DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 11, 2023

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

RE: CCN: 245585
Cycle Start Date: March 16, 2023

Dear Administrator:

On May 5, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2023

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

RE: CCN: 245585
Cycle Start Date: March 16, 2023

Dear Administrator:

On March 16, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 16, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by September 16, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

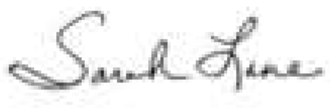
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/13/23, to 3/16/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		4/26/23

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

Electronically Signed | 04/21/2023

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

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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community exercise, or a facility-based exercise to test their emergency preparedness program twice per year or to document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This deficient practice had the potential to affect all 33 residents who currently resided in the facility, along with staff who work in the facility. Findings include: During an interview on 3/16/23, at 1:00 p.m. the administrator was interviewed regarding the facility's Emergency Preparedness Plan. The administrator stated she believed the facility participated in a full scale exercise and a table top exercise before she had started at the facility in 7/22, however, administrator was not able to locate any evidence or any documentation of the exercises being completed. Administrator confirmed she was unable to locate any documentation of the facility's Emergency Preparedness Program being activated related to an actual emergency in the past year.	E 039	EO39 Corrective Action Traverse Care Center will perform a community wide tornado drill on April 20th, 2023 and will complete a tabletop drill on April 24th, 2023 Identification of other Residents All residents have the potential to be affected Measures Put in Place Tasks have been created and input into our Tasks Management System (TELS) and Executive director has been educated on the requirement to perform 2 annual exercises/drills – 1 tabletop and 1 full scale. Monitoring Mechanisms QAPI will review Emergency preparedness exercises/drills Quarterly for the first year and annually thereafter. Compliance date is 04/26/2023	

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	245585	A. BUILDING _____ B. WING _____	C 03/16/2023

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F 000	Continued From page 10	F 000		
F 000	INITIAL COMMENTS On 3/13/23, to 3/16/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55859223C (MN00091782), H55859238C (MN00091579), H55859219C (MN00090416), H55859220C (MN00091460) and H55859160C (MN00091686). In addition, the following complaints were reviewed: H55859218C (MN00091681), H55859162C (MN00091682), H55859161C (MN00091684), H55859196C (MN00091685), and H55859239C (MN00091242) with a deficiency issued at (F550). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		4/26/23

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F 550	Continued From page 11 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 12 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain dignity for 1 of 1 resident (R30) who utilized an incontinent pad and wore a gait belt. Findings include: R30's significant change Minimum Data Set (MDS) dated 3/1/23, identified R30 was severely cognitively impaired and had diagnoses which included dementia, hypertension and coronary artery disease. Indicated R30 required extensive assistance of one staff with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Identified R30 was always incontinent of urine and continent of bowel and was not on a toileting program. R30's care plan revised on 3/14/23, indicated R30 required staff assistance with toileting, peri cares and changing the brief. Indicated staff were to toilet upon rising, between meals, at night time and as needed. R30's nursing assistant Kardex dated 3/15/23, indicated R30 required staff assistance with toileting upon rising, between meals, at night time, as needed as well as assistance with peri care and brief changes. R30's significant change Care Area Assessment (CAA) dated 3/1/23, indicated R30 was always incontinent, had urinary urgency and required staff assistance with toileting. During observations on 3/13/23, at 2:20 p.m. R30	F 550	F550 Residents Right/Exercise of Rights R30's medical record, care plan and living areas have been audited/evaluated. Education provided to nursing staff that white incontinent pad in view for others to see, and keeping gait belt on after cares and transfers is a dignity concern. White pad and gait belt were removed. All residents have the potential to be affected by this practice. All white incontinence protection items used to protect the furniture have been replaced by protective items the same coloring of the furniture to protect dignity. Gait belts were removed from residents' waists when not in use for cares, transfers, or ambulation. DON/Designee have provided staff education on the need to ensure residents rights and dignity by ensuring others cannot see any furniture protectors not the color of furniture, and that gait belts are to be removed when cares, transfers, or ambulation are not being provided. DON/Designee will develop audit to monitor compliance with no use of white colored furniture protectors, and gait belts are removed when not in use for cares, transfers, or ambulation. Audits will be completed to ensure compliance as follows: 5x a week for 2 weeks, 3x a week for 2 weeks, and weekly x1 month. A summary of the audit findings will be reported to the IDT at the monthly QAPI meeting for further recommendations.	

