P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 5, 2021

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

RE: CCN: 245585
Cycle Start Date: December 17, 2020

Dear Administrator:

On December 17, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 20, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 20, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 20, 2021.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 20, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Traverse Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 17, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 5, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: OC1X11

Dear Administrator:

The above facility was surveyed on December 16, 2020 through December 17, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING ______ B. WING ______	C 12/17/2020

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 On 12/16/20 through 12/17/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5585014C, with a deficiency cited at F689. 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		1/7/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/07/2021

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 689	Continued From page 1 by: Based on observation, interview and document review, the facility failed to provide assessment and supervision to prevent falls for 1 of 3 residents (R1) reviewed for falls. R1 was left alone in her room following a surgical procedure with sedation. R1 subsequently fell sustaining harm, a right femur (leg) fracture, due to a self-transfer attempt when left alone. Findings include: R1's 9/17/20, annual Minimum Data Set (MDS) and 9/29/20, Care Area Assessment (CAA) identified R1 had severe cognitive impairment with diagnoses of arthritis, osteoporosis (disease that causes bones to become weak and brittle) and muscle weakness. R1's MDS indicated R1 required limited assistance with transfers and walking in corridors, and required supervision when walking in room. R1's MDS further identified R1's balance during transitions and walking was not steady, but R1 was able to stabilize without human assistance, and R1 used a walker. R1's 9/29/20 CAA indicated R1 had experienced no falls within the last 90 days. In addition, the CAA indicated R1 had a walker and would walk to dining room for breakfast, walk around her room and take herself to toilet. The CAA also identified R1 was forgetful at times but very careful not to fall and indicated falls would be care planned to slow or minimize decline, avoid complications, maintain current level of functioning, and to minimize risks. R1's 9/17/20, Fall Risk Screening Tool identified R1 had a history of falls and was at risk for falls, but had not experience a fall within the prior 90 days.	F 689	1. Resident (R1) is recovering and receiving the necessary care and services. Care plan was updated to demonstrate those services. 2. Residents residing in the facility have the potential to be affected. An audit was completed with no other issues identified. A system of communication on appointments/aftercare was created and implemented by the facility on December 18th-22nd, 2020 . Education was provided to receptionist (s) and nursing staff to NOT take any residents returning from outpatient procedures directly to their rooms. A licensed nurse will be responsible to take resident's aftercare paperwork and do an immediate assessment for caress required after re-admission back to the facility, and nursing staff will assist the resident back to their room or location of choice. 3. The facility completed a root cause analysis and has implemented a communication system for residents who receive out-patient procedures to prevent reoccurrence. A system of communication on appointments/aftercare was created and implemented by the facility on December 18th-22nd, 2020 . Education was provided to receptionist (s) and nursing staff to NOT take any residents returning from outpatient procedures directly to their rooms. A licensed nurse will be responsible to take resident's aftercare paperwork and do an immediate assessment for caress	

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F 689	Continued From page 2 Review of a 12/9/20, report filed to the State Agency (SA) by the facility, identified R1 returned from a same day procedure at a local hospital and an unidentified staff assisted R1 back to her room in wheelchair upon return. The report indicated R1 had then attempted to self-transfer from her wheelchair and fell. R1 complained of right hip pain and was transferred to a local hospital for evaluation where a right femur (upper leg) fracture was diagnosed. R1 required transfer to a higher level of care at a regional hospital where she underwent surgical intervention. R1's 12/9/20, Post Fall Review identified R1's fall occurred at 1:55 p.m. in R1's room after return from the clinic. The Post Fall Review indicated R1 had been transferred to his room, was left alone, and attempted self transfer to a recliner chair. R1's review also identified R1 sustained a fracture of right femur. The review report summary identified staff had been educated to ensure when residents return from clinic appointments, they are assisted by the nurse rather then the receptionist assisting them to their room right away. R1's 12/9/20, operative note and discharge instructions identified R1 had an excision (removal) of left axillary (arm pit) mass. R1's operative notes also identified R1 had received local MAC (conscious sedation where pain medication and sedating medication is given). R1's discharge instructions included: "have someone stay with you to watch for problems and help keep you safe". Staff were advised in the discharge instructions: R1 "may be weak, feel sick, or become dizzy. The effects of the medication may last for 12 to 24 hours." Fall	F 689	required after re-admission back to the facility, and nursing staff will assist the resident back to their room or location of choice. Receptionist(s) and nursing staff have been educated on the communication system and demonstrated competency of the communication system for out-patient procedures. 4. The Director of Nursing and/or designee will audit process daily for 2 weeks; then weekly for 2 weeks; then monthly for 6 months. Results of the audits will be presented to the quarterly Quality Assurance Performance Improvement Committee to determine compliance and/or further action.	

