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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RMHS
Facility ID: 00669

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245585**
2. STATE VENDOR OR MEDICAID NO. (L2) **145240100**

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

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **12/01/2010**
6. DATE OF SURVEY **04/12/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Gail Anderson, Unit Supervisor — Date : 04/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Mark Meath, Enforcement Specialist — Date: 05/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **04/05/2016** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On February 25, 2016 a standard survey was completed by the Departments of Health and Public Safety. The most serious deficiencies in the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. In addition, at the time of the standard survey, complaint investigation number H5585007 was conducted and found to be unsubstantiated.

Refer to the CMS 2567 for both health and life safety code along with the plan of correction.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245585

May 20, 2016

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

Dear Ms. Bergerson:

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

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

Effective April 4, 2016 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 18, 2016

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

RE: Project Number S5585026

Dear Ms. Bergerson:

On March 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 25, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 7, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2016, effective April 4, 2016 and therefore remedies outlined in our letter to you dated March 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245585		4/12/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 04/04/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 04/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GA/kfd	4/18/2016	28034	4/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245585	A. Building 01 - MAIN BUILDING 01 B. Wing	4/7/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/04/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	4/18/2016	36536	4/7/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/23/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245585	A. Building 02 - 2ND BUILDING B. Wing	4/7/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/04/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 4/18/2016	SIGNATURE OF SURVEYOR 36536	DATE 4/7/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RMHS
Facility ID: 00669

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **02/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sherri Softing, HFE NEII 03/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 04/01/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On February 25, 2016 a standard survey was completed by the Departments of Health and Public Safety. The most serious deficiencies in the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. In addition, at the time of the standard survey, complaint investigation number H5585007 was conducted and found to be unsubstantiated.

Refer to the CMS 2567 for both health and life safety code along with the plan of correction.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 15, 2016

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

RE: Project Number S5585026, H5585007

Dear Ms. Bergerson:

On February 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 25, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5585007.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 25, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5585007 that was found to be unsubstantiated.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 5, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 25, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

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

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 ______	02/25/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the standard survey completed on February 25, 2106, complaint H5585007 was unsubstantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to ensure care plan interventions for fall prevention were followed to minimize the risk of further falls for 2 of 3 resident (R45, R9) reviewed for accidents. Findings include: R45's current care plan dated 2/25/16 indicated R45 was at high risk for falls due to generalized muscle weakness, altered cerebral function	F 282	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute	4/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/24/2016

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

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F 282	Continued From page 1 secondary to cerebrovascular accident. The care plan instructed staff to assist R45 with ambulation and transfer. The care plan instructed staff to utilize a laser alarm when R45 was in his room to alert staff when he is trying to self transfer and to ensure R45's call light was with in reach to prevent further falls. Review of the current nursing assistant assignment sheet provided by the facility indicated R45 needed assistance of one staff for activities of daily living and transfers. The assignment sheet also indicated staff was to check on R45 often due to fall risk. The assignment sheet did not address the use of a laser alarm or having call light within reach. During continual observation on 2/23/16 from 12:13 p.m. until 3:45 p.m. During this time, although multiple staff members interacted with R45, he did not have his laser alarm in place throughout the observation. In addition, R45's call light was removed from reach for occupational therapy services and was not returned to his reach. Although staff had interactions with R45 throughout this period of time, no one activated his laser alarm or returned the call light to within his reach. R45 had been without his call light for approximately 1 hour of time. On 2/23/16 at 3:17 p.m. NA-C confirmed R45 did not have his laser alarm in place all day and did not have his call light in place when she returned to his room. "My bad. I should of put it in place when I left the room." At 3:45 p.m. NA-D verified R45's laser alarm was not in place.	F 282	an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F282 The facility failed to ensure fall prevention care planned interventions were in place and followed to minimize the risk of further resident accidents. Care planned falls risk interventions for R45 and R9 were immediately reviewed post survey and revised according to fall risks. For R45, the laser alarm was discontinued, replaced by a chair alarm for R45's recliner as resident has tendency to lean forward in an effort to turn off laser alarm. R45 wears gripper socks and is assist of 1 with gait belt for transfers. Call light is placed within reach while R45 is in room. For R9, Physical Therapy continues to recommend use of standing lift for first transfer in morning and prn when resident exhibits increased weakness. Following the morning transfer, R9 is assist of 1 with gait belt for pivot transfers. Anti-roll back brakes have	

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F 282	Continued From page 2	F 282		

On 2/25/16 at 10:03 a.m. director of nursing (DON) and administrator confirmed R45 was high risk for falls and verified R45's current care plan. The DON verified R45 had a recent fall and the intervention was to place a laser alarm. The DON stated "I would expect them to follow the care plan and have the interventions in place."

On 2/25/16 at 12:06 p.m. OT-A verified that R45 was to have his call light in reach at all times and stated she should have placed the call light within his reach. "I completely forgot about the call light."

Review of facility policy titled, Care Planning, dated 4/1/08, indicated the facility used the results of the assessments to develop and revise the resident comprehensive plan of care. The care plan included measurable objectives designed to meat the needs of the residents medical, nursing, mental and psychosocial needs, as identified the comprehensive assessment.