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F 550	Continued From page 13 was seated in a brown recliner out in the commons area by the fire place. A white incontinent pad was draped over R30's entire seat of the recliner and hung down the front and the sides of the recliner. The white incontinent pad was visible to other residents and visitors. - at 5:23 p.m. R30 remained seated in the brown recliner with the incontinent pad still visible to other residents and visitors. Nursing assistant (NA)-B placed a white gait belt around R30's waist and assisted R30 to stand with his walker in front of him. NA-B assisted R30 to walk down to the dining room area, had R30 sit down in his chair and immediately left. R30 continued to have a white gait belt around his waist. - at 5:49 p.m. R30 remained seated at the dining room table with the white gait belt around his waist while he ate his supper with other residents. - at 5:51 p.m. the director of nursing (DON) assisted R30 to stand up utilizing his walker and assisted him to walk down the hallway toward the commons area with the fire place. The DON assisted R30 to sit down on the brown recliner. A white incontinent pad was draped over R30's entire seat of the recliner and hung down the front and the sides of the recliner. The white incontinent pad remained visible to other residents and visitors. The gait belt around R30's waist remained around his waist. During observations on 3/14/23 at 9:20 a.m. R30 was seated in a chair out in the TV room, with his walker at his side and a white gait belt around his waist. - at 9:26 a.m. NA-C approached R30, assisted him to stand with his walker and gait belt around his waist and walked him to the commons area by the fire place. NA-C assisted R30 to sit down in a brown recliner and removed the gait belt from his	F 550	Compliance date is 04/26/2023	

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F 550	Continued From page 14 waist. A white incontinent pad was draped over R30's entire seat of the recliner and hung down the front and the sides of the recliner. The white incontinent pad was visible to other residents and visitors. - at 2:26 p.m. R30 was seated in a brown recliner in the commons area by the fire place and continued to have the white incontinent pad hanging on the recliner. - at 3:18 p.m. R30 remained the same. - at 3:50 R30 remained the same. NA-B approached R30 and began visiting with him. During this time, R30 requested a glass of water, NA-B provided R30 with a glass of water and immediately left the area. During observations on 3/15/23, at 7:26 a.m. was seated in a brown recliner out in the commons area by the fire place. A white incontinent pad was draped over R30's entire seat of the recliner and hung down the front and the sides of the recliner. The white incontinent pad was visible to other residents and visitors. - at 8:03 a.m. R30 remained the same. During an interview on 3/16/23, at 10:54 a.m. NA-D indicated R30 was incontinent of bladder at times, wore a brief and required staff assistance with toileting and incontinent brief changes. NA-D stated R30 required staff assistance with transfers and ambulation with the use of a gait belt and his walker. NA-D confirmed all the recliners in the commons area by the fire place had incontinent pads on them and identified they were used to protect the recliner from becoming soiled with urine. NA-D indicated it was not dignified to have the pads on the recliners and to leave gait belts around R30's waist for long periods of time. The NA-D stated staff attempted	F 550		

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F 550	Continued From page 15 to remember to remove the gait belts however have forgotten at times. During an interview on 3/16/23, at 11:15 a.m. the DON indicated R30 was incontinent of urine at times, wore a brief and required staff assistance with toileting and peri cares. The DON verifed the facility had white incontinent pads on all the recliners in the commons area by the fire place to protect the chairs from being soiled with urine. The DON indicated the facility only had the white colored incontinent pads and verifed staff should have been taking them off for dignity concerns. The DON stated when staff utilized the gait belts, they should be removed after use to maintain dignity. During an interview on 3/16/23, at 11:58 a.m. family member (FM)-B indicated staff have used the gait belt for R30 due to weakness and safety concerns. FM-B stated she would not want the gait belt left on for long periods of time due to it being uncomfortable for R30. FM-B indicated she would not want R30 seated on the incontinent pads out in the commons area due to them possibly being soiled with urine. FM-B stated she felt placing R30 on the pads and leaving the gait belt on was depressing and stated "this is their home." Review of the facility policy titled, Dignity-Quality of life revised on 10/2022, indicated the facility would provide recognition of his or her individuality, the facility would promote car for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.	F 550		
F 576 SS=C	Right to Forms of Communication w/ Privacy	F 576		4/26/23

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F 576	Continued From page 16 CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.	F 576		

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F 576	Continued From page 17 (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 5 of 5 residents (R1,R9, R21, R27 and R185) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 33 residents residing in the facility. Findings include: During a resident council meeting on 3/15/23, at 1:29 p.m. held with five residents, R1, R9. R21, R27 and R185 confirmed mail had not been consistently delivered on Saturdays at the facility. R1 stated they usually had to wait until Mondays to receive mail that had been delivered to the facility on Saturdays. During an interview on 3/15/23, at 2:18 p.m. social worker designee (SWD) stated the mail was delivered to the facility on Saturdays and activity aide (AA)-A was expected to deliver the mail to the residents. SWD was not certain why AA-A had not been delivering the mail on Saturdays. During an interview on 3/15/23, at 2:23 p.m. administrator confirmed residents had not been receiving mail on Saturdays. Administrator stated AA-A forgot to deliver the mail to the residents on Saturdays. Administrator indicated AA-A was not available for an interview. A facility policy titled Resident Mail dated 4/2008, revised 5/20, revealed all mail, letters, packages,	F 576	F576 Right to Forms of Communication w/Privacy R1, R9, R21, R27, and R185's medical record, care plan and mail delivery have been audited/evaluated. Education provided to staff regarding the need of mail delivery on days when mail is delivered. All residents have the potential to be affected by this practice. ED/Designee have provided staff education on the need to ensure residents mail is delivered daily when mail is delivered. DON/Designee will develop audits to monitor compliance with mail delivery on the days when mail is delivered. Audits will be completed to ensure compliance as follows: 5x a week for 2 weeks, 3x a week for 2 weeks, and weekly x1 month. A summary of the audit findings will be reported to the IDT at the monthly QAPI meeting for further recommendations. Compliance date is 04/26/2023	

