-A returned to R46's room after not finding a self administration order to watch him take his medication, but R46 had already taken his medications that LPN-A had left on his bedside table. At this time LPN-A verified R46 had already taken his medications with no supervision. During review on 3/2/15, at 7:38 a.m. with LPN-A of R46's MAR, standing orders, physicians orders, care plan, and the computer system point click care, there was no physician orders, assessment or care plan for R46 to self administer his medications without any supervision by licensed staff. During interview on 3/2/15, at 12:37 p.m. registered nurse (RN)-A confirmed R46 did not have a self administration order from the doctor, no care plan and no assessment had been completed to self administer medications prior to R46 receiving his medications on 3/2/15, at 7:35 a.m.. RN-A verified that LPN-A should not have left R46's medication in his room without an order for self administration. During interview on 3/2/15, at 12:59 p.m. LPN-A confirmed that R46 did not have a order to self administer his medications and stated, "I did not realize he did not have an order." During interview on 3/2/15, at 1:07 p.m. director of nursing (DON) confirmed R46 did not have a	F 176		

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F 176	Continued From page 4 self administration order from the doctor, no care plan and no assessment had been completed to self administer medications prior to R46 receiving his medications on 3/2/15 at 7:35 a.m.. The DON verified RN-A had completed the assessment, received an order and updated the care plan later in the day on 3/2/15, and stated, "We did not have the order because of the fear of the family taking his medication, they have a history of being drug seekers, so we did not pursue the order." The DON confirmed LPN-A should have stayed in R46's room until he took his medications because there was no order to self administer his medications. Review of facility policy titled, Self Administration of Medications, dated 4/1/2008, indicated an individual resident may self administer medication if the resident requests and the interdisciplinary team has determined that the resident is safe in this practice. The policy also indicated staff would complete a self administration assessment, obtain a physicians order, and revise the residents care plan to enable the resident to self administer the specific medications.	F 176	F329 • R4's drug regimen and medical record has been reviewed with physician and updated accordingly and proper diagnosis has been completed for the use of Amitriptyline. • Nurse Managers have been re-educated on when to complete sleep logs regarding resident medications for depression. • Facility policy has been updated and reviewed with Nurse Managers. • DON, or designee, will conduct weekly audits for three months. • QAA will review audits to ensure compliance. • Completion date by: 4/8/2015	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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F 329	Continued From page 5 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify the clinical indications for the continued use of an antidepressant prescribed as a sleep aid for 1 of 5 resident (R4) reviewed receiving an antidepressant, and failed to identify non-pharmacological interventions to aid with sleep. Findings include: R4's annual Minimum Data Set (MDS) dated 1/12/15, identified R4 had moderate cognitive impairment, had diagnoses which included dementia, anxiety and depression, and did not have trouble falling asleep or staying asleep. The corresponding Care Area Assessment (CAA) identified R4 stated able to sleep all night without difficulty. The facility form titled Insomnia/Sleep Record, dated 2014, R4 routinely had fallen asleep between 11 and 12 o'clock p.m., remained asleep and awoke between 6 and 7 o'clock a.m..	F 329		