R9'S current care plan dated 1/3/16, indicated R9 was a high risk for falls related to being unaware of safety needs, confusion, gait, balance problems and wheeled self back and forth in his w/c. The care planidentified multiple interventions for R9 which included to wear appropriate foot wear, pressure alarm to his bed to alert staff if attempting to self transfer and for physical therapy (PT) to evaluate and treat as needed. In addition, R9's care plan identified to re-educate staff to stay in the bathroom with the resident, assist the resident back to his recliner when he got back to his room, toilet before going to bed and anti-rollback brakes on R9's w/c.

R9's undated nursing assistant (NA) care plan indicated R9 was to wear gripper socks at

Provider's Plan of Correction (F 282, continued):

been re-applied to R9's wheelchair; R9 wears gripper socks, is assisted to recliner upon going back to room and staff stays with resident while in bathroom. R9 is offered urinal at noc. Call light is placed within reach of R9 while in room. Geo-mat is not currently care planned/being used for R9 as mat currently identified as a trip hazard for resident. R9 is checked hourly when not in presence of staff or wife; wife aware to not provide assist to resident and makes staff aware of resident needs. CNA care guides were reviewed and revised to include current fall prevention interventions for R45 and R9. Nursing and therapy staff received education regarding fall risk care plans for R45 and R9 on 2/29/16.

All residents are at risk for falls.

Current therapy/nursing communication form is being revised to provide written communication of resident interventions between nursing and therapy staff. All facility staff will receive education on fall risks and care planning interventions to reduce the risk of resident falls.

5 random residents identified at high risk for falls will be monitored for appropriate fall risk care planning interventions in place weekly x 4 weeks, monthly x 2 months with findings reported monthly to QAPI Committee x 3 months with follow-up to recommendations of Committee.

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F 282	Continued From page 3 bedtime, pivot transfer except for the first thing in the morning, use a stand lift [mechanical device used for transfers) for pivot transfers to get out of bed and use a T bar (bed rail) for all bed transfers. In addition, to toilet R9 in the a.m., noon, 4 p.m., and as needed and to check the resident or change him if incontinent. Give the resident an urinal at midnight, 3:00 a.m. and 5:30 a.m. R9's quarterly Minimum Data Set (MDS) dated 1/27/16, indicated R9 had diagnoses which included non Alzheimer's dementia, depression and Schizophrenia. The MDS identified R9 had severe cognitive impairment. The MDS also indicated R9 had required total assistance with transfers, was not steady and needed assistance for transfers and ambulation. In addition, R9 required assistance with turning around, moving on and off the toilet and transfers between bed and chair or wheelchair. Review of R9's Fall Incident Reports (FIR) dated from 9/4/15 to 2/8/16 revealed R9 had 6 falls in the facility and revealed the following: On 9/4/16, at 4:40 p.m. the FIR revealed R9 fell in the bathroom. R9had self locking breaks on his w/c prior to the fall and the new intervention was to monitor R9 while in the bathroom. On 11/2/16, at 10:44 a.m. FIR revealed R9 fell in his room. The new fall intervention was to have staff assist R9 into his recliner chair as soon as he gets to his room. On 11/24/15, at 1:30 p.m. the FIR indicated that R9 fell in the bathroom. The Post Fall Risk Assessment revealed R9's current intervention in	F 282	Corrections to deficient practice will be completed by April 4, 2016.	

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F 282	Continued From page 4	F 282		

use was not to leave the resident alone in the bathroom. The new fall intervention was to re-educate staff that R9 can't be left alone in the bathroom.

On 12/21/15, at 1:20 p.m. the FIR indicated R9 fell in his room. The new fall intervention was R9 had a doctor appointment scheduled for that day due to the resident not feeling well and to rule out pneumonia.

On 1/6/16, at 11:30 a.m. FIR revealed R9 fell in his room. The new intervention was to have PT work with R9 due to increased weakness from pneumonia. Staff was to re-educate R9's wife to not assist him with transfers for their safety. A PT referral was made.

On 2/8/16, at 9:50 p.m. the FIR revealed R9 fell in his room. R9's new intervention was a pressure pad alarm for his bed to alert staff if R9 attempted to get up without assist, staff to toilet the resident at bedtime and offer every 2 hours.

During observation on 2/23/16, at 12:51 p.m. R9 had no anti roll roll back brakes on his w/c. He wa sleft alone in the dining room.

During observations on 2/24/16, from 6:27 a.m. to 7:04 a.m. R9 had no bed alarm on the bed.

On 2/23/16, at 1:16 p.m. NA-A stated they have used dycem in the resident's w/c, kept the resident in eye view and checked on him often because of his falls. NA-A stated a couple of weeks ago R9 had utilized alarms in his bed and w/c. NA-A stated R9's nursing assistant care sheet had indicated they were to check on the resident every 2 hours not leave the resident

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F 282	Continued From page 5	F 282		

unattended. At 2:30 p.m. NA-A stated there were no anti tip bars or anti roll back brakes on R9's w/c.

On 2/23/16, at 3:34 p.m. NA-E stated R9 had a mat on the floor after his last fall and was unsure if it was used after the resident's last fall. During visual inspection of R9's room NA-E verified R9 did not have an alarm on the bed or chair and no mat on the floor. NA-E stated the night R9 had fallen they put a gray mat on the floor and didn't know if R9 had alarms.