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F 576	Continued From page 18 and other materials addressed to the resident were to be delivered to him/her promptly and unopened.	F 576		
F 577 SS=C	. Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 577		4/26/23

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F 577	Continued From page 19 Based on observation and interview, the facility failed to ensure three years of survey results were readily accessible for residents or visitors. This deficient practice had the potential to affect all 33 residents currently residing in the facility. Findings include: During an observation on 3/13/23, at 2:02 p.m. there was a white sign approximately four feet off the ground at the business office which identified the following: "Minnesota Department of Health (MDH) survey results. Surveys , certifications and complaint investigations conducted by Federal or State surveyors for the preceding three years are available for review upon request as well as any plans of correction in effect. Our most recent MDH survey is available in a white binder next to this notice." No white facility survey results binder was observed. No survey results were observed next to the notice. During an observation on 3/14/23, at 4:05 p.m. the facility survey results binder continued to not be present for residents and the public. The white sign continued to be posted. The facility lacked survey results being readily available for surveys completed form 5/2021, till present. During a resident council meeting on 3/15/23, at 1:29 p.m. where five residents were present. R1, R9, R21, R27 and R185 all stated they were unaware of where the facility's survey results were located.	F 577	F577 Right to Survey Results/Advocacy Agency Info R1, R9, R21, R27, R185s concern of not knowing where Facilities Survey Results Binder was kept was reviewed. All residents have the potential to be affected by this practice. A new sign designating where Facilities Survey Results Binder was kept was updated and Binder with results was placed in designated areas. ED/Designee have provided resident education to identified residents as well as resident council to educate on the location of the binder containing Survey results. The survey results binder was updated with most recent survey results and previous three (3) years of survey results. Staff were also inserviced on location of survey results binder location. ED/Designee will develop audit to monitor compliance to ensure Postings of location of Survey Results binder are present and accurate, as well as being in designated locations. Audits will be completed to ensure compliance as follows: 5x a week for 2 weeks, 3x a week for 2 weeks, and weekly x1 month. A summary of the audit findings will be reported to the IDT at the monthly QAPI meeting for further recommendations. Compliance date is 04/26/2023	

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F 577	Continued From page 20 During an interview on 3/14/23, at 4:24 p.m. director of nursing (DON) confirmed the above findings. DON confirmed the facility had a recertification survey completed in 5/2021, and had several complaint surveys completed since then. DON verified there was no binder readily available upon request for the last survey or for the past three years of facility surveys for the residents and the public. A facility policy titled Resident Rights dated 4/1/2008, revised 5/20, revealed residents had the right to examine the results of the most recent survey of the community conducted by Federal or State Surveyors and any plans of correction in effect with respect to the community. The policy identified the community would have three years of posting with respect to any surveys, certifications, and complaint investigations, for review upon request.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		4/26/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 21 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in all areas of the medical record for 1 of 5 residents (R1) reviewed for advanced directives. R1 's significant change Minimum Data Set (MDS) dated 3/1/23, indicated R1 was cognitively intact and had diagnosis which included cancer, hypertension, and diabetes mellitus (DM). Identified R1 required limited assistance from staff with bed mobility, transfers, and toileting	F 578	F578 Reques/Refuse/Dscntnue Trmnt; Formulate Adv Dir R1's medical record, care plan and Code Status was reviewed and corrected. Education provided to staff on the need for review of records and documents to ensure residents Code Status match and are correct to depict residents code status preference. All residents have the potential to be affected by this practice. All residents code status documents, orders and electronic medical records were audited to	

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	245585	A. BUILDING _____ B. WING _____	C 03/16/2023