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F 329	Continued From page 6 R4 had been prescribed Amitriptyline HCL 25 mg (milligrams) one time a day for insomnia, prior to admit to the facility on 2/5/13. R4's current care plan revised 1/22/15, did not address R4's insomnia and lacked non-pharmacological interventions to aid with sleep. During an interview on 3/05/2015, at 1:41 p.m. nursing assistant (NA)-A stated R4 displays behaviors "when she gets tired and can't sleep." During an interview on 3/05/2015, at 1:51 p.m. registered nurse (RN)-A verified R4 did receive Amitriptyline for sleep. With review of R4's record RN-A verified the start date of the Amitriptyline was 1/31/13, prior to R4's admission date of 2/5/13. RN-A stated the usual facility practice to evaluate a resident receiving a medication to aid in sleep was to review the resident's sleep pattern with a "sleep log for 7 days every 6 months." RN-A verified the only sleep study found for R4 was dated 2014, and indicated no sleep difficulty. During an interview on 3/05/2015, at 4:01 p.m. the director of nursing (DON) verified the lack of follow through for the use of Amitriptyline as a sleep aid, which would include the care planned interventions and review of R4's sleep pattern. A requested facility policy was not provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 7 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consulting pharmacist failed to identify a drug irregularity for 1 of 5 residents (R4) who received an antidepressant medication for the treatment of insomnia, had justification for continued use and non-pharmacological interventions were in place to aid in sleep. Findings include: R4's annual Minimum Data Set (MDS) dated 1/12/15, identified R4 had moderate cognitive impairment, had diagnoses which included dementia, anxiety and depression, and did not have trouble falling asleep or staying asleep. The corresponding Care Area Assessment (CAA) identified R4 stated able to sleep all night without difficulty. The facility form titled Insomnia/Sleep Record, dated 2014, R4 routinely had fallen asleep between 11 and 12 o'clock p.m., remained asleep and awoke between 6 and 7 o'clock a.m.. R4 had been prescribed Amitriptyline HCL 25 mg (milligrams) one time a day for insomnia, prior to admit to the facility on 2/5/13. R4's current care plan revised 1/22/15, did not	F 428	F428 • R4's drug regimen and medical record has been reviewed with physician and updated with proper diagnosis for medication use. • Process for provider review of pharmacy consultant recommendations has been updated. • DON, or designee, will conduct monthly audits after consultant visit for three months. • QAA will review audits to ensure compliance. • Completion date by: 4/8/2015	

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F 428	Continued From page 8 address R4's insomnia and lacked non-pharmacological interventions to aid with sleep. During an interview on 3/05/2015, at 1:41 p.m. nursing assistant (NA)-A stated R4 displays behaviors "when she gets tired and can't sleep." During an interview on 3/05/2015, at 1:51 p.m. registered nurse (RN)-A verified R4 did receive Amitriptyline for sleep. With review of R4's record RN-A verified the start date of the Amitriptyline was 1/31/13, prior to R4's admission date of 2/5/13. RN-A stated the usual facility practice to evaluate a resident receiving a medication to aid in sleep was to review the resident's sleep pattern with a "sleep log for 7 days every 6 months." RN-A verified the only sleep study found for R4 was dated 2014, and indicated no sleep difficulty. During an interview on 3/05/2015, at 4:01 p.m. the director of nursing (DON) verified the lack of follow through for the use of Amitriptyline as a sleep aid, which would include the care planned interventions and review of R4's sleep pattern. During a phone interview on 3/5/15, at 5:20 p.m. the consulting pharmacist indicated she had not reviewed R4's care plan for non-pharmalogical interventions to aid with sleep, nor had she reviewed the record for sleep monitoring. The consulting pharmacist verified her expectation and instructions for the facility had been to incorporate sleep monitoring and non-pharmacological interventions in to a resident's care and treatment plan when a sleep aid was ordered. A requested facility policy was not provided.	F 428		

Rec. 4-8 email NHA

Addendum to Traverse Care Center PoC April 2015

F329

R4's physician has documented justification for continued use of Amitriptyline; it is for anxiety versus sleep. Unsuccessful non-pharma logical interventions have been attempted with resident R4 to address her targeted behavior for using this medication for anxiety. All residents in the facility have been reviewed for use of medications for sleep and appropriate action non pharmacological interventions will be reviewed annually.

F428

R4's physician has documented justification for continued use of Amitriptyline; it is for anxiety versus sleep. Unsuccessful non-pharma logical interventions have been attempted with resident R4 to address her targeted behavior for using this medication for anxiety. All residents in the facility have been reviewed for use of medications for sleep and appropriate action non pharmacological interventions will be reviewed annually.

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	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as two buildings due to the construction dates of the buildings. The original building (Bldg. 1) was constructed in 1967 and was determined to be of at least Type II(111) construction. It is 1 story with partial basement and is fully protected with fire sprinklers. This building consists of the 100, 200 and 600 Wings and was surveyed to Chapter 19 Existing Health Care. The facility has a fire alarm system that is monitored for automatic fire department notification and smoke detectors in all resident rooms, areas open to the corridors as well as by barrier doors held open with magnetic hold-openers. The facility has a capacity of 49 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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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	245585	A. BUILDING **02 - 2ND BUILDING** B. WING _____	**03/06/2015**

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