DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION A								D: KIW1
		I - TO BE COM	PLETED BY TI	HE STAT	E SURVEY	AGENCY		Facility ID: 00669
 MEDICARE/MEDICAID PROVIDER N (L1) 245585 	Ю.	3. NAME AND ADI (L3) TRAVERSE (Y			4. TYPE OF ACTION:	<u>7 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 303 SEVENTH STREET SOUTH					1. Initial 3. Termination	 Recertification CHOW
(L2) 145240100		(L5) WHEATON,	MN		(I	L6) 56296	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SUP	PLIER CATEGORY			(L7)	7. On-Site Visit	9. Other
(L9) 12/01/2010		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After Co	omplaint
	/ 2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING	GDATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray 08 OPT/SP	11 ICF/III) 15 ASC 16 HOSPIC	F	12/31	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OF 1/SF	12 RHC	16 HOSPIC	E	12/51	
11LTC PERIOD OF CERTIFICATION		10. THE FACILITY I	IS CERTIFIED AS:					
From (a):		X A. In Complian	ce With		-	-	Following Requirements:	
To (b) :		Program Ree Compliance				Technical Personnel	6. Scope of Serv	
12.Total Facility Beds	49 (L18)	-	cceptable POC			24 Hour RN 7-Day RN (Rural SNF)	7. Medical Direc 8. Patient Room	
					5. 1	Life Safety Code	9. Beds/Room	
13. Total Certified Beds	49 (L17)		bliance with Program ents and/or Applied W	/aivers:	* Code:	A *	(L12)	
14. LTC CERTIFIED BED BREAKDOWN	Ĩ				15. FACILITY	Y MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1)) or 1861 (j) (1):	(L15)	
49								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY API	PROVAL	Date:
Pam Kerrsen, APM			04/14/2015	(L19)	Mar	h Meath,	Enforcement Specia	04/14/2015 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA RE	GIONA	L OFFICE O	R SINGLE STAT	EAGENCY	(==:)
19. DETERMINATION OF ELIGIBILITY	7	20. COM	PLIANCE WITH CI	VIL	21.	1. Statement of Financia	al Solvency (HCFA-2572)	
X 1. Facility is Eligible to Par			ITS ACT:				nterest Disclosure Stmt (HCF.	A-1513)
2. Facility is not Eligible	T T					5. Dom of the risore .		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMI	NATION ACTION:	((L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE		VOLUNTAR	<u>Y</u> 00	INVOLUN	TARY
10/01/1991					01-Merger, C	losure	05-Fail to M	leet Health/Safety
(L24)	(L41)		(L25)			ction W/ Reimbursemen	t 06-Fail to M	leet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS				voluntary Termination	OTHER	
	A. Suspension	of Admissions:			04-Other Reas	son for Withdrawal		Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)				00-Active	
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARI	KS		
		03001						
	(L28)	00001		(L31)				
	· · /			/	-			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	Е	Posted (04/22/2015 Co.		
	(L32)	04/14/2015		(L33)	DETERM	INATION APPRO	VAL	