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F 578	Continued From page 22 R1's current care plan dated 1/31/23, identified R1's advance directives were (do not resuscitate) DNR. Review of R1's electronic medical record (EMR) identified the following: -R1's Order summary Report identified physician order life-sustaining treatment (POLST) DNR dated 10/3/22. -R1's dashboard profile on computer screen identified Advance Directive DNR. Review of a black binder at the nurses station labeled POLST identified the following: -R1's Traverse Care Center Code Status Consent Form signed 6/10/22, identified Full Code - R1 wishes to be resuscitated. This resident was considered a "Full Code" status. In the same black binder behind the above documented identified the following: -R1's POLST signed 10/3/22, identified R1 as a DNR. During an interview on 3/14/23, at 10:45 a.m. R1 stated when she had first arrived at the facility she had wanted to be a full code status however she had recently changed her mind and decided to be a DNR code status. During an interview on 3/14/23, at 10:56 a.m. nursing assistant (NA)-A indicated her usual practice to locate a resident's code status was to review the dashboard on the computer. NA-A stated there was a binder at the desk however that would have been the last place she would have looked to locate a resident's code status During an interview on 3/14/23, at 11:03 a.m. trained medication aide (TMA)-A indicated her	F 578	ensure accuracy of code status. DON/Designee have provided staff education on the need to ensure Code Status orders, documents and electronic medical records match to ensure residents choice of code status is correctly documented. DON/Designee will develop audit to monitor compliance to ensure orders, documents and electronic medical records for code status are correctly documented to ensure wishes are carried out should code status need to be put in place. Audits will be completed to ensure compliance as follows: 5x a week for 2 weeks, 3x a week for 2 weeks, and weekly x1 month. A summary of the audit findings will be reported to the IDT at the monthly QAPI meeting for further recommendations. Compliance date is 04/26/2023	

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F 578	Continued From page 23 usual practice to locate a resident's code status was to review the dashboard on the computer. TMA-A stated there was a binder at the desk however she would have only looked there if she had been unable to access in the computer. During an interview on 3/14/23, at 11:06 a.m. licensed practical nurse (LPN)-A stated her usual practice to locate a resident's code status was to review the profile page in the computer. LPN-A pulled up the profile page which identified R1 was a DNR code status. LPN-A indicated there was a binder at the desk which contained the POLST for all residents if staff were not at the computer. During an interview on 3/15/23, at 11:46 a.m. director of nursing (DON) verified in the binder titled POLST at the nurses station, R1 had a signed code status sheet dated 6/10/22, which indicated R1 was a full code status and additionally, R1 had a signed POLST dated 10/3/22, which identified R1 was a DNR code status. DON stated her expectation would have been staff would first review the profile in the EMR to determine each resident's code status. DON stated the binder with the POLST would have been used secondary if a computer was not available. DON indicated her expectation would have been the EMR and the POLST binder would have matched since both have the potential to be used to determine a resident's code status. A facility policy titled Advanced Directives and Rights Regarding Treatment dated 4/2008, last revised 10/22, identified the resident had the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive. The policy indicated the	F 578		

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F 578	Continued From page 24 community promoted the rights by incorporating the residents choices regarding these rights into treatment, care and services and the resident's choices would have been documented and communicated to the interdisciplinary team.	F 578		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 640		4/26/23

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F 640	Continued From page 25 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Minimum Data Set (MDS) was accurately completed to reflect current health status for 1 of 1 residents (R12) with a unstagable pressure ulcer (full thickness tissue loss in which actual. depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed) who was reviewed for pressure ulcers. Findings include: During observations on 3/15/23, at 1:08 p.m. R12 was seated in her wheel chair in the commons area. R12 had blue pressure relieving boots on both feet, when the director of nursing (DON) approached R12 and informed her she was going to change the dressing on her foot. The DON wheeled R12 back to her room and gathered	F 640	F640 Encoding/Transmitting Resident Assessments R12's medical record, wound assessments, care plan and MDS were reviewed for accuracy. All residents have the potential to be affected by this practice. DON/Designee have provided staff education on the need to ensure that all wounds are staged properly, and weekly measurements are documented and discussed with MDS Coordinator or person entering data into MDS and transmitting following RAI manual instructions in completing/transmitting the MDS's. DON/Designee will develop audit to monitor compliance with accurate MDS entries for wounds ensuring correct staging is entered and transmitted.	

