Electronically delivered
March 24, 2021

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

RE: CCN: 245585
Cycle Start Date: March 8, 2021

Dear Administrator:

On March 8, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 8, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 8, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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
March 24, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 5DZL11

Dear Administrator:

The above facility was surveyed on March 3, 2021 through March 8, 2021 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:

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

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
	00669	A. BUILDING: _____ B. WING _____	C 03/08/2021

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 3/3/21 through 3/8/21, surveyors of this Department's staff visited the above provider and the following correction order was issued. The following complaints were found to be substantiated:	2 000		

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2 000	Continued From page 1 H5585015C (MN00070343) Licensing order was issued at 1880. H5585016C (MN00070408) 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 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	2 000		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not	21880		4/3/21

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21880	Continued From page 3 otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure grievances, related to missing personal property, were acted upon for timely resolution for 2 of 3 residents (R1, R6) reviewed with missing property. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/31/20, identified R1 was cognitively intact and had diagnoses which included depression, hypertension and ulcers of the lower extremities. R1's MDS further identified R1 required extensive assistance with transfers, and limited assistance with dressing and personal hygiene. R6's annual MDS dated 12/22/20, identified R6 was cognitively intact and had diagnoses which included heart failure, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed air flow) and arthritis. R6's MDS also identified R6 required supervision with bed mobility, toilet use and personal hygiene.	21880	Traverse Care Center Plan of Correction – Survey Exit 03/08/2021 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Concerns about missing items have been voiced by R1 and R6, which have been documented on the facility Grievance form. R1 and R6 were offered replacements for all their missing items. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. Residents expressing grievances have the potential to be affected if their grievances are not addressed and resolved timely or within 5 working days of receipt of grievance. 3. What measures will be put in place, or systemic changes made, to ensure that	

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21880	Continued From page 4 On 3/3/21, at 12:41 p.m. R1 indicated she had missing items which include a notebook, letter, a few pens, 2 scissors, an ointment for her legs and a clock. R1 indicated the facility located the letter, notebook and pens which had been boxed up for her. R1 stated the facility was unable to locate the scissors, ointment and clock. R1 indicated she was aware another female resident had 2 missing coats. R1 indicated she had informed staff of the missing items right after she moved back from the COVID unit. On 3/3/21, at 2:58 p.m. nursing assistant (NA)-A indicated the usual facility practice was to inform the charge nurse when a resident was missing property. NA-A stated the nurse would complete a missing item slip so everyone was informed and could look for the items. NA-A indicated the forms were then given to administrator, director of nursing (DON) and one would be posted at the nurses station. On 3/4/21, at 12:23 p.m. R6 indicated she had multiple items lost on 1/20/21, after she was moved to the COVID unit. R6 identified her lotion and hair brush were missing and stated the facility had replaced her hair brush. Additionally, R6 stated her barber scissors given to her by her father were missing. R6 indicated the facility brought her a different pair of scissors to replace them however really wanted the pair her father gave her. R6 indicated she had informed the head nurse and several other staff of the missing property. On 3/4/21, at 1:24 p.m. licensed practical nurse (LPN)-A indicated she was aware some residents had missing items after they returned from the COVID unit. LPN-A stated she was aware a	21880	the deficient practice will not recur a. All departments have received education on proper Grievance Policy and Procedures. The purpose of Traverse Care Center's Grievance Procedure is to encourage residents and/or families/responsible party to communicate verbally or in writing, any concerns, or problems. IDT has received education on the grievance process resolution. The Executive Director will oversee the investigative process to ensure resolution. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur a. Grievances will be reviewed daily as applicable during the morning meeting. The executive Director and/or designee will audit the grievance process daily for 2 weeks; then weekly for 1 month; then monthly for 2 months. Audit Results will be reviewed at QAPI for recommendations and need to continue interviews. 5. The date that each deficiency will be corrected a. Alleged Date of Compliance: April 3, 2021	

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21880	Continued From page 5	21880		

resident had a couple of quilts and a sweater missing. LPN-A indicated she was aware other residents had expressed concerns of missing property too.