On 2/23/16, at 4:04 p.m., licensed practical nurse (LPN-A) confirmed R9 had an history of falls and had a bed alarm on his bed. LPN-A stated someone needed to sit with R9 in the bathroom. LPN-A indicated R9 had anti roll back brakes on his w/c. During visual inspection R9 was in his room, seated in his w/c and LPN-A verified there were no anti lock brakes on his w/c. In addition, LPN-A stated the type of w/c R9's had was changed out and she was not sure how long he had been without the anti roll back brakes on the w/c.

On 2/24/16, at 7:07 a.m. NA-A was in R9's room and confirmed there was no alarm on the resident's bed. NA-A stated she had tried to find an alarm last night and there were none. NA-A stated if R9's wife was not in the room they would check on him every hour and take R9 out of the room so they can have a visual checks of the resident. NA-A stated if R9 and his wife are in the room they like to have the door shut and if R9 was in the room alone the door was open.

On 2/24/16, at 9:30 p.m. Environmental Service Manager (ESM) stated he was notified by the

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F 282	Continued From page 6 director of nursing (DON) yesterday afternoon to put the anti lock roll back brakes back on R9's w/c. ESM stated therapy had changed out the w/c and therapy thought he hadn't needed them anymore. On 2/24/16, at 11:48 a.m. LPN-A stated the pressure alarm was placed on the mattress after R9's last fall on 2/28/16. LPN-A understood the alarm was functioning yesterday. LPN-A stated she was not sure if any other interventions were implemented since R9's pressure alarm was not working. On 2/24/16, at 1:23 p.m. the DON stated on 2/19/16, staff told her they needed an alarm for R9 and she ordered some alarms. The DON stated if R9 had no functional alarm then hourly resident's checks were to be implemented when R9's wife was not in the room. The DON stated R9's room door was shut for privacy, they don't check R9 when the wife was in the room and the wife would let staff know if R9 would need anything. The DON indicated she was not aware of R9's anti roll back brakes were not in place until yesterday at 4:00 p.m. The DON stated she had talked to Occupational therapy (OT) and OT was not aware they had care plan interventions and didn't think R9 would get out of his w/c. The DON indicated she had been told therapy had replaced R9's w/c and had not replaced the anti roll back brakes. The DON verified the pressure alarm was on R9's care plan, the alarm was to be on the bed, there was no documentation for hourly checks and R9 was to have anti roll back brakes.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		4/4/16

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F 323	Continued From page 7 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent fall safety interventions were implemented to minimize the risk for further falls for 2 of 3 residents (R45, R9) reviewed for accidents. Findings include: R45's current Medication Review Report, dated 2/14/16, indicated R45 had diagnoses which included Alzheimer's disease, dementia without behavioral disturbances and a history of falls. R45's admission Minimum Data Set (MDS) dated 11/24/15, indicated R45 required extensive assistance of one staff for ambulation, transfers, locomotion off and on unit, dressing, toileting, and personal hygiene. R45's MDS also indicated R45 was not steady and only stabilized with staff assistance for walking, moving from sitting to a standing position, turning and facing the opposite direction while walking, moving on and off toilet and surface to surface transfers. R45's Fall Risk Assessment completed on 2/17/16 , identified R45 had three or more falls in the last six months, had standing and sitting	F 323	F323 The facility failed to ensure consistent fall interventions were implemented to minimize the risk for further falls of residents. A new falls risk assessment and medication regimen review were completed for R45 and R9. Care plans and CNA care guides were reviewed and revised in accordance with findings. For R45, the laser alarm was discontinued, replaced by a chair alarm for resident's recliner as resident has tendency to lean forward in effort to turn laser alarm off. Resident wears gripper socks and is assist of 1 with gait belt for transfers. Call light is placed within reach while resident in room. For R9, Physical Therapy continues to recommend use of standing lift for first transfer in morning and prn when resident exhibits increased weakness. Following a.m., R9 is assist of 1 with gait belt for pivot transfers. Anti-roll back brakes have been re-applied to R9's wheelchair; resident wears gripper socks,	