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F 689	Continued From page 3	F 689		

prevention items were noted to include: "Have [R1] get up slowly, ask for help when walking, wear eyeglasses and use assistive devices such as a walker." In addition, the directions indicated staff were to monitor for fever, nausea, chest pain, lightheadedness or dizziness.

R1's 12/9/20, regional hospital History and Physical and orthopedic consult note identified R1 had experienced a fall while transferring from her wheelchair into her bed. As a result of the fall, it was discovered R1 had right hip fracture and was scheduled for surgery the following day on 12/10/20 to repair her fractured hip.

The facility's fall investigation dated 12/10/20, identified the facility's receptionist was the staff person who had wheeled R1 down to the nurses' station, gave the nurse her paperwork, and asked if she should bring her to her room. According to the fall investigation report, the receptionist had said the nurse had told her she could take the resident to her room. The receptionist reporting having asked R1 if she knew where her walker was, and indicated the receptionist knew R1 could walk independently with her walker. The receptionist had also reported that R1's call light was within reach when she'd left R1 in her room. R1 then tried to transfer herself from her wheelchair to the recliner and experience a fall. The fall investigation further identified the charge nurse had then found out R1 had received conscious sedation anesthesia instead of a local anesthesia for her procedure earlier in the day prior to the fall. It was determined the anesthesia could have been the root cause of the fall, causing R1 to be more unsteady and "groggier". Further, the fall investigation indicated the receptionist had been educated immediately that

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F 689	Continued From page 4	F 689		

when a resident returns from a clinic appointment she should assist the resident to the nurses' station and notify the nursing staff member that the resident has returned. The investigation made no mention other staff were educated on procedures for appropriate nursing assessment following a resident's return from a surgical procedure.

R1's 12/14/20, hospital Discharge Summary identified R1 was admitted 12/9/20 after a fall from her wheelchair resulting in a right hip fracture requiring R1 to undergo hip-pinning surgery.

R1's 12/14/20, Physical Therapy (PT) Evaluation and Plan of Treatment identified R1 was referred to PT upon return from an acute hospitalization due to right hip fracture with subsequent surgical pinning. The PT evaluation indicated R1 was a fall risk due to history of right hip fracture and dementia. R1's PT evaluation identified R1 had surgical pain at rest rated at 6/10 (pain scale of 0-10, with 0-no pain to 10-most intense pain possible), and 9/10 sharp pain with movement. R1's PT evaluation summary identified R1 had pain/weakness which limited functional mobility and required skilled PT to improve functional mobility and to maximize functionality independence in facility.

Review of R1's progress notes identified on:

1. 12/9/20 at 1:10 p.m., R1 left for an outpatient procedure at the local hospital.

2. 12/9/20 at 1:35 p.m., R1 returned via local transport accompanied by family with orders to leave Steri-strips on until they fall off and monitor

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F 689	Continued From page 5	F 689		

for infection at the surgical site. R1 was to follow up with CNP (certified nurse practitioner) for a post-operative visit. Post procedure instruction sheet given. There was no mention staff had identified the discharge instructions included the above measures to be safe, nor that staff had assessed her upon return to monitor for post-op concerns as indicated in the discharge instructions.

3. 12/9/20 at 4:00 p.m., R1 fell at 1:55 p.m.. R1 stated she was trying to get to her recliner from being seated in the wheelchair and fell. R1 was laying at end of bed, flat on floor, with her legs straight out in front of her. R1 denied hitting her head, but had experienced a lot of pain in her right hip and down to her knee and was unable to move her right leg. R1 was sent to the emergency room (ER) via ambulance at 2:30 p.m. Staff called for update and were informed at 4:00 p.m., R1 had fractured her femur and was transferred to the regional hospital for higher level of care required.