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



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

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245585	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(1) (Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0170	04/08/2015	ID Prefix	F0176	04/08/2015	ID Prefix	F0329		04/08/2015
0	483.10(i)(1)	_	-	483.10(n)		-	483.25(I)		_
LSC		_	LSC			LSC			_
		Correction			Correction				Correction
ID Prefix	E0428	Completed 04/08/2015	ID Prefix		Completed				Completed
					-				_
	483.60(c)	_	Reg. #			Reg. #			-
L3C		_	L3C						-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		•	ID Prefix		-	ID Prefix			_
Reg. #						Reg. #			
LSC		-	LSC						-
		Correction			Correction				Correction
		Completed	ID Des fee		Completed				Completed
ID Prefix		_	ID Prefix		-	ID Pretix			_
Reg. #		_	Reg. #			Reg. #			-
LSC			LSC						
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix		-	ID Prefix			_
Reg. #			Reg. #			Reg. #			
LSC		_	LSC			LSC			-
						_			
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
State Agency	, PK/n	nm	04/14/20	15	1067	79		04/11	/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to	Survey Completed on:			Check for any	Uncorrected De	eficiencies. Was	a Summary of		
	3/5/2015			Uncorrecte	d Deficiencies (CMS-2567) Sent	to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		D: KIW1 Facility ID: 00669
1. MEDICARE/MEDICAID PROVIDER (L1) 245585 2.STATE VENDOR OR MEDICAID NO. (L2) 145240100	NO.	 NAME AND ADI (L3) TRAVERSE (L4) 303 SEVENT (L5) WHEATON, 	CARE CENTER 'H STREET SOU		(L6) 56296	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
 5. EFFECTIVE DATE CHANGE OF OW (L9) 12/01/2010 		7. PROVIDER/SUF 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 03/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 49 (L37) (L38)	49 (L18) 49 (L17) 19 SNF (L39)	X B. Not in Com	ce With quirements		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Serv 7. Medical Direc	tor
16. STATE SURVEY AGENCY REMAR					18. STATE SURVEY AGENCY A	PPROVAL	Date:
Patrici Bernstetter,			04/09/2015	(L19)	Mark Meath	, Enforcement Specia	
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa 2. Facility is not Eligible	Y	20. COM	D BY HCFA RE		21. 1. Statement of Finant 2. Ownership/Control 3. Both of the Above state	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCF	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/01/1991	23. LTC AGREEMI BEGINNING I		4. LTC AGREEME ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	0 INVOLUN	(L30) <u>TARY</u> leet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	of Admissions:	(L25) (L44)		02-Dissatisfaction W/ Reimbursend 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	leet Agreement Status Change
28. TERMINATION DATE:	29	INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS		
	(L28)			(L31)	-		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (JF APPROVAL DAT	Е (L33)	DETERMINATION APPRO	DVAL	



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:

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

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

<u>Remedies</u> - 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; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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

Traverse Care Center March 20, 2015 Page 3

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.

Traverse Care Center March 20, 2015 Page 4

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

Traverse Care Center March 20, 2015 Page 5 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Traverse Care Center March 20, 2015 Page 6 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

NAME OF PROVIDER OR SUPPLIER 245585 B. WING APR OF CAUS 03/05/2015 TRAVERSE CARE CENTER SIME OF PROVIDERS PLAN OF DESCRIPTING REACH DEFICIENCY WIST BE PRECEDED BY FULL PEER R REQUILATORY OR USCIDENTIFYING INFORMATION ISTREM ADDRESS, CITY, STATE, 2P CODE SUMMARY STATEMENT OF DESCRIPTING INFORMATION SIME OF DORINGET OF DESCRIPTING WHEATON, MN 56296 Opposite WHEATON, MN 56296 Opposite PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION NOTED BE CROSS-REFERENCED TO THE APPAOPRIATE DEFIDENCY) Opposite PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION NOTED BE CROSS-REFERENCED TO THE APPAOPRIATE DEFIDENCY) Opposite PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION NOTED BE CROSS-REFERENCED TO THE APPAOPRIATE DEFIDENCY) Opposite PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION NOTED BEDEDICENCY) PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION NOTED (EACH ODRECTIVE ACTION NO	TATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DA	O. 0938-0: ATE SURVEY DMPLETED
TRAVERSE CARE CENTER Summary statement or periciencies reach deficiency must be reacted by FULL PREFX Description of the state period of the state of th	NAME OF	PROVIDER OR SUPPLIER	245585		APR 0 6 2015	03	3/05/2015
CMU ID TAG SUMMARY STATEMENT OF DEFICIENCIES RECARD BEFICIENCY UNST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION PREV PREX TAG PROVIDERE ALL OCORRECTION PREV TAG PROVIDERE ALL OCORRECTION RECOVER DEFICIENCY COMPLET INFORMATION COMPLETION INFORMATION COMPLETION INFORMATION COMPLETION INFORMATION COMPLETION INFORMATION COMPLETION INFORMATION COMPLETION INFORMATION COMPLETION INFORMATION COMPLETION C		SE CARE CENTER			303 SEVENTH STREET SO		
 F 170 <	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ÍD PREFIX	PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCEI	E ACTION SHOULD BE D TO THE APPROPRIATE	
 By Our 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. F170 483.100(11) RIGHT TO PRIVACY-SS=C SEND/RECEIVE UNOPEND 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 	F 000	INITIAL COMMENT	S	F 000			
 Promptiy 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 	F 170 SS=C	as your allegation of Department's accept bottom of the first patheter be used as verification Upon receipt of an a revisit of your facility that substantial com has been attained in verification. 483.10(i)(1) RIGHT SEND/RECEIVE UN	f compliance upon the tance. Your signature at the age of the CMS-2567 form will on of compliance. Acceptable POC an on-site will be conducted to validate pliance with the regulations accordance with your TO PRIVACY - OPENED MAIL	F 170			
	- I I I I I I I I I I I I I I I I I I I	This REQUIREMEN by: Based upon interview facility failed to ensur their personal mail or residents (R23, R35, nad the potential to a facility. Findings: During an interview or stated the facility does faturdays. The annual lated 1/2/15, indicate	T is not met as evidenced w and document review, the e the residents received n Saturdays for 3 out of 3 R15). This deficient practice ffect all 42 residents in the n 3/5/15, at 1:52 p.m. R23 a not deliver mail on al Minimum Data Set (MDS)		 Local post office start Saturday n Activity aides ha mail to resident Charge nurse, o audits to assure Saturday for 3 n QAA will review ensure compliar 	nail delivery to the fac ave been educated to s on Saturdays. r designee, will condu mail has been deliver nonths. audits for three mon- nce.	cility. deliver Ict weekh red on