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F 323	Continued From page 8 problems, used an assistive device/adaptive equipment and was able to use a call light independently. The Fall Risk Assessment also indicated R45 had problems with cognition, judgement, memory, safety awareness, pain and was a high risk to for falls due to self transfer. Review of R45's Minnesota Incident Reports (MIR) from 12/14/15 to 2/17/16 revealed R45 had 5 falls in the facility. On 2/17/16 at 3:49 p.m. R45 was found lying on his left side in-between the wheelchair and the recliner. R45 stated he was trying to transfer himself, R45 was confused, had impaired memory, improper foot wear, ambulating without assistance and no witness to fall. Review of R45's Post Fall Risk Assessment dated 2/17/16 at 4:00 p.m. revealed R45 was confused and was found laying on his left side on the floor in his room in-between the his wheelchair and recliner. R45 stated he tried to transfer himself to his wheelchair. R45 did not use his call light prior to the fall, had increased pain in left leg/hip and had been trying to self transfer to the chair. The report identified immediate interventions were to place a laser alarm, supervision from staff, and physical/occupational therapy to treat left leg/hip pain. During continual observation on 2/23/16, beginning at 12:13 p.m. R45 was seated in his recliner eating lunch. R45's laser alarm was sitting on top of his bed side table and was not being utilized. At 12:43 p.m. dietary staff entered R45's room and took his room tray out of his room. R45's laser alarm continued to sit on top of his bed side table. At 1:14 p.m. NA-C entered	F 323	resident is assisted to recliner upon going back to room and staff stays with resident while in bathroom and resident is offered urinal at noc. Call light is placed within reach of resident while in room. Geo-mat is not currently care planned/being used for R9 as mat is currently identified as a trip hazard for resident. R9 is checked hourly when not in presence of staff or wife; wife aware to not provide assist to resident and makes staff aware of resident needs. Education was provided to nursing and therapy staff regarding R45 and R9 fall risk care plan interventions on 2/29/16. All residents are at risk for falls. DON and Therapy Supervisor will review all current facility residents receiving therapy to review all current fall risk interventions to assure these interventions are in place. Current therapy/nursing communication form is being revised to provide written communication of resident interventions between nursing and therapy staff. Falls risk education will be provided to all staff. 5 random residents identified at high risk for falls through a falls risk assessment will be monitored weekly x 4 weeks, monthly x 2 months for appropriate fall risk care planning interventions in place with findings reported monthly to QAPI Committee x 3 months with follow-up to recommendations of Committee. Corrections to deficient practice will be completed by April 4, 2016.	

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F 323	Continued From page 9 R45's room and emptied R45's catheter bag, cleaned up supplies, placed R45's call light with in reach and left the room at 1:26 p.m. R45's laser alarm continued to sit on top of his bed side table. At 1:26 p.m. occupational therapy (OT)-A entered R45's room and stated she was going to be working with R45 on his transfers. OT-A unhooked R45's call light from his recliner and placed it on the chair on the other side of the room. OT-A placed a transfer belt around R45's waist and assisted R45 with several surface to surface transfers. During this time R45 was unsteady with the transfers and stated his "legs were tired." At 1:40 p.m. OT-A brought R45 out of the bathroom and had him transfer from his wheelchair to his recliner with assistance,and left the room at 1:44 p.m. R45's laser alarm was sitting on top of his bed side table and was not turned on. R45's call light remained across the room on the chair and out of reach for R45. At 1:47 p.m. OT-A entered the room and told R45 he had received a pain pill at 12:00 p.m. and would be getting another one soon. OT-A left the room without activating the laser alarm or providing the call light. At 2:05 p.m. NA-C entered R45's room and asked him if he needed anything. R45 stated "no" and NA-C left his room. At 2:07 p.m. NA-C entered 45's room,assisted R45 to wash his face and hands, change his shirt, and clean his glasses. At 2:23 p.m. NA-C asked R45 "where is your call light?" R45 stated "I don't know maybe it's on the chair." NA-C placed the call light to the right side of R45's recliner within his reach. NA-C left the room at 2:32 p.m. R45's laser alarm remained sitting on top of his bed side table not being utilized. At 2:35 p.m. a staff member entered R45's room and gave him a snack. R45 remained seated in his recliner until 3:45 p.m. R45's laser alarm was sitting on top of his bed	F 323		

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	245585	A. BUILDING ______ B. WING ______	02/25/2016

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

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F 323	Continued From page 10 side table not being utilized. On 2/23/16 at 3:17 p.m. NA-C confirmed R45 needed assistance by staff for ambulation and transfers. NA-C indicated she was not sure if R45 was a fall risk, but verified R45 was to have his laser alarm in place and his call light within reach. NA-C confirmed R45 did not have his laser alarm in place all day and did not have his call light in place when she returned to his room. NA-C stated the laser alarm should be on the floor in front of R45 so it went off when he got up. "My bad. I should of put it in place when I left the room." On 2/23/16 at 3:40 p.m. NA-D confirmed R45 needed assistance by staff for ambulation and transfers. NA-D indicated R45 was a high risk for falls stating "he has an alarm because he has been self transferring." NA-D also verified that R45 has been receiving therapy for his leg due to pain. Follow up interview on 2/25/16 at 9:11 a..m. NA-D confirmed R45 did have episodes of confusion and was forgetful at times. NA-D also verified R45 did not always make safe choices when transferring. At 3:45 p.m. NA-D entered R45's room, verified his laser alarm was not in place. NA-D took the laser alarm off the bedside table and placed it on the floor to the left side of R45. R45's current care plan dated 2/25/16 indicated R45 was at high risk for falls due to generalized muscle weakness, altered cerebral function secondary to cerebrovascular accident. The care plan instructed staff to assist R45 with ambulation and transfer. The care plan also directed staff to utilize a laser alarm when R45 was in his room and to ensure R45's call light was with in reach to	F 323		