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F 640	Continued From page 26 supplies to complete the dressing change to her left heel area. The DON gloved her hands, removed R12's blue boot, sock and the old gauze and dressing from the left inner aspect of her heel. The area on R12's left heel had a small brown scabbed area measuring approximately 0.4 centimeters (cm) round and the surrounding outer skin was pink and blanchable. The DON removed her gloves, sanitized her hands, donned a new pair of gloves and cleaned the area with wound cleanser. The DON removed her gloves, sanitized her hands, donned a new pair of gloves and applied medi honey (wound gel) to a small Telfa dressing and applied it to R12's left heel area. The DON stated R12's heel started out as a blister a while ago and had become an unstagable ulcer with a black scab covering it on her left heel. The DON proceeded to wrap R15's left heel and ankle with gauze, removed her gloves, sanitized her hands and placed the blue boot on R12's left foot. Review of R12's Weekly Skin Check Tools from 11/14/22, to 3/11/23, revealed the following: - on 11/14/22, indicated the wound on R12's heel measured 1.5 cm x 1 cm, with a brown/black area and the edges separating from the wound edges. - on 12/14/22, indicated the wound measured 1.9 cm x 0.9 cm with a dark area on the medial side of heel and was tan/brown in color. - on 1/5/23, indicated the wound measured 1.8 cm x 0.4 cm with a yellow/brown base and the surrounding skin was red/pink in color. - on 1/29/23, indicated the wound measured 1.7 cm x 0.8 cm and the base of the wound was pink with yellow/gray and had a purple like scab. - on 2/19/23, indicated the wound measured 0.9 cm x 0.3 cm x 0.1 cm and the base of wound was pink and yellow on outer edges.	F 640	Audits will be completed to ensure compliance as follows: 5x a week for 2 weeks, 3x a week for 2 weeks, and weekly x1 month. A summary of the audit findings will be reported to the IDT at the monthly QAPI meeting for further recommendations. Compliance date is 04/26/2023	

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F 640	Continued From page 27 - on 3/5/23, indicated the wound measured 1.3 cm x 0.3 cm x 0.1 cm and had a yellow base covering one third of the wound. - on 3/11/23, indicated the wound measured 0.4 cm x 0.2 cm x 0.1 cm and the wound bed was pink with a small amount of white tissue noted around the edges. R12's significant change Minimum Data Set (MDS), dated 2/17/23, identified R12 had long and short term memory problems and had diagnoses which included dementia, diabetes mellitus and heart failure. Indicated R12 required extensive assistance of staff for bed mobility, transfers, dressing, toileting, bathing and personal hygiene. Identified R12 was at risk for pressure ulcers, had an unhealed pressure ulcer, had one stage two pressure ulcer and had no unstagable or deep tissue injuries. Indicated R12 was receiving an application of dressing to her feet. However, after further review, the pressure ulcer on her left heel had not been accurately staged and coded on the MDS. Review of R12's significant change Care Area Assessment (CAA) dated 2/17/23, indicated R12 was at risk for developing pressure ulcers, currenlty had a stage two pressure ulcer and to refer to her weekly skin tools. The CAA indicated staff would proceed with R12's current plan of care and the goal was to maintain skin integrity. During an interview on 3/15/23, at 1:55 p.m. the MDS coordinator confirmed R12 had a blister on her heel and stated she believed it had become unstagable. The MDS coordinator indicated the DON was responsible for completing wound rounds every week. The MDS coordinator stated she received her information from the wound	F 640		

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F 640	Continued From page 28 charting, guidance from other staff members which included the DON, the provider and followed the MDS manual for completion of the MDS's. During an interview on 3/15/23, at 2:10 p.m. with nurse consultant (NC)-A and NC-B, NC-A indicated R12's heel started out as a stage two blister and eventually the blister opened up. The NC-A indicated the orders were for staff to clean the area, place antibiotic ointment on it and apply a dressing. The NC-A confirmed the area had become soft, had some purulent drainage and she could not recall what the wound bed currently looked like. The NC-A indicated she thought the area on R12's heel had become a stage three ulcer, however was not certain. The NC-B confirmed R12's left heel ulcer had progressed to an unstagable ulcer due to not being able to visualize the wound bed. NC-B verifed the MDS's had not been completed inaccurately. During an interview on 3/16/23, at 9:58 a.m. the DON confirmed the above findings and indicated R12's heel started out as a blister and progressed into an unstagable ulcer with eschar tissue present on it. The DON stated the heel ulcer had been present since August, 2022, and it was healing. The DON stated she completed the assessment of the wounds and the MDS coordinator completed the actual coding on the MDS's. The DON indicated she would expect staff to refer to the MDS manual as a guide and to ensure the MDS was completed accurately. Review of facility policy titled, Nursing Documentation revised on 5/2020, indicated staff would complete the MDS per CMS and Medicare guidelines. Additionally, back-up documentation	F 640		