When interviewed on 12/16/20 at 11:01 a.m., nursing assistant (NA)-A stated prior to R1's fall, she used a walker, and transferred and ambulated herself. NA-A stated the staff would supervise R1. NA-A stated R1 now required a PAL [mechanical] lift for transfers and 2 staff assistance. NA-A stated staff had not received any education following R1's fall, but indicated the usual practice when a resident returned to the facility following an appointment was to give any paperwork to a nurse when the resident returned.

When interviewed on 12/16/20 at 1:15 p.m., licensed practical nurse (LPN)-A stated she had gotten R1 ready for her appointment to have the

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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 689	Continued From page 6	F 689		

mass removed from her side and had put R1 in a wheelchair for the appointment. LPN-A stated she was later informed by the nurse manager registered nurse (NM)-A, R1 had fallen and was being transferred to the hospital. LPN-A stated prior to the fall, she didn't know R1 had returned. LPN-A indicated she had not received any further education following R1's fall.

Interview on 12/16/20 at 2:40 p.m., with NM-A confirmed R1 had been independent with walking with a walker in the building prior to the fall. NM-A said R1 was now working with therapy and would be considered a very high risk for falling. NM-A indicated she was on the other end of the building when R1 fell, and was informed that R1 had fallen and her hip was hurting so she sent her to the hospital for evaluation. NM-A thought a nurse was in R1's room when she'd arrived to assess her. NM-A stated R1 had gone to the outpatient hospital to have a nodule removed from under her arm. NM-A said staff later learned R1 had received conscious sedation instead of a local anesthesia, which affected her mental status. NM-A confirmed they had sent R1 over in a wheelchair and when she returned to her room in the wheelchair, R1 had not been used to being in a wheelchair. NM-A indicated education was provided to some staff involved after the incident but was unsure of who or what education was given.

Interview on 12/16/20, at 2:50 p.m. registered nurse (RN)-A indicated she had been informed 12/9/20, that R1 had fallen. RN-A indicated she was working in other areas of the facility at that time and had not worked with R1 that day. RN-A was informed by a nursing assistant at the nurses station that R1 had fallen, while another nursing

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 12/17/2020

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

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F 689	Continued From page 7 assistant remained with R1 in her room. RN-A indicated R1 was laying on the floor and had informed RN-A she was trying to get to her recliner when she fell. R1's right side was hurting and she unable to move her right leg. RN-A indicated R1 was able to answer some questions, but had cognitive impairment. RN-A indicated they used a total lift to put R1 in her bed and called for an ambulance. RN-A indicated the fall was unwitnessed. Prior to R1's fall, R1 had been to an appointment to remove a mass under her left armpit and had been at the appointment all day. RN-A had not taken report from the hospital, and stated she was not sure when she returned or what was needed to be done after R1's appointment. The usual process was for the hospital to call with a report and send paperwork. RN-A was aware R-A had taken R1 to her room, however RN-A had not assessed R1 upon return to the facility. Some staff involved received education to bring residents to the nursing station after appointments so nurse could assist them and assess, but had not received any education herself. Interview on 12/16/20 at 2:59 p.m., with family member (FM)-A during a phone interview, identified R1 had surgery at the hospital on 12/9/20 to remove a lump from under her arm. R1 had some sedation during the procedure and was transferred back to the facility. FM-A had rode with R1 back to the facility and had brought R1 to the front door, then an unidentified staff member had taken R1 into the facility. About a half an hour later she had received a phone call by another family member who informed her R1 had a fallen and fractured her hip. FM-A indicated on 12/15/20, she had spoken to the facility administrator and was informed someone	F 689		