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F 323	Continued From page 11 prevent further falls. Review of the current nursing assistant assignment sheet provided by the facility indicated R45 needed assistance of one staff for activities of daily living and transfers. The assignment sheet directed staff to check on R45 often due to fall risk. The assignment sheet did not address the use of a laser alarm or having call light within reach. On 2/25/16 at 9:24 a.m. licensed practical nurse (LPN)-A confirmed R45 needed assistance of staff for ambulation and transfers per his care plan. LPN-A also verified R45 would self transfer and stated "he is not cognitive enough to make those safe judgment calls." LPN-A verified R45 was to have a laser alarm in place to notify staff he was self transferring and stated "he should not be dong it himself." On 2/25/16 at 10:03 a.m. director of nursing (DON) and administrator confirmed R45 was high risk for falls and verified R45's current care plan. The DON indicated R45 had a recent fall and the intervention was to place a laser alarm to alert staff when self transferring. The DON indicated that R45 self transferred at times and did not cognitively understand his safety. The DON stated "I would expect them [staff] to follow the care plan and have the interventions in place." On 2/25/16 at 12:06 p.m. OT-A confirmed R45 needed assistance from staff with ambulation and transfers. OT-A also verified R45 was currently seeing therapy due to recent falls and leg pain. OT-A also indicated that R45 was not cognitively aware enough to have safety awareness. OT-A verified that R45 was to have a alarm in place	F 323		

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F 323	Continued From page 12	F 323		

and stated if the intervention was on the care plan staff should be doing it. OT-A also verified R45 was to have his call light within reach at all times. OT-A stated she knew she forgot to give R45 the call light and that it should be placed by him.

Review of facility policy titled, Accidents/Falls, dated 2/14 indicated the facility strived to promote safety, dignity and overall quality of life for its resident by providing an environment that is free from hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents.
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R9's quarterly Minimum Data Set (MDS) dated 1/27/16, indicated R9 had diagnoses which included non Alzheimer's dementia, depression and Schizophrenia. The MDS identified R9 had severe cognitive impairment, and required extensive assistance with his activities of daily living (ADL's). The MDS also indicated R9 had required total assistance with transfers, was not steady and needed assistance for transfers and ambulation. In addition, R9 required assistance with turning around, moving on and off the toilet and transfers between bed and chair or wheelchair. Further, the MDS identified R9 required the use of a walker and wheelchair (w/c) for ambulation.

Review of R9's Care Area Assessment (CAA) dated 1/22/16, identified R9 had severe cognitive impairment, had dementia which continued to progress and R9's cognition was expected to continue to decline. The Falls CAA identified R9 had 2 falls in the past quarter, had difficulty maintaining sitting balance and had an impaired balance during transitions. In addition, the Fall

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F 323	Continued From page 13 CAA identified R9 had instability with transfers, recent falls and antidepressant use. R9 required assistance with ADL's but did not consistently recognize the need due to decreased cognition. Frequent reminders were provided to call for assistance as needed. R9'S current care plan dated 1/3/16, indicated R9 was a high risk for falls related to being unaware of safety needs, confusion, gait, balance problems and wheeled self back and forth in his w/c. The care plan listed various interventions for R9 which included to wear appropriate foot wear, pressure alarm to his bed to alert staff if attempting to self transfer and for physical therapy (PT) to evaluate and treat as needed. In addition, R9's care plan identified to re-educate staff to stay in the bathroom with the resident, assist the resident back to his recliner when he got back to his room, toilet before going to bed and anti-rollback brakes on R9's w/c. R9's undated nursing assistant (NA) care plan indicated R9 was to wear gripper socks at bedtime, pivot transfer except for the first thing in the morning, use a stand lift [mechanical device used for transfers) for pivot transfers to get out of bed and use a T bar (bed rail) for all bed transfers. In addition, to toilet R9 in the a.m., noon, 4 p.m., and as needed and to check the resident or change him if incontinent. Give the resident an urinal at midnight, 3:00 a.m. and 5:30 a.m. Review of R9's Fall Incident Reports (FIR) dated from 9/4/15 to 2/8/16 revealed R9 had 6 falls in the facility and revealed the following: On 9/4/16, at 4:40 p.m. the FIR revealed the NA	F 323		

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F 323	Continued From page 14 had helped R9 onto the toilet in the bathroom, checked on him a few minutes later and found the resident on the floor on his back in the bathroom. The NA had informed R9 to put his call light on when he was done. In addition, the FIR indicated the resident was unsteady and needed help with transfers. There were no injuries. The Post Fall Risk Assessment revealed R9 had fallen 1 to 3 times in 3 months, was at risk for falls, had self locking breaks on his w/c prior to the fall and the new intervention was to monitor R9 while in the bathroom. On 11/2/16, at 10:44 a.m. FIR revealed R9 was in his room, noted to be laying on his back with feet facing his recliner with his head by the w/c. R9's wife stated the resident slid out of the w/c, did not hit his head and was tired from exercise class. R9 stated he slid out of the chair. In addition, R9 had gait imbalance and weakness, faintness. There was no injury. The Post Fall Risk Assessment revealed R9 had fallen in his room and was a high fall risk. The new fall intervention was to have staff assist R9 into his recliner chair as soon as he gets to his room. On 11/24/15, at 1:30 p.m. the FIR indicated that R9's wife had informed the charge nurse that R9 was on the floor in the bathroom. R9 was found laying on the floor on his back away from the toilet. R9 stated he lost his balance when he was trying to wipe himself and pull up his pants. The NA had checked on R9 3 times and the resident stated he wanted to stay on the toilet for a little longer. The FIR indicated R9 was forgetful, confused, and had a gait imbalance. The resident had not turned on the call light or waited for the NA to return to help him off the toilet. There were no injuries. The Post Fall Risk Assessment	F 323		