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that obtained at a formation of 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.

DEPA <u>CENT</u>	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES				FOR	D: 03/20/20	ED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) D	O. 0938-03 ATE SURVEY OMPLETED	<u>91</u>
		245585	B. WING	i				
NAME O	F PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE	0	3/05/2015	\neg
TRAVE	RSE CARE CENTER				303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	N
F 17(Continued From page	ge 1	F 1	70				-
	stated the facility do	on 3/5/15, at 2:24 p.m. R35 es not deliver mail on rterly MDS dated 12/8/14, no cognitive deficit.						
	stated the facility do	on 3/5/15, at 2:45 p.m. R15 es not deliver mail on terly MDS dated 11/14/14, no cognitive deficit.						
	activities director (AE	on 3/5/15, at 2:45 p.m. the D) stated the mail does not urdays it is delivered on						
	the mail and there ar	on 3/5/15, at 3:03 p.m. the the activities staff delivers e activities staff working on ated she was not aware of ssed on Saturdays.						
	the activities coordina office was opened on delivered mail to the f stated there was not a p.m. activities aide bu	in 3/05/15, at 3:20 p.m. with ator (AC) she stated the post o Saturdays and they facility's mailbox. The AC a list of job duties for the at she would add it to the ated she didn't know it was						
	Review of the p.m. ac no print date on it, it d to the residents on Sa	tivities aide check list with id not include to pass mail aturdays.						
	The resident Mail polic April 2009, indicated a promptly and unopene	cy with a revision date of all mail is to be delivered ed.						

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If continuation sheet Page 2 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 245585 B. WING 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **303 SEVENTH STREET SOUTH** TRAVERSE CARE CENTER WHEATON, MN 56296 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 176 | Continued From page 2 F 176 F 176 483.10(n) RESIDENT SELF-ADMINISTER F 176 DRUGS IF DEEMED SAFE SS=D An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this F176 practice is safe. R46 has been assessed for self administration This REQUIREMENT is not met as evidenced of medication. by: Nurses have been re-educated on self Based on observation, interview, and document administration of medication policy. review, the facility failed to comprehensively assess, care plan, and obtain physician orders for All residents have been reviewed to ensure a self administration of medication for 1 of 1 self administration assessment has been resident (R46) whom was observed during medication administration. completed for residents who are appropriate for self administration. Findings include: Nurse Managers have been educated that self R46's Medication Administration Record (MAR) of administration assessments must be 3/2/15, indicated licensed practical nurse (LPN)-A completed upon admission, with change of had administered Amiodarone HCL 100 mg, condition, and on an annual basis. aspirin 81 mg, vitamin D 2000 units, Colace 100 mg, Nephrocaps 1 mg, Coreg 6.25 mg, Lasix 40 DON, or designee, will conduct audits three mg and Senna S 8.6 mg-2 tablets for a.m. times per week for three months to assure medications. that residents only are given meds to self R46 was observed on 3/2/15, at 7:35 a.m. sitting administer if that resident has a current self in an upright position in his bed with his bed side administration assessment. table in front of him eating breakfast QAA will review audits to ensure compliance. independently. At this time LPN-A bought R46's medication in a white paper medication cup and Completion date by: 4/8/2015 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00669