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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 689	Continued From page 8 had taken R1 to her room and left her sitting in the wheelchair. R1 did not like to sit in the wheelchair, and had tried to get up herself and had fallen. FM-A had been told by the administrator, the staff who transported R1 to her room was not a nursing assistant or nurse, but worked in the office and did not know how to assist R1 into her chair. FM-A indicated it had been 6-8 months since R1 had a fall. Interview on 12/17/20 at 9:12 a.m., with physical therapist (PT)-A confirmed R1 had some cognitive impairment and was independent walking with her walker in her room and hallways prior to the fall, but required some cuing to destinations. PT-A indicated R1 would not use her call light for help most of the time, and would not always be cognitively able ask for help. R1 had a definite decline since her fall with hip fracture on 12/9/20. R1 now required maximum assistance with transfers and was not able to walk. R1 was not safe to be left alone in a wheelchair prior to her fall and had not been taught how to use wheelchair brakes and would have required supervision if in a wheelchair. PT-A indicated R1 would have required to be supervised after she had been sedated. On 12/17/20, at 9:31 a.m. receptionist (R)-A stated when R1 came back to the facility on 12/9/20 following an outpatient surgical procedure, R1 was in a wheelchair. R-A said she'd transported R1 to her room and left her in the wheelchair in her room with her call light on the bedside table next to her. R-A indicated she had handed R1's paperwork to RN-A who was sitting at the nurses desk. R-A indicated later she assisted another resident to the nursing station, when she was informed R1 had fallen. The	F 689		

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F 689	Continued From page 9 director of nursing (DON) later provided education to her advising R-A not to take resident's back to their rooms and leave them at the nurses station. The DON had informed her she was not certified to provide resident care, and should not bring residents down to their rooms because she did not know what cares were needed. R-A was to get a nurse or nursing assistant to take residents to their rooms. During a phone interview with R1's primary care physician on 12/17/20 at 1:19 p.m., he stated was aware of R1's fall, by reviewing R1's medical record but was not aware of the details. The primary care physician stated when a resident returned from an appointment, he would expect the nursing staff to look through the paperwork and assess the resident. Further he stated R1 had received a MAC and elderly persons under any anesthesia would be slower to recover from it therefore, nursing staff should have followed the orders, assessed and supervised R1 upon return to the nursing home. During interview with the director of nursing (DON) on 12/17/20 at 11:40 a.m., the DON confirmed R1 had a lump removed from under her armpit on 12/9/20. The DON stated the receptionist had handed R1's paperwork to RN-A, then just transported R1 to her room in a wheelchair. The DON confirmed R1 had a fall with fracture. The DON further stated her expectation was since R1 underwent a surgical procedure requiring anesthesia, nursing staff should have read through her paperwork right away when she'd returned to the facility. The DON said R1 had only been back in the facility 5-10 minutes prior to falling when she tried to transfer herself from the wheelchair. The DON	F 689		

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F 689	Continued From page 10 also acknowledged it was unusual for R1 to be in a wheelchair, indicating R1 usually walked with a walker. Further she stated R1 had severe cognitive impairment and osteoporosis which put her at greater risk for breaking bones. The DON said staff were unaware R1 had received sedative anesthesia and stated she would've expected nursing staff to assess R1 right away when she returned to the facility, especially since R1 had been sedated which made her more at risk for falling. Review of the facility's 7/6/18, policy Accidents/Falls, indicated the facility strived to promote safety, dignity and overall quality of life for its residents by providing an environment free from any hazards for which the facility had control, and by providing appropriate supervision and interventions to prevent avoidable accidents. The policy also indicated a care plan for fall risk was to be developed and communicated to all appropriate staff, and included: "Each fall must be investigated and or assessed to determine the cause of the episode to prevent any further injury". Review of the facility's 7/11/18, policy First Aid-Falls, included: "Residents who fall shall be provided with care/treatment, as necessary. If the resident has painful areas, bumps, and/or limbs in unnatural position, keep resident on the floor. If fractured hip, back or other major injury is suspected, make resident comfortable unit emergency medical assitance arrives." The policy also instructed staff to complete an incident report and document any incidents in medical record.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2021

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

RE: CCN: 245585
Cycle Start Date: December 17, 2020

Dear Administrator:

On January 5, 2021, we notified you a remedy was imposed. On January 20, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 7, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 20, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 5, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 7, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

January 22, 2021

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

Re: Reinspection Results
Event ID: OC1X12

Dear Administrator:

On January 20, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 20, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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