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F 323	Continued From page 15 revealed R9's current intervention in use was not to leave the resident alone in the bathroom. R9 had 1 to 3 falls in the past 3 months. In addition, the post summary findings indicated R9 needed to be on a Pal lift (mechanical lift) when being toileted, to lock it in place when toileting due to the resident standing without assistance. The new fall intervention was to re-educate staff that R9 can't be left alone in the bathroom. On 12/21/15, at 1:20 p.m. the FIR indicated kitchen staff had delivered a lunch tray to R9's room and R9 was found on the floor. R9 was face up and was partially under his w/c. There were no injuries. In addition, R9 was forgetful, confused, impaired memory, ambulating without assistance and had a recent illness. The Post Fall Risk Assessment revealed the fall occurred in R9's room, had 3 or more falls in the last 6 months and was at high risk for falls. The new fall intervention was R9 had a doctor appointment scheduled for that day due to the resident not feeling well and to rule out pneumonia. On 1/6/16, at 11:30 a.m. FIR revealed R9 was found sitting on the floor with his wife trying to hold his head up. R9 was trying to go to the bathroom and wash his hands. There were no injuries. The FIR indicated R9 was forgetful, had impaired memory and confused. The Post Fall Risk Assessment indicated R9 had fallen in his room, had problems with cognition, judgement, memory or safety awareness. R9 was at high risk for falls. The new intervention was to have PT work with R9 due to increased weakness from pneumonia. Staff was to re-educate R9's wife to not assist him with transfers for their safety. A PT referral was made.	F 323		

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On 2/8/16, at 9:50 p.m. the FIR revealed R9 was on the floor by his bed and his head was bleeding. Resident had stated he passed out and fell. R9 had a gash on his head and was taken to the hospital by an ambulance. R9 was confused, incontinent, had recent change in his medications, improper footwear and recent changes in cognition. The Post Fall Assessment revealed R9 was in his room when he had fallen, R9 had 3 or more falls with in the past 6 months, problems with cognition, judgement, memory or safety awareness. R9 was not steady on his feet and didn't have safety awareness and continued to be at high risk for falls. R9's new intervention was a pressure pad alarm for his bed to alert staff if R9 attempted to get up without assist, staff to toilet the resident at bedtime and offer every 2 hours.

Review of R9's progress noted revealed on 2/8/16, at 10:43 p.m. a nurse had been called into R9's room by a N-A who had stated R9 had fallen. The progress notes indicated when the nurse arrived there was another nurse holding pressure on R9's head, R9 had fallen and had a gash in his head. The progress note revealed there was an indentation and a lot of bleeding and R9 was sent to the hospital by ambulance to have stitches put in the resident's head. In addition, R9 had stated he had passed out and that is why he fell. The progress note revealed the nurse didn't believe that had happened.

Review of R9's Fall Assessments completed from 9/4/16 to 2/8/16 revealed he had multiple falls and was at high risk for falls.

Review of R9's physician progress notes from 9/5/15 to 2/23/16 revealed R9 had Alzheimer's

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F 323	Continued From page 17 disease without behaviors and was progressively declining. He was alert and not oriented with periodic falls. During observation on 2/23/16, at 12:51 p.m. R9 was wheeled in his w/c by staff to the north dining room and was left there. R9 began to self propel his w/c using his feet toward the hallway by his room. There were no anti roll roll back brakes observed on R9's w/c. At 12:56 p.m., R9 was sitting in his w/c in front of his recliner in his room and NA -A entered the resident's room to assist R9 to the bathroom. R9 required the assist of one and verbal cueing through out the procedure. R9 was assisted off the toilet, placed in his recliner in the room with one assist. During observations on 2/24/16, from 6:27 a.m. to 7:04 a.m. R9 was in his room lying on his back with his eyes open. R9's call light was attached to the bed covers near the head of the bed. There was no bed alarm observed on the R9's bed. On 2/23/16, at 1:16 p.m. NA-A stated the amount of assistance R9 needed would depend on how well the resident slept the night before. NA-A stated they use the Pal lift to get him out of bed in the a.m. NA-A stated R9 had fallen before and was getting more confused. NA-A stated R9 had transferred himself in the past. NA-A stated they have used dycem in the resident's w/c, kept the resident in eye view and checked on him often because of his falls. NA-A stated a couple of weeks ago R9 had utilized alarms in his bed and w/c. NA-A stated R9's nursing assistant care sheet had indicated they were to check on the resident every 2 hours not leave the resident unattended. At 2:30 p.m. NA-A stated there were no anti tip bars or anti roll back brakes on R9's	F 323		

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F 323	Continued From page 18	F 323		

w/c.

On 2/23/16, at 3:34 p.m. NA-E stated R9 had a history of falls and his last fall was out of his bed. NA-E understood R9 had a mat on the floor after his last fall and was unsure if it was used after the resident's last fall. During visual inspection of R9's room NA-E verified R9 did not have an alarm on the bed or chair and no mat on the floor. NA-E stated the night R9 had fallen they put a gray mat on the floor and didn't know if R9 had alarms.

