

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 26, 2021

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

RE: CCN: 245585

Cycle Start Date: May 6, 2021

Dear Administrator:

On May 6, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Rd., Suite 300 Fergus Falls, Mn. 56537

Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by August 6, 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 November 6, 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.

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

> William Abderhalden, Fire Safety Supervisor **Deputy State Fire Marshal** Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

May 26, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: YZZ311

Dear Administrator:

The above facility was surveyed on May 3, 2021 through May 6, 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 <u>only a suggestion</u> 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

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

PRINTED: 06/09/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00669	B. WING		05/0	; 6/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00.0		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56290				
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2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall limit a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber a	nether a violation has been					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	conducted at your for Minnesota Department facility was found N the MN State Licenscorrection orders are	TS: I, a licensing survey was acility by surveyors from the nent of Health (MDH). Your OT to be in compliance with sure and the following re issued. Please indicate in of correction you have					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/03/21 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		nsure orders consistent with					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1)

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	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related or segregated or gene care staff and their supervisor care.	disorders, whether in a cral unit, the facility's direct rs must be trained in dementia				
	(b) Areas of require	a training include:				

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2 302	Continued From pa	ge 3	2 302			
	(1) an explanation of	of Alzheimer's disease and				
	related disorders;	or / werrenner o diodado aria				
	I	activities of daily living;				
		with challenging behaviors;				
	and	chancinging boliaviols,				ļ
	(4) communication	ekille				
	· ,	provide to consumers in				
		form a description of the				
		e categories of employees				
		cy of training, and the basic				
	topics covered.	ley of training, and the basic				
		document compliance with				
	this section.	document compliance with				
	uns secuon.					
	This MN Requireme	ent is not met as evidenced				
	by:	ent is not met as evidenced				
		and document review, the		The Director of Nursing or designe	lliw oc	
				enroll all direct care staff in the ap		
		ure 3 of 5 new employees,				
		IA)-A, trained medication		Alzheimer's training courses and r them of a timeline for completion.	loury	
		and TMA-B received		them of a limeline for completion.		
		ner's training upon hire per the		"The data that apple defining according	h -	
		protocol . This had the		"The date that each deficiency will	be	
		Il 39 residents residing in the		corrected: July 12, 2021		
	facility.					
	Cindings includes					
	Findings include:					
	During record review	w of annual domantia and				
		w of annual dementia and				
		for 2020 into 2021, nine staff				
		ted and reviewed. Records				
		ng had not been completed for				ļ
		MA-A, and TMA-B who				
	provided direct care	e to residents.				ļ
	Duning or interview	on ElEIO4 of 44:00 11				ļ
		on 5/5/21, at 11:30 a.m., the				ļ
		fied that dementia training was				ļ
		ding process for new hires and				
	completed annually	for all staff. The director of				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	The state of the	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		C	.
		00669	B. WING			, 6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
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2 302	nursing (DON) was and Alzheimer's tra family medical leav months. He confirm put into place to en the dementia and A DON's absence. SUGGESTED MET The DON or design staff in the appropriate courses and notify completion. The DO staff complete the rand could develop education course conew staff orientation appropriate.	responsible for the dementia ining but had been out on e (FML) for approximately two ned there had been no system sure the new hires received alzheimer's training in the THOD OF CORRECTION: nee could enroll all direct care rate Alzheimer's training them of a timeline for DN could ensure all direct care missed courses via an audit, a regular audit of facility completion to be done following in and throughout the year as	2 302			
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintain and personal and of This MN Requirements. Based on observation review the facility factories assistance for 2 of	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920	How corrective action will be accomplished for those residents for have been affected by the deficient practice.		7/12/21