If continuation sheet Page 3 of 9

PRINTED: 03/20/2015

	TMENT OF HEALTH	AND HUMAN SERVICES			F	RINTE	D: 03/20/2015 MAPPROVED	5 ר
	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB N	<u>D. 0938-039</u>	1
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY	
		245585	B. WING	G				
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2015	-
TRAVER	RAVERSE CARE CENTER				303 SEVENTH STREET SOUTH			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			WHEATON, MN 56296			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 176	Continued From pag	ae 3	E 4	17				1
	At approximately 7:3	38 a.m. LPN-A was asked if order for self administration	F1	170	0			
	of medication. LPN-	A stated "yes he does" and						
	she proceeded to lo	ok at R46's MAR. No found on the MAR, nor on						
	the standing house of	orders, or the care plan. At						
	room after not findin	a.m. LPN-A returned to R46's g a self administration order						
	to watch him take his	s medication, but R46 had						
	on his bedside table	edications that LPN-A had left . At this time LPN-A verified						
	R46 had already take supervision.	en his medications with no						
	of R46's MAR, stand orders, care plan, an	ations without any						
	have a self administra no care plan and no a completed to self adn R46 receiving his me a.m RN-A verified th)-A confirmed R46 did not ation order from the doctor, assessment had been ninister medications prior to dications on 3/2/15, at 7:35 nat LPN-A should not have in his room without an order						
e e	confirmed that R46 di	/2/15, at 12:59 p.m. LPN-A d not have a order to self ations and stated, "I did not e an order."						
C	During interview on 3/ of nursing (DON) cont	2/15, at 1:07 p.m. director firmed R46 did not have a						

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DEPAF CENTE	RTMENT OF HEALTH ERS FOR MEDICABE	AND HUMAN SERVICES				FORI	D: 03/20/2015 M APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		245585	B. WING	à		05	0.05/2015
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03	3/05/2015
TRAVE	RSE CARE CENTER				03 SEVENTH STREET SOUTH /HEATON, MN 56296		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
SS=D	self administration of plan and no assess self administer medi his medications on 3 verified RN-A had cor received an order ar in the day on 3/2/15, have the order becau taking his medication drug seekers, so we The DON confirmed R46's room until he to there was no order to medications. Review of facility poli of Medications, dated individual resident mai if the resident request team has determined this practice. The pol complete a self admi obtain a physicians of residents care plan to administer the specifit 483.25(I) DRUG REC UNNECESSARY DR Each resident's drug unnecessary drugs. A drug when used in ex duplicate therapy); or without adequate mor indications for its use;	and the interdisciplinary is and the interdisciplinary is and the resident to self a continued, or any easons above.	F 1	29	F329 R4's drug regimen and medica been reviewed with physician accordingly and proper diagno completed for the use of Amit Nurse Managers have been re when to complete sleep logs r resident medications for depro Facility policy has been update with Nurse Managers. DON, or designee, will conduct for three months. QAA will review audits to ensu Completion date by: 4/8/2015	and upda osis has be triptyline. e-educated regarding ession. ed and rev t weekly a	ated een d on viewed audits

Facility ID: 00669

If continuation sheet Page 5 of 9

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARF	AND HUMAN SERVICES				FOR	D: 03/20/2015
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DELE CONSTRUCTION	(X3) D,	O. 0938-0391 ATE SURVEY DMPLETED
		245585	B. WING	ì	· · · · · · · · · · · · · · · · · · ·		2/05/2015
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	3/05/2015
TRAVER	TRAVERSE CARE CENTER				303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG			ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	resident, the facility who have not used a given these drugs u therapy is necessary as diagnosed and do record; and resident drugs receive gradu behavioral interventi	ge 5 hensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug y to treat a specific condition ocumented in the clinical s who use antipsychotic al dose reductions, and ons, unless clinically n effort to discontinue these	F	329			
- - - - - - - - - - - - - - - - - - -	by: Based on interview a facility failed to identi the continued use of prescribed as a sleep reviewed receiving a to identify non-pharm aid with sleep. Findings include: R4's annual Minimum I/12/15, identified R4 mpairment, had diag dementia, anxiety and have trouble falling as corresponding Care A	a aid for 1 of 5 resident (R4) n antidepressant, and failed acological interventions to n Data Set (MDS) dated had moderate cognitive noses which included d depression, and did not sleep or staying asleep. The area Assessment (CAA)					
F a a	lifficulty. The facility f Record, dated 2014, I Isleep between 11 ar	ble to sleep all night without orm titled Insomnia/Sleep R4 routinely had fallen Ind 12 o'clock p.m., remained tween 6 and 7 o'clock a.m					