On 2/23/16, at 4:04 p.m., licensed practical nurse (LPN-A) confirmed R9 had an history of falls, had a bed alarm on his bed and the resident had just fallen from the bed. LPN-A stated R9's other falls were in the bathroom and someone needed to sit with R9. LPN-A indicated R9 had anti roll back brakes on his w/c. During visual inspection R9 was in his room, seated in his w/c and LPN-A verified there were no anti lock brakes on his w/c. In addition, LPN-A stated the type of w/c R9's had was changed out and she was not sure how long he had been without the anti roll back brakes on the w/c.

On 2/24/16, at 7:07 a.m. NA-A was in R9's room and confirmed there was no alarm on the resident's bed. NA-A stated she had tried to find an alarm last night and there were none. NA-A stated if R9's wife was not in the room they would check on him every hour and take R9 out of the room so they can have a visual checks of the resident. NA-A stated if R9 and his wife are in the room they like to have the door shut and if R9 was in the room alone the door was open.

On 2/24/16, at 9:30 p.m. Environmental Service

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F 323	Continued From page 19 Manager (ESM) stated he was notified by the director of nursing (DON) yesterday afternoon to put the anti lock roll back brakes back on R9's w/c. ESM stated therapy had changed out the w/c and therapy thought he hadn't needed them anymore. On 2/24/16, at 11:48 a.m. LPN-A stated the pressure alarm was placed on the mattress after R9's last fall on 2/28/16. LPN-A understood the alarm was functioning yesterday. LPN-A stated she was not sure if any other interventions were implemented since R9's pressure alarm was not working. On 2/24/16, at 1:23 p.m. the DON stated on 2/19/16, staff told her they needed an alarm for R9 and she ordered some alarms. The DON stated if R9 had no functional alarm then hourly resident's checks were to be implemented when R9's wife was not in the room. The DON stated R9's room door was shut for privacy, they don't check R9 when the wife was in the room and the wife would let staff know if R9 would need anything. The DON indicated she was not aware of R9's anti roll back brakes were not in place until yesterday at 4:00 p.m. The DON stated she had talked to Occupational therapy (OT) and OT was not aware they had care plan interventions and didn't think R9 would get out of his w/c. The DON indicated she had been told therapy had replaced R9's w/c and had not replaced the anti roll back brakes. The DON verified the pressure alarm was on R9's care plan, the alarm was to be on the bed, there was no documentation for hourly checks and R9 was to have anti roll back brakes. The DON stated staff should have put the information on the care plan,	F 323		

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

F5585025

PRINTED: 03/24/2016
FORM APPROVED
OMB NO. 0938-0391

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	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _______________	**02/23/2016**

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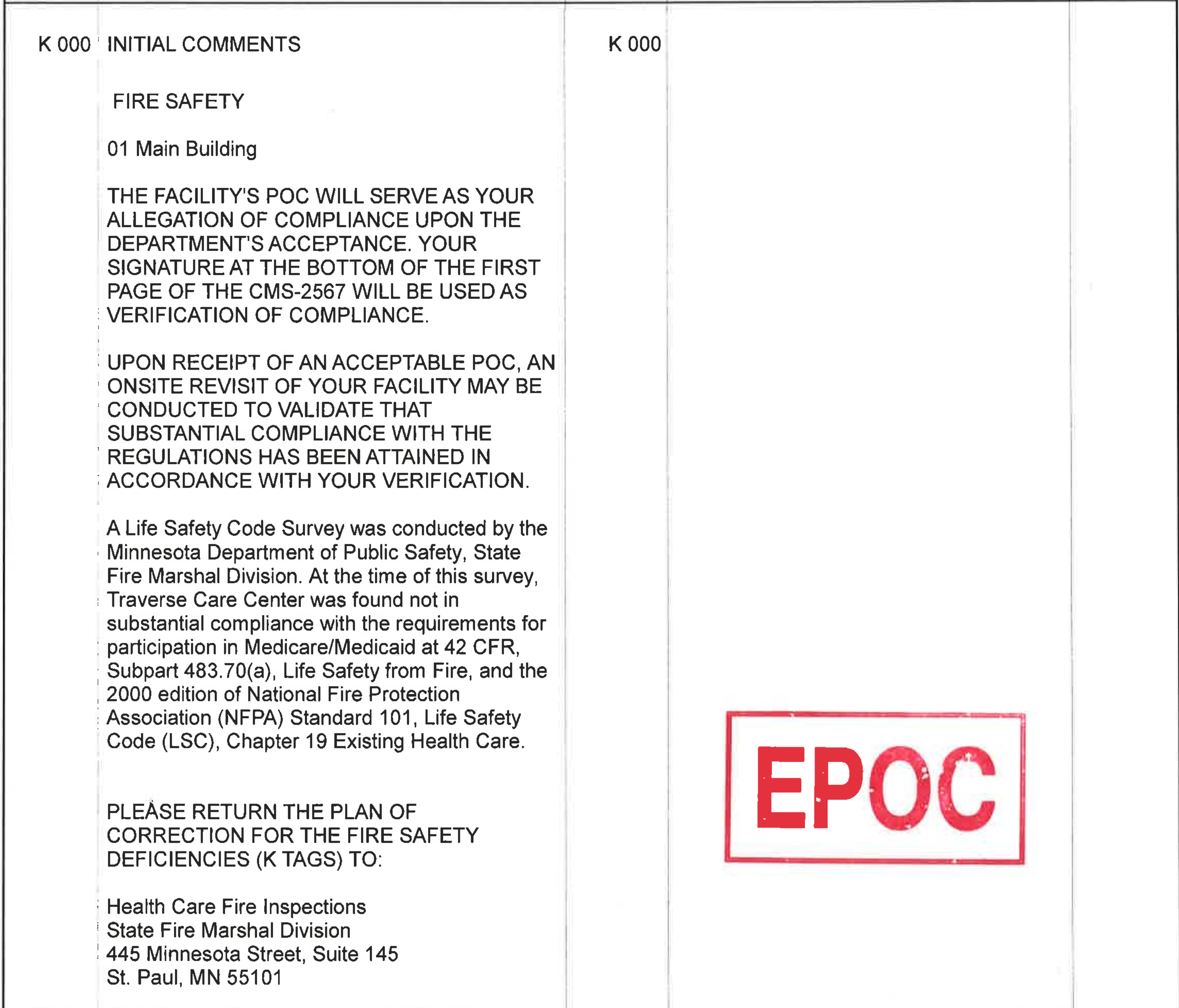