On 3/4/21, at 1:42 p.m. administrator indicated the facility's usual practice for locating resident missing items was to first look for the items and if the property was not found a missing item form would be completed. Administrator stated the facility would speak to the resident to determine what type of item was missing and to help determine the best way to locate it. For example, the administrator stated if the resident was missing clothing they would talk to the laundry department and ask them to assist with searching for the missing clothing. Administrator confirmed he had not received any missing items forms recently. Administrator indicated admission and marketing director (AMD)-A was responsible for investigating missing property. Administrator stated he would expect staff would complete the Resident Missing Item Report (RMIR) if the item was not found and stated the usual process was for staff to notify the supervisor who would in turn notify AMD-A.

On 3/4/21, at 2:15 p.m. trained medication aide (TMA)-A indicated when everyone was moved around during an outbreak of COVID-19 in the building, some residents reported missing property. TMA-A stated one resident lost a phone and the phone was found in someone else's box however the charger was still missing. TMA-A indicated her usual practice was to tell the charge nurse when a resident was missing property and the charge nurse would complete a RMIR form and post the form at the desk for staff to be aware of. TMA-A identified where blank copies of the facility RMIR forms were located at the

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21880	Continued From page 6	21880		

nursing station and indicated no current forms were posted. TMA-A stated she had not seen any RMIR forms posted for awhile.

On 3/4/21, at 3:15 p.m. registered nurse (RN)-A indicated the usual facility practice was for nurses to complete the RMIR form whenever missing property was reported. RN-A indicated she had never filled out a form herself and stated the nurse manager (NM)-A would be the person responsible to complete the form. RN-A indicated she reported to the director of nursing (DON) last week that a resident reported her special personal soap was missing.

On 3/8/21, at 12:15 p.m. NM-A confirmed R1 had reported missing some items after residing on the COVID unit and indicated they had returned a mirror and letter to her. NM-A indicated she was not aware of R1 missing any other items or of any other residents reporting missing items. NM-A stated the usual facility practice was to look for items reported missing and if they could not locate the items staff would complete a RMIR form. NM-A indicated she would give the completed form to AMD-A or administrator. NM-A indicated if the missing property was clothing she would also give a copy to laundry and speak to the laundry staff if they were working at the time. NM-A indicated she had not completed a RMIR form in over a month.

On 3/8/21, at 12:48 p.m. AMD-A indicated the usual facility practice for locating resident missing items was for staff to look for the item and if not found staff would report it to their supervisor right away. AMD-A stated a RMIR form would be completed and AMD-A or NM-A were the usual staff who completed the forms. AMD-A indicated no RMIR forms had been completed and turned

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21880	Continued From page 7	21880		

in to her since before the outbreak which began on 1/18/20. AMD-A stated there were many residents who reported missing items since they had made room changes due to the COVID outbreak. AMD-A indicated she thought the missing items could have been in boxes and bags and indicated the facility had not finished looking in the boxes and bags. AMD-A stated she was aware of some missing items like clothing and lotion and was not aware of anything major missing. AMD-A did not provide a definition of what a major item was. AMD-A confirmed the facility had moved the residents off of the COVID unit on 2/16/21, or 2/17/21, and had not looked for missing items or completed any forms since that time. AMD-A stated the facility should have completed the forms by the end of the day for missing property that could not be found. AMD-A confirmed multiple resident missing items had not been found.

On 3/8/21, at 3:17 p.m. in a follow-up interview administrator indicated to let their supervisor or AMD-A know when residents were missing belongings and stated staff were expected to follow the facility Grievance policy for missing items.