Facility ID: 00669

If continuation sheet Page 6 of 9

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				FOF	D: 03/20/20	
STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G	(X3) D	O. 0938-03 ATE SURVEY OMPLETED	
		245585	B. WING			00/05/00/7		
NAME OI	F PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	3/05/2015	
TRAVE	RSE CARE CENTER				303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID					
PRÉFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		(X5) COMPLETIO DATE	
F 329	Continued From page	ge 6	F 3	29	9			
	R4 had been prescr (milligrams) one tim admit to the facility o	ibed Amitriptyline HCL 25 mg e a day for insomnia, prior to 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."							
	registered nurse (RN Amitriptyline for slee RN-A verified the sta was 1/31/13, prior to 2/5/13. RN-A stated t evaluate a resident n in sleep was to review with a "sleep log for 7 RN-A verified the only	on 3/05/2015, at 1:51 p.m. J)-A verified R4 did receive p. With review of R4's record int date of the Amitriptyline R4's admission date of the usual facility practice to eceiving a medication to aid w the resident's sleep pattern 7 days every 6 months." y sleep study found for R4 indicated no sleep difficulty.						
	the director of nursing follow through for the sleep aid, which woul	n 3/05/2015, at 4:01 p.m. g (DON) verified the lack of use of Amitriptyline as a d include the care planned iew of R4's sleep pattern.						
F 428 SS=D	A requested facility po 483.60(c) DRUG REC IRREGULAR, ACT O	blicy was not provided. GIMEN REVIEW, REPORT N	F 428	8				
	The drug regimen of e reviewed at least once pharmacist.	each resident must be e a month by a licensed						
	7(00.00) D							

Facility ID: 00669

If continuation sheet Page 7 of 9

	T OF DEFICIENCIES	& MEDICAID SERVICES				/ APPROV). 0938-03
AND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DA	TE SURVEY MPLETED
		245585	B. WING		03	/05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE 100	03/2013
TRAVER	SE CARE CENTER			303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 428	Continued From page	ge 7	F 428			
	the attending physic	st report any irregularities to ian, and the director of eports 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			 F428 R4's drug regimen and med been reviewed with physicil with proper diagnosis for m Process for provider review consultant recommendatio updated. DON, or designee, will cond after consultant visit for thr QAA will review audits to er Completion date by: 4/8/20 	ian and updat nedication use of pharmacy ns has been luct monthly a ee months. nsure complia	ed · udits
F (Record, dated 2014, asleep between 11 ar asleep and awoke be R4 had been prescrib	R4 routinely had fallen nd 12 o'clock p.m., remained tween 6 and 7 o'clock a.m ed Amitriptyline HCL 25 mg a day for insomnia, prior to				

If continuation sheet Page 8 of 9

		AND HUMAN SERVICES			Р		D: 03/20/2015
STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	MB N	O. 0938-0391 ATE SURVEY DMPLETED
	NAME OF PROVIDER OR SUPPLIER		B. WING	i			2/05/0045
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2015
TRAVER	SE CARE CENTER				303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE
	address R4's insom pharmacological interviewed nursing assistant (N. behaviors "when she During an interviewed registered nurse (RN Amitriptyline for slee RN-A verified the sta was 1/31/13, prior to 2/5/13. RN-A stated evaluate a resident r in sleep was to revie with a "sleep log for RN-A verified the only was dated 2014, and During an interviewed the director of nursin follow through for the sleep aid, which wou interventions and rev During a phone interviewed R4's care p nterventions to aid w reviewed the record f consulting pharmacis and instructions for the ncorporate sleep mo non-pharmacological esident's care and tra aid was ordered.	nia and lacked non- erventions to aid with sleep. on 3/05/2015, at 1:41 p.m. A)-A stated R4 displays e gets tired and can't sleep." on 3/05/2015, at 1:51 p.m. N)-A verified R4 did receive p. With review of R4's record art date of the Amitriptyline R4's admission date of the usual facility practice to eceiving a medication to aid w the resident's sleep pattern 7 days every 6 months." y sleep study found for R4 I indicated no sleep difficulty. on 3/05/2015, at 4:01 p.m. g (DON) verified the lack of e use of Amitriptyline as a ld include the care planned iew of R4's sleep pattern. <i>v</i> iew on 3/5/15, at 5:20 p.m. acist indicated she had not lan for non-pharmalogical ith sleep, nor had she or sleep monitoring. The t verified her expectation he facility had been to nitoring and	F 4	128			

Facility ID: 00669

If continuation sheet Page 9 of 9

lec. 4.8 with

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.