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F 640	Continued From page 29 from the nursing staff would be completed.	F 640		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with routine grooming which included facial hair removal and providing oral cares for 2 of 3 residents (R12 and R6) who was dependent upon staff for activities of daily living (ADLs). Findings include: R12 R12's significant change Minimum Data Set (MDS), dated 2/17/23, identified R12 had long and short term memory problems and had diagnoses which included dementia, diabetes mellitus and heart failure. Indicated R12 required extensive assistance from staff with bed mobility, transfers, dressing, toileting, bathing and personal hygiene. R12's significant change Care Area Assessment (CAA) dated 2/17/23, indicated R12 had long and short memory problems and required staff assistance with ADL's. R12's care plan dated 2/12/23, indicated R12 had actual complications with deficits with ADL's related to dementia. The care plan identified staff	F 677	F 677 ADL Care Provided for Dependent Residents R12, R6's medical record, care plan and Kardex were reviewed to ensure oral care and grooming were on the list of required ADL assistance. Cares were provided. All residents have the potential to be affected by this practice. Care Plan and Kardex's were reviewed and updated as needed to ensure ADL care level/needs are present. DON/Designee have provided staff education on the need to ensure residents ADLS are completed per the care plan/Kardex to ensure oral care, shaving and grooming are completed per Kardex. DON/Designee will develop audit to monitor compliance to ensure residents receive oral care, grooming and shaving. Audits will be completed to ensure compliance as follows: 5x a week for 2 weeks, 3x a week for 2 weeks, and weekly x1 month. A summary of the audit findings will be reported to the IDT at the monthly QAPI meeting for further recommendations. Compliance date is 04/26/2023	4/26/23

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F 677	Continued From page 30 were to assist R12 with personal hygiene. During observations on 3/13/23, at 7:14 p.m. R12 was seated in her wheel chair in the commons area across from the nurses station eating popcorn independently. R12 had several long white hairs approximately 1/4 inch long or longer on her chin area. R12 remained unshaven all evening until approximately 8:00 p.m. During observations on 3/14/23, at 9:29 a.m. R12 was seated in her wheel chair in the dining room area eating independently. R12 continued to have several long white hairs approximately 1/4 inch long or longer on her chin area. - at 2:23 p.m. R12 was lying in bed on her right side, with head of bed slightly elevated and was resting. R12's facial hair remained the same. - at 4:21 p.m. R12 remained the same. During observations on 3/15/23, at 9:06 a.m. R12 was lying in bed, nursing assistant (NA)-C entered the room, asked R12 if she was ready to get up for breakfast and R12 agreed. NA-C gathered his supplies and NA-D entered the room. NA-C and NA-D proceeded to provided morning cares by assisting R12 with getting washed up, providing incontinent cares and dressing R12. NA-C and NA-C transferred R12 via mechanical lift from her bed into her wheel chair. NA-D obtained a comb and began to comb R12's hair while NA-C collected the linen. NA-D proceeded to collect the garbage and dirty linen while NA-C covered R12's lap with a blanket. NA-C wheeled R12 out of her room and down to the dining room for breakfast. R12 had natural teeth in good condition and NA-C and NA-D were not observed to offer or provide oral cares to R12 while getting her ready for the day.	F 677		

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F 677	Continued From page 31 During an interview on 3/15/23, at 11:23 a.m. NA-C confirmed R12 required staff assistance with oral cares and shaving. NA-C verified R12 had her own teeth and he had not offered or provided oral cares or shaving to R12. During an interview on 3/16/23, at 9:43 a.m. NA-D confirmed R12 required staff assistance with oral cares, personal hygiene and shaving. NA-D verified she had not offered to shave or provide oral cares to R12. During an interview on 3/15/23, at 1:19 p.m. the director of nursing (DON) confirmed the above findings and indicated R12 required staff assistance with all of her ADL's. The DON stated she expected staff to assist residents with shaving and providing oral cares in the morning and in the evening. The DON indicated she would expect staff to follow R12's care plan. R6 Findings include: R6's significant change Minimum Data Set (MDS) dated 2/25/23, identified R6 had moderate cognitive impairment and had diagnosis which included hypertension, (elevated blood pressure) muscle weakness, and dementia. Indicated R6 required limited assistance from staff with bed mobility and required extensive assistance with transfers and dressing. Identified R6 required limited assistance from staff with personal hygiene. R6's current care plan dated 1/23/23, indicated	F 677		

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F 677	Continued From page 32	F 677		

R6 had deficits with activities of daily living (ADL's) related to history of traumatic brain injury, chronic limitation in right shoulder and dizziness. R6 required staff assistance with personal hygiene.

R6's significant change Care Area Assessment (CAA) dated 2/25/23, identified R6 required assistance with ADL's. Indicated R6 had generalized weakness and shortness of breath with exertion.

During an observation on 3/13/23, at 1:22 p.m. R6 was seated in a recliner in the day room and had dark long facial hair present on his chin, above his lips and on his cheeks which were approximately 1/4 an inch or longer.

During an observation on 3/14/23, at 9:51 a.m. R6 was seated in his wheelchair in the day room and continued to have long dark facial hair on his chin, above his lips and on his cheeks that were approximately 1/4 an inch or longer.

- at 11:58 a.m. facial hair remained the same as he ate lunch sitting in his wheelchair in the dining room.

During an interview on 3/13/23, at 6:07 p.m. family member (FM)-A stated R6 would not have liked to have long facial hair and wished the facility would have shaved R6 at least two or three times per week.