Minnesota Department of Health

STATE FORM YZZ311 If continuation sheet 5 of 46

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56290			
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2 920	Continued From pa	ge 5	2 920			
	were dependent on living (ADL's). Findings include:	staff with activities of daily		¿ R9 received oral hygiene at th survey and as directed by their ca R9 and R33 were shaved at the til survey and have been shaved as	re plan. me of	
	R9			by their care plans.	an ootou	
	2/5/21, identified R'impairment and had Alzheimer's disease MDS further identificassistance of one shygiene and limited	Im Data Set (MDS) dated I had severe cognitive Id diagnoses which included In the desired extensive It is a series of the desired extensive extensive extensive It is a series of the desired extensive extens		How the facility will identify other in having the potential to be affected same deficient practice. ¿ Residents currently residing if facility who are dependent on staff grooming / hygiene including oral shaving have the potential to be at An audit was completed, and thos required care received those care the time of survey.	by the n the f for care and ffected. e who	
	an ADL self care de required staff assist noted. R9's care pla assistance with con soiled clothes and e brush her teeth.	d 4/10/21, indicated R9 had efficit related to Alzheimer's and tance with shaving chin hairs if an identified R9 required staff anbing hair, nail care, changing encouraging/cueing her to		What measures will be put into pla systemic changes made, to ensur the deficient practice will not recur ¿ The Director of Nursing will preducation to nursing assistants re the importance of offering oral hyg and shaving as directed by the rescare plan.	e that covide garding jiene	
	2/2/21, indicated R9 indicated R9 was all after staff assistance. During observations	ata Collection Tool dated had her own teeth and ble to brush her own teeth ee with set up and cueing s on 5/3/21, at 3:12 p.m. R9 recliner in the living room		How the facility will monitor its cor actions to ensure that the deficien practice is being corrected and will recur. ¿ The Director of Nursing or deswill Audit those dependent on staff	t I not signee	
	area rocking back a her eyes closed. RS long white facial ha were approximately	and forth in the recliner with was noted to have several irs on her lower chin area that 1/2 inch or longer.		shaving and/or oral care daily for 2 then weekly for 2 months. Audit will be reviewed at QAPI for recommendations and need to coaudits.	2 weeks; results	
		s on 5/4/21, 9:30 a.m. R9 was oom area eating breakfast		" The date that each deficiency wi	ll be	

independently and was noted to have several

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corrected: July 12, 2021

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00669	B. WING			C 06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
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2 920	long white facial hai were approximately - at 2:51 p.m. R9 with room area looking of hair remained on here at 3:01 p.m. R9 with remained on here at 3:12 p.m. R9 facontinued to visit with staff offer or provide the long white facial. During observations was laying in bed, wand NA-E entered has ready to get up R9 to the bathroom which included was body, applying a cled dressing R9 while send to send make assisted R9 to standard walker and gait belt up her brief and here walk R9 out of her room area holding of with walker. NA-E had room table next to the room table next to the room table next to the proceeded to get R began to eat her broatural teeth preser mouth and continue facial hairs on her leapproximately 1/2 in NA-C or NA-E offer	irs on her lower chin area that in 1/2 inch or longer. It is seated out in the living out the window and R9's facial er lower chin area. It is seated out in the living with her family and R9's facial er lower chin area. It is cial hair remained while she with her family. At no time did expressed assistance to R9 to remove I hairs present on her chin. It is on 5/5/21 at 10:05 a.m. R9 when nursing assistant (NA)- Comer room and asked her if she of for breakfast. NA-E assisted and provided morning cares hing R9's face, hands, upper ean incontinent brief and the sat on the toilet. It collected the dirty linen and diately left R9's room. NA-E do up from the toilet using her is, provided peri cares, pulled or pants. NA-E proceeded to froom and down to the dining on to the back of the gait belt had R9 sit down at the dining he nurses station and elt from her waist. NA-E 9's breakfasts for her and R9 eakfast independently. R9 had not on the top and bottom of her ed to have several long white ower chin area that were not or longer. At no time did or provide assistance to R9 to lite facial hairs present on her	2 920			

Minnesota Department of Health

STATE FORM YZZ311 If continuation sheet 7 of 46

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00669	B. WING		05/0) 6/2021
NAME OF F	ROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 03/0	0/2021
			NTH STREE	,		
IKAVEK	SE CARE CENTER	WHEATON	N, MN 56296	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 920	dining room table exindependently where (TMA)-C approached table visiting with he supplement to drink drink and TMA-C in table and left while R9's facial hair remor provide assistant white facial hairs or cares. On 5/4/21, at 3:41 prindicated staff assist personal hygiene. Fit if she knew she hastated "I wish they with the stated "I wish they with the stated "I wish they will be stated assistance grooming and shaving aid was the one where sidents. NA-E corroffered to shave R9 provide oral cares. In the stated it to her. R33 R33's quarterly MD2 R33 had severe conditional renal insufficier identified she required one staff for person	continued to be seated at the	2 920			