The facility policy titled Grievance Process, revised 3/2018, indicated the facility would make prompt efforts to resolve grievances the residents may have. The policy further identified the facility would take immediate action to prevent further potential violations of any resident rights while the alleged violation was being investigated. The executive director was identified as the grievance officer and would oversee the grievance process, receive and track the grievances through to the conclusion. The policy further identified prompt reporting was encouraged so that constructive

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21880	Continued From page 8 action could be taken and investigation and resolution of grievances would be completed as soon as possible, no later than 5 working days after submission and communicated to the person who submitted the grievance, along with the reason for delay. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies pertaining to handling resident grievances, educate staff on these policies and perform audits to ensure each resident grievance has been addressed by the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS On 3/3/21, to 3/8/21, 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 complaints were found to be SUBSTANTIATED: H5585015C (MN00070343) Deficiency was cited at F585. H5585016C (MN00070408) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		4/3/21

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

Electronically Signed | 03/30/2021

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 585	Continued From page 1 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

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F 585	Continued From page 2	F 585		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the

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F 585	Continued From page 3 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure grievances, related to missing personal property, were acted upon for timely resolution for 2 of 3 residents (R1, R6) reviewed with missing property. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/31/20, identified R1 was cognitively intact and had diagnoses which included depression, hypertension and ulcers of the lower extremities. R1's MDS further identified R1 required extensive assistance with transfers, and limited assistance with dressing and personal hygiene. R6's annual MDS dated 12/22/20, identified R6 was cognitively intact and had diagnoses which included heart failure, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed air flow) and arthritis. R6's MDS also identified R6 required supervision with bed mobility, toilet use and personal hygiene. On 3/3/21, at 12:41 p.m. R1 indicated she had missing items which include a notebook, letter, a few pens, 2 scissors, an ointment for her legs and a clock. R1 indicated the facility located the letter, notebook and pens which had been boxed up for her. R1 stated the facility was unable to locate the scissors, ointment and clock. R1 indicated she was aware another female resident had 2 missing	F 585	Traverse Care Center Plan of Correction – Survey Exit 03/08/2021 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Concerns about missing items have been voiced by R1 and R6, which have been documented on the facility Grievance form. R1 and R6 were offered replacements for all their missing items. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. Residents residing at the facility and/or those expressing grievances have the potential to be affected if their grievances are not addressed and resolved timely or within 5 working days of receipt of grievance. Executive Director and/or designee will conduct interview with current residents and/or responsible party to evaluate for any unresolved grievances. 3. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur a. All departments have received education on proper Grievance Policy and Procedures. The purpose of Traverse Care Center's Grievance Procedure is to	

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F 585	Continued From page 4 coats. R1 indicated she had informed staff of the missing items right after she moved back from the COVID unit. On 3/3/21, at 2:58 p.m. nursing assistant (NA)-A indicated the usual facility practice was to inform the charge nurse when a resident was missing property. NA-A stated the nurse would complete a missing item slip so everyone was informed and could look for the items. NA-A indicated the forms were then given to administrator, director of nursing (DON) and one would be posted at the nurses station. On 3/4/21, at 12:23 p.m. R6 indicated she had multiple items lost on 1/20/21, after she was moved to the COVID unit. R6 identified her lotion and hair brush were missing and stated the facility had replaced her hair brush. Additionally, R6 stated her barber scissors given to her by her father were missing. R6 indicated the facility brought her a different pair of scissors to replace them however really wanted the pair her father gave her. R6 indicated she had informed the head nurse and several other staff of the missing property. On 3/4/21, at 1:24 p.m. licensed practical nurse (LPN)-A indicated she was aware some residents had missing items after they returned from the COVID unit. LPN-A stated she was aware a resident had a couple of quilts and a sweater missing. LPN-A indicated she was aware other residents had expressed concerns of missing property too. On 3/4/21, at 1:42 p.m. administrator indicated the facility's usual practice for locating resident missing items was to first look for the items and if	F 585	encourage residents and/or families/responsible party to communicate verbally or in writing, any concerns, or problems. IDT has received education on the grievance process resolution. The Executive Director will oversee the investigative process to ensure resolution. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur a. Grievances will be reviewed daily as applicable during the morning meeting. The executive Director and/or designee will audit the grievance process daily for 2 weeks; then weekly for 1 month; then monthly for 2 months. Audit Results will be reviewed at QAPI for recommendations and need to continue interviews. 5. The date that each deficiency will be corrected a. Alleged Date of Compliance: April 3, 2021	

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F 585	Continued From page 5	F 585		

the property was not found a missing item form would be completed. Administrator stated the facility would speak to the resident to determine what type of item was missing and to help determine the best way to locate it. For example, the administrator stated if the resident was missing clothing they would talk to the laundry department and ask them to assist with searching for the missing clothing. Administrator confirmed he had not received any missing items forms recently. Administrator indicated admission and marketing director (AMD)-A was responsible for investigating missing property. Administrator stated he would expect staff would complete the Resident Missing Item Report (RMIR) if the item was not found and stated the usual process was for staff to notify the supervisor who would in turn notify AMD-A.