During an interview on 3/14/23, at 2:15 p.m. nursing assistant (NA)-B stated R6 required assistance from staff to shave. NA-B stated she was unsure how often R6 had been shaved. NA-B indicated the long dark facial hair on R6's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33 face appeared to be more than a few days growth. During an interview on 3/14/23, at 2:27 p.m. NA-C stated staff were expected to shave residents when the facial hair became visible. NA-C stated R6 had visible long facial hair and confirmed he had not offered to shave R6 recently. NA-C indicated R6 was usually shaved once per week on his bath day. During an interview on 3/14/23, at 2:31 p.m. licensed practical nurse (LPN-A) stated her expectation was R6 would have been shaved daily. LPN-A verifed R6 had long dark facial hair and she was uncertain when the last time R6 had been shaved however it appeared it had been a while. During an interview on 3/15/23, at 11:46 a.m. director of nursing (DON) verified R6 required staff assistance with shaving. DON stated her expectation was R6 would have been shaved at least two or three times per week to avoid long facial hair. Review of a facility policy titled Activities of Daily Living- ADL dated 4/2008, last revised 10/22, revealed a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal hygiene.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2023**

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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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/16/2023. At the time of this survey, Traverse Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This facility was surveyed as one building due to no 2 hour fire barrier between the construction types and considered as the least fire resistive construction as per 8.2.1.3 (3) and with the adoption of the 2012 LSC, they are now considered existing buildings. Wings 100, 200.and 300 were constructed in 1967 and was determined to be of Type II(111) construction. It is 1 story with partial basement and is fully protected with fire sprinklers with smoke detectors in the corridors and spaces	K 000		

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	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2023**

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K 000	Continued From page 2 open to the corridors. Wings 300, 400 and 500 were constructed in 2005 and was determined to be of Type V(111) construction. It is 1 story with no basement and is fully protected with fire sprinkler with smoke detectors in the resident rooms and spaces open to the corridors. The facility is separated by one two hour fire barrier and 4 smoke barriers. The entire building is considered type V (111) due to the fire barrier separating the two has 20 minute doors only. The facility has a capacity of 47 beds and had a census of 43 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 211	K-211 Corrective Action Traverse Care Center has removed all storage items and miscellaneous equipment in the means of egress by the employee exit. Identification of other Residents Residents in this area have the potential	4/26/23

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K 211	Continued From page 3 On 03/16/2023 between 1:00pm and 4:00pm, it was revealed by observation that there was storage items and miscellaneous equipment in the egress stairwell landing by employee exit. An interview with the Facility Administrator verified this deficient finding at the time of discovery.	K 211	to be affected. Measures Put in Place Plant operations staff have been educated on NFPA 101 (2012 Edition) sections 19.2.1 and 7.1.10.1 and will be responsible for auditing means of egress. Monitoring Mechanisms Plant operations staff or designee will conduct weekly audits for 3 months of the means of egress to ensure a clear path is maintained and report results at QAPI. Compliance date is 04/26/2023	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		4/26/23

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 03/16/2023, between 1:00pm and 4:00pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Facility Administrator verified this deficient finding at the time of discovery.	K 324	K-324 Corrective Action Hood Suppression System was inspected by Summit Fire Protection in December of 2022 and June of 2022 and reports were received to verify completion. Identification of other Residents No other residents were affected. Measures Put in Place Schedule has been set up with Summit Fire Protection to do a semi-annual inspection in June and an annual inspection in December of every year. Tasks were created in our Tasks Management System (TELS) to manage completion of these inspections. Monitoring Mechanisms Plant Operations Staff or designee will audit hood suppression records on a semi-annual basis and report findings at QAPI. Compliance date is 04/26/2023	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		4/26/23

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K 345	Continued From page 5 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/16/2023, between 1:00pm and 4:00pm, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Facility Administrator that the facility could not provide current documentation verifying that a semiannual inspection of initiating devices had been completed. 2. On 03/16/2023, between 1:00pm and 4:00pm,, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Facility Administrator that the facility could not provide an annual fire alarm testing documentation that provided a complete listing of each individual device tested, to include device type, address, location and the test results for each individual device. An interview with the Facility Administrator verified these deficient findings at the time of	K 345	K-345 Corrective Action Annual Fire alarm testing was done in January of 2023. Semi Annual inspection is scheduled to be done in June of 2023. Identification of other Residents All residents have the potential to be affected Measures Put in Place Schedule has been set up with Summit Fire Protection to do a semi-annual inspection in June and an annual inspection in December of every year. Tasks were created in our Tasks Management System (TELS) to manage completion of these inspections. Monitoring Mechanisms Plant Operations Staff or designee will audit Fire Alarm System Testing records on a semi-annual basis and report findings at QAPI. We will identify each individual smoke detector for the annual and semi-annual fire alarm testing which will be provided to us by our inspection company which is summit. Compliance date is 04/26/2023	