6899

NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 920 Continued From page 8 R33's care plan dated 5/6/21, indicated R33 had an ADL self care deficit related to dementia and required staff assistance with personal hygiene/oral care. The Care plan indicated staff were to assist R33 with shaving her chin hairs, combing hair, and oral cares. During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room working on a puzzle book. R33 was noted to have several long		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		SURVEY PLETED
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) 2 920 Continued From page 8 R33's care plan dated 5/6/21, indicated R33 had an ADL self care deficit related to dementia and required staff assistance with personal hygiene/oral care. The Care plan indicated staff were to assist R33 with shaving her chin hairs, combing hair, and oral cares. During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room working on a			00669	B. WING		I	_
CALCE CARE CENTER WHEATON, MN 56296	NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	03/	00/2021
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 920 Continued From page 8 R33's care plan dated 5/6/21, indicated R33 had an ADL self care deficit related to dementia and required staff assistance with personal hygiene/oral care. The Care plan indicated staff were to assist R33 with shaving her chin hairs, combing hair, and oral cares. During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room working on a	TRAVER	SE CARE CENTER					
R33's care plan dated 5/6/21, indicated R33 had an ADL self care deficit related to dementia and required staff assistance with personal hygiene/oral care. The Care plan indicated staff were to assist R33 with shaving her chin hairs, combing hair, and oral cares. During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room working on a	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
white facial hairs on her lower chin area and the sides of her upper lip that were approximately 1/4 inch or longer. During observations on 5/4/21, at 9:27 a.m. R33 was seated in the main dining room eating breakfast. R33 was noted to have several long white facial hairs on her lower chin area and the sides of her upper lip that were approximately 1/4 inch or longer. - at 2:46 p.m. R33 was seated in a recliner in her room working on a puzzle book and her facial hair remained on her lower chin area and the side of her upper lip. - at 3:14 p.m. R33 remained seated in her room and her facial hair remained on her lower chin area and the side of her upper lip. During observations on 5/5/21, at 12:37 p.m. R33 was seated at a table in the main dining room with other residents present. R33 was noted to have several long white facial hairs on her lower chin area and the sides of her upper lip that were approximately 1/4 inch or longer. At no time did staff offer or provide assistance to R33 to remove the long white facial hair on her chin and the sides of her upper lip. On 5/6/21, at 2:17 p.m. NA-E confirmed R33 needed staff assistance with personal hygiene	2 920	R33's care plan data an ADL self care derequired staff assist hygiene/oral care. It were to assist R33 combing hair, and of During observations was seated in a recepuzzle book. R33 white facial hairs or sides of her upper linch or longer. During observations was seated in the nubreakfast. R33 was white facial hairs or sides of her upper linch or longer. - at 2:46 p.m. R33 was white facial hairs or sides of her upper linch or longer. - at 2:46 p.m. R33 was white facial hairs or sides of her upper lip. - at 3:14 p.m. R33 mand her facial hair marea and the side of During observations was seated at a tab with other residents have several long white facial sides of her upper lips.	ted 5/6/21, indicated R33 had eficit related to dementia and tance with personal The Care plan indicated staff with shaving her chin hairs, oral cares. Is on 5/3/21, at 2:54 p.m. R33 eliner in her room working on a vas noted to have several long in her lower chin area and the ip that were approximately 1/4 is on 5/4/21, at 9:27 a.m. R33 main dining room eating in noted to have several long in her lower chin area and the ip that were approximately 1/4 was seated in a recliner in her puzzle book and her facial hair wer chin area and the side of remained seated in her room remained on her lower chin in the rupper lip. Is on 5/5/21, at 12:37 p.m. R33 ole in the main dining room is present. R33 was noted to white facial hairs on her lower ides of her upper lip that were ench or longer. At no time did a assistance to R33 to remove II hair on her chin and the ip.				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
744012744	OF CONTRECTION	BENTI IOMITEN NEWBER.	A. BUILDING:			
		00669	B. WING		05/0	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56290			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 9	2 920			
	have been complet	indicated the bath aid should ing the cares on her bath day ve been offering to shave her				
	(DON) confirmed the indicated she would residents daily. The	o.m. the director of nursing the above findings and the expect staff to shave the eDON stated she expected offer dental care and follow the state of the expected of the expec				
	3/1/2014, indicated	olicy titled, Shaving revised on residents will be provided laily which included shaving as and/or care plan.				
	4/1/2008, indicated	olicy titled, Oral Hygiene dated residents who are unable to ygiene will receive assistance.				
	The director of nurs all residents unable living to assure they services to maintain and personal and o nursing or designed audits of the delive appropriate care an	THOD OF CORRECTION: sing or designee, could review to carry out activities of daily y are receiving the necessary n good nutrition, grooming, ral hygiene. The director of e, could conduct random ery of care; to ensure nd services are implemented. udits could be brought to the at for review.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 965	MN Rule 4658.0600 -Nutritional Status	Subp. 2 Dietary Service	2 965			7/12/21