On 3/4/21, at 2:15 p.m. trained medication aide (TMA)-A indicated when everyone was moved around during an outbreak of COVID-19 in the building, some residents reported missing property. TMA-A stated one resident lost a phone and the phone was found in someone else's box however the charger was still missing. TMA-A indicated her usual practice was to tell the charge nurse when a resident was missing property and the charge nurse would complete a RMIR form and post the form at the desk for staff to be aware of. TMA-A identified where blank copies of the facility RMIR forms were located at the nursing station and indicated no current forms were posted. TMA-A stated she had not seen any RMIR forms posted for awhile.

On 3/4/21, at 3:15 p.m. registered nurse (RN)-A indicated the usual facility practice was for nurses to complete the RMIR form whenever missing

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F 585	Continued From page 6	F 585		

property was reported. RN-A indicated she had never filled out a form herself and stated the nurse manager (NM)-A would be the person responsible to complete the form. RN-A indicated she reported to the director of nursing (DON) last week that a resident reported her special personal soap was missing.

On 3/8/21, at 12:15 p.m. NM-A confirmed R1 had reported missing some items after residing on the COVID unit and indicated they had returned a mirror and letter to her. NM-A indicated she was not aware of R1 missing any other items or of any other residents reporting missing items. NM-A stated the usual facility practice was to look for items reported missing and if they could not locate the items staff would complete a RMIR form. NM-A indicated she would give the completed form to AMD-A or administrator. NM-A indicated if the missing property was clothing she would also give a copy to laundry and speak to the laundry staff if they were working at the time. NM-A indicated she had not completed a RMIR form in over a month.

On 3/8/21, at 12:48 p.m. AMD-A indicated the usual facility practice for locating resident missing items was for staff to look for the item and if not found staff would report it to their supervisor right away. AMD-A stated a RMIR form would be completed and AMD-A or NM-A were the usual staff who completed the forms. AMD-A indicated no RMIR forms had been completed and turned in to her since before the outbreak which began on 1/18/20. AMD-A stated there were many residents who reported missing items since they had made room changes due to the COVID outbreak. AMD-A indicated she thought the missing items could have been in boxes and

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F 585	Continued From page 7	F 585		

bags and indicated the facility had not finished looking in the boxes and bags. AMD-A stated she was aware of some missing items like clothing and lotion and was not aware of anything major missing. AMD-A did not provide a definition of what a major item was. AMD-A confirmed the facility had moved the residents off of the COVID unit on 2/16/21, or 2/17/21, and had not looked for missing items or completed any forms since that time. AMD-A stated the facility should have completed the forms by the end of the day for missing property that could not be found. AMD-A confirmed multiple resident missing items had not been found.

On 3/8/21, at 3:17 p.m. in a follow-up interview administrator indicated to let their supervisor or AMD-A know when residents were missing belongings and stated staff were expected to follow the facility Grievance policy for missing items.

The facility policy titled Grievance Process, revised 3/2018, indicated the facility would make prompt efforts to resolve grievances the residents may have. The policy further identified the facility would take immediate action to prevent further potential violations of any resident rights while the alleged violation was being investigated. The executive director was identified as the grievance officer and would oversee the grievance process, receive and track the grievances through to the conclusion. The policy further identified prompt reporting was encouraged so that constructive action could be taken and investigation and resolution of grievances would be completed as soon as possible, no later than 5 working days after submission and communicated to the person who submitted the grievance, along with

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F 585	Continued From page 8 the reason for delay.	F 585		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 20, 2021

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

RE: CCN: 245585
Cycle Start Date: March 8, 2021

Dear Administrator:

On April 16, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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