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K 345	Continued From page 6 discovery.	K 345		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/16/2023, 1:00pm and 4:00pm, during documentation review it was revealed that the facility was without a fire watch policy or fire watch documentation for a fire alarm system outage. An interview with the Facility Administrator verified this finding at the time of discovery.	K 346	K346 Corrective Action Traverse Care Center created a Fire Protection Systems Out of Service Policy that addresses notification to the State Fire Marshal if the building fire alarm system is out of service for more than 4 hours and if the sprinkler system is out of service for more than 10 hours in a 24-hour period. The policy also addresses fire watch procedures. Identification of other Residents All residents have the potential to be affected Measures Put in Place Staff were educated on the Fire Protection Systems out of service Policy and Fire Watch Procedures. Monitoring Mechanisms Fire Protection System Out of Service Policy and Fire watch Procedures will be trained upon hire of new staff and annually thereafter. Training records will	4/26/23

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K 346	Continued From page 7	K 346	be audited once a month for 3 months and quarterly thereafter and findings reported at QAPI. Compliance date is 04/26/2023	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact	K 351	K351 Corrective Action Materials were removed from top of storage rack to give 18-inch clearance to sprinkler head. Identification of other Residents No other residents were affected. Measures Put in Place Tape was placed on wall marking 18 inches from sprinkler head and culinary	4/26/23

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K 351	Continued From page 8 on the residents within the facility. Findings include: On 03/16/2023, between 1:00pm and 4:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in kitchen store room. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 351	staff were educated that they cannot store anything above this line. Monitoring Mechanisms Plant operations staff or designee will inspect the storage room weekly for 3 months and monthly thereafter and report findings at QAPI. Compliance date is 04/26/2023	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/16//2023 between 100pm and 4:00pm, it	K 355	K355 Corrective Action Annual Fire Extinguisher inspection was completed in April of 2023. Identification of other Residents All residents have potential to be affected. Measures Put in Place Annual Schedule was put in place with Summit Fire Protection to complete annual inspection December of every Year. Task was created in our Tasks Management System (TELS) to manage	4/26/23

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K 355	Continued From page 9 was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with Facility Administrator verified this deficient finding at the time of discovery.	K 355	completion of this inspection. Monitoring Mechanisms Plant Operations Staff or designee will inspect fire extinguishers on a monthly basis and report findings to QAPI. Compliance date is 04/26/2023	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespreed impact on the residents within the facility. Findings include: 1) On 03/16/2023 between 1:00pm and 4:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors at east end	K 372	K372 Corrective Action Penetration above doors at east end of dining room by office 107 and above door on east end of nurse station were sealed with fire caulk. Identification of other Residents All residents have potential to be affected. Measures Put in Place Visual inspections of walls near smoke barriers and fire walls has been added to our Tasks Management System (TELS) to manage completion of this inspection.	4/26/23

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K 372	Continued From page 10 of dining room (by office 107) 2) On 03/16/2023 between 1:00pm and 4:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors at east end of Nurse Station. An interview with Facility Administrator verified these deficient findings at the time of discovery	K 372	Monitoring Mechanisms Plant operations staff or designee will inspect walls in or near smoke barrier and fire walls for damage or holes monthly and record results in TELS and report at QAPI. Compliance date is 04/26/2023	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 8.5.4.1 and 8.5.4.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 374	K374 Corrective Action Smoke doors on west end of dining room were fixed and now close and latch. Identification of other Residents All residents have potential to be affected. Measures Put in Place Inspections of corridor doors have been	4/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2023**

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
K 374	Continued From page 11 On 03/16/2023 between 1:00pm and 4:00pm, it was revealed by observation that smoke barrier doors on west end of dining room did not completely close when tested. An interview with the Facility Administrator verified this deficient finding at the time of discovery.	K 374	added to our Tasks Management System (TELS) to manage completion of this inspection. Monitoring Mechanisms Plant operations staff or designee will inspect corridor doors monthly and record results in TELS and report at QAPI. Compliance date is 04/26/2023	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/16/2023 between 1:00pm and 4:00pm, it was revealed by a review of available	K 521	K521 Corrective Action Fire Damper inspection was completed on 12/5/2019 by Protection Systems Inc. Next scheduled inspection is 12/2023. Identification of other Residents No other residents have potential to be affected. Measures Put in Place Fire damper inspections have been added to our Tasks Management System (TELS) to manage completion of this inspection. Monitoring Mechanisms Fire Inspections will be audited, and	4/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2023**

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
K 521	Continued From page 12 documentation that the facility could not provide a fire damper inspection report. An interview with the Facility Administrator verified this deficient finding at the time of discovery.	K 521	results presented at QAPI quarterly. Compliance date is 04/26/2023	