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/23/2016

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 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two buildings due to the construction dates of the buildings. The original building (Bldg. 1) was constructed in 1967 and was determined to be of at least Type II(111) construction. It is 1 story with partial basement and is fully protected with fire sprinklers. This building consists of the 100, 200 and 600 Wings and was surveyed to Chapter 19 Existing Health Care. The facility has a fire alarm system that is monitored for automatic fire department notification and smoke detectors in all resident rooms, areas open to the corridors as well as by barrier doors held open with magnetic hold-openers. The facility has a capacity of 49 beds and had a census of 41 at the time of the survey.	K 000		

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 ________	02/23/2016

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	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 41 residents and undetermined amount of staff and visitors Findings include: During the facility tour between 8:30 am to 12:00 pm on 02/23/2016 documentation review revealed the fire drills were not conducted during a range of times to cover varied conditions as required by the LSC (00) 18.7.1.2 and 19.7.1.2 This deficient condition was verified by the Maintenance Supervisor and the facility	K 050	K050 The facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. A fire drill was completed on 2/29/16. A calendar of alternating shift fire drills with varying times was developed by Environmental Services Manager to include a fire drill for each shift quarterly. The Environmental Services Manager was re-educated on the policy and procedure for completing monthly fire drills. The community Administrator or designated QAPI representative will conduct an audit 1x/month for three months to ensure continued compliance.	4/4/16

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 ______	**02/23/2016**

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 050	Continued From page 3 Administrator	K 050	The audit results will be reviewed at QAPI and recommendations will be made for continued review or compliance Correction to the deficient practice will be completed by April 4, 2016	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 41 residents, staff, and visitors. Findings include: During the facility tour between 8:30 am to 12:00 pm on 02/23/2016 documentation review revealed that the generator log did not contain a record of the 5 min. cool down period or the amperes of the monthly load test. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 144	K144 The facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The Environmental Services Manager will conduct a 5 minute cool down test of the facility generator. A 5 minute generator cool down test was added to emergency maintenance log to be checked monthly by Environmental Services Manager. The Environmental Services Manager was re-educated on the policy and procedure for generator operation. The community Administrator or designated QAPI representative will conduct an audit 1x/month for three months to ensure continued compliance. The audit results will be reviewed at QAPI and recommendations will be made for continued review or compliance Corrections to the deficient practice will be	4/4/16

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 ______	**02/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 4	K 144	completed by April 4, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **02 - 2ND BUILDING** B. WING	**02/23/2016**

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 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2016

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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 02 - 2ND BUILDING B. WING	02/23/2016

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	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two buildings due to the construction dates of the buildings. Building 2 was 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 sprinklers. This building consists of the 300, 400 and 500 Wings. and was surveyed to Chaper 18 New Health Care. The facility has a fire alarm system that is monitored for automatic fire department notification and smoke detectors in all resident rooms, areas open to the corridors as well as by barrier doors held open with magnetic hold-openers. The facility has a capacity of 49 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING 02 - 2ND BUILDING B. WING	02/23/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **02 - 2ND BUILDING** B. WING ______	**02/23/2016**

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 050	Continued From page 3	K 050	completed by April 4, 2016	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 41 residents, staff, and visitors. Findings include: During the facility tour between 8:30 am to 12:00 pm on 02/23/2016 documentation review revealed that the generator log did not contain a record of the 5 min. cool down period or the amperes of the monthly load test. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator.	K 144	K144 The facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The Environmental Services Manager will conduct a 5 minute cool down test of the facility generator. A 5 minute generator cool down test was added to emergency maintenance log to be checked monthly by Environmental Services Manager. The Environmental Services Manager was re-educated on the policy and procedure for generator operation. The community Administrator or designated QAPI representative will conduct an audit 1x/month for three months to ensure continued compliance. The audit results will be reviewed at QAPI and recommendations will be made for continued review or compliance Corrections to the deficient practice will be completed by April 4, 2016.	4/4/16