							03/13/2015 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER					PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
245585				B. WING		03/06/2015	
	ROVIDER OR SUPPLIER SE CARE CENTER		303 SE\		STATE, ZIP CODE REET SOUTH 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000	1		
	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.					•	
	the construction dat original building (Bla was constructed in be of at least Type I story with partial ba with fire sprinklers. 100, 200 and 600 V Chapter 19 Existing a fire alarm system automatic fire depai detectors in all resid corridors as well as with magnetic hold- capacity of 49 beds time of the survey.	veyed as two buildings. dg. 1) 1967 and was detern I(111) construction. Isement and is fully p This building consist Vings and was surve Health Care. The f that is monitored for thent notification ar dent rooms, areas op by barrier doors hel- openers. The facility and had a census of 42 CFR, Subpart 48	The mined to lt is 1 protected is of the yed to acility has acility has ond smoke ben to the d open thas a of 46 at the				
LABORATO	RY DIRECTOR'S OR PROV	DER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	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.

Printed: 03/13/2015

	MENT OF HEALTH		ICES +	5585	024		APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - 2ND BUILDING		(X3) DATE SURVEY COMPLETED		
		245585		B. WING		03/0	6/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
TRAVER	SE CARE CENTER			VENTH ST 'ON, MN 5	REET SOUTH 6296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	ES	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	Minnesota Departm Fire Marshal Divisio Traverse Care Cen compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conduct nent of Public Safety, on. At the time of this ter was found in sub requirements for pa id at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc 01, Life Safety Code ealth Care.	, State s survey, stantial articipation art e 2000 ciation				
	the construction da was constructed in be of Type V(111) of no basement and is sprinklers. This buil and 500 Wings. and New Health Care. T system that is moni department notifica resident rooms, are well as by barrier de hold-openers. The	rveyed as two building tes of the buildings. 2005 and was detern construction. It is 1 st s fully protected with lding consists of the d was surveyed to C The facility has a fire itored for automatic f tion and smoke deter as open to the corric cors held open with a facility has a capacit hsus of 46 at the time	Building 2 mined to fory with fire 300, 400 hapter 18 alarm fire ectors in all dors as magnetic y of 49				
	The requirement at MET.	42 CFR, Subpart 48	33.70(a) is	1			
LABORATO	RY DIRECTOR'S OR PROV	UDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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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.

Printed: 03/13/2015

	-	ID HUMAN SERVICES					FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245585	B. WING				03/06/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH				
				V	VHEATON, MN 56296		1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
K 000	INITIAL COMMENTS	к	000					
	FIRE SAFETY							
	A Life Safety Code Su Minnesota Departmen Fire Marshal Division Traverse Care Center compliance with the r in Medicare/Medicaid 483.70(a), Life Safety edition of National Fir (NFPA) Standard 101 Chapter 19 Existing F							
	the construction dates original building (Bldg was constructed in 19 be of at least Type II(story with partial base with fire sprinklers. Th 100, 200 and 600 Wir Chapter 19 Existing H a fire alarm system th automatic fire departr detectors in all reside corridors as well as b with magnetic hold-op capacity of 49 beds a time of the survey.	967 and was determined to 111) construction. It is 1 ement and is fully protected his building consists of the ngs and was surveyed to Health Care. The facility has						
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED: 03/20/2015

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM							APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2ND BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245585	B. WING			03	/06/2015	
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE				
TRAVERS	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)			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS		кo	000				
	FIRE SAFETY							
	A Life Safety Code Si Minnesota Departme Fire Marshal Division Traverse Care Cente compliance with the r in Medicare/Medicaid 483.70(a), Life Safety edition of National Fir (NFPA) Standard 101 Chapter 18 New Hea							
	the construction date was constructed in 20 be of Type V(111) cor no basement and is f sprinklers. This buildi and 500 Wings. and v New Health Care. Th system that is monito department notification resident rooms, areas well as by barrier door hold-openers. The fact	eyed as two buildings due to s of the buildings. Building 2 005 and was determined to nstruction. It is 1 story with ully protected with fire ng consists of the 300, 400 was surveyed to Chapter 18 e facility has a fire alarm red for automatic fire on and smoke detectors in all s open to the corridors as ors held open with magnetic cility has a capacity of 49 us of 46 at the time of the						
	The requirement at 4. MET.	2 CFR, Subpart 483.70(a) is						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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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