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
					C	;
		00669	B. WING		05/0	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE			
			N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 10	2 965			
	must ensure that a which supplies the determined by the dassessment. Subs	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observati review, the facility for nutritional assessme impaired nutritional approaches to main parameters for 2 of had a significant we reviewed for nutrition frindings include: R18 R18's significant che (MDS) dated 2/22/2 diagnoses which indementia with behade pression and hear R18 required exten mobility, dressing, properties and location of the modern of the m	ent is not met as evidenced on, interview and document ailed to complete ongoing ent, address risk factors for status and implement ntain acceptable nutrition 4 resident (R18, R22), who eight loss of 10.8% and 13.1%, on. ange Minimum Data Set e1, identified R18 had cluded right hip fracture, evioral disturbance, major art failure. The MDS indicated sive assistance with bed bersonal hygiene, and eating. R18 required total assistance comotion. R18's MDS ght at 162 and indicated no DS indicated R18 coughed or lls or when swallowing		How corrective action will be accomplished for those residents have been affected by the deficier practice. ¿ R18, and R22 were reviewed scheduled monitoring of weekly wappropriate nutritional supplement nutritional interventions, and reside preferences to address significant loss. ¿ Registered dietitian has comp dietary risk assessment on R18, Further recommendations to modif of care. How the facility will identify other rehaving the potential to be affected same deficient practice. ¿ Residents residing in the facility potential to be affected. The E of Nursing and Registered Dieticial review current residents for signification weight loss, and care plans update appropriate interventions.	for eights; as, eent weight leted a a 222 for ied plan esidents by the ty have Director in will cant ed with	
	medications.			What measures will be put into pla systemic changes made, to ensure		

winnesc	ita Department of He	aitii					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED	
					l c		
		00669	B. WING		05/06/2021		
NAME OF	2D0/(DED 0E 0) (D2) :==	OTDE : -	ODEOO OITY	OTATE ZID CODE			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TRAVER	SE CARE CENTER		NTH STREE				
		WHEATON	N, MN 56296	6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED TO THE	D BE	(X5) COMPLETE DATE	
2 965	Continued From pa	ge 11	2 965				
	R18's care plan und assistance of one stransfers, toileting, personal hygiene. Texhibited adequate appetite as evidence healthy range and geneals. The care platabs, monitor meal routine house snac diet as ordered, use serve meals in the recommended by the R18's Comprehens (CAA) dated 2//22/2 mechanically altere The CAA identified for nutrition. The CA swallowing problem perform activities of assistance. R18's Dietary Profil R18 was on a regulatexture and regular lacked documentation interventions to prea stable weight.	dated, identified R18 required taff with bed mobility, bathing, dressing and The care plan indicated R18 intake related to usual good ed by stable body wight, good oral intake at most an instructed staff to monitor intakes, monitor weights, offer ks between meals, provide a clothing protector, and main dining room as nerapy. ive Care Area Assessment 21, indicated R18 had a diet and a therapeutic diet. R18 had a potential problem AA indicated R18 had a and had an inability to f daily living (ADL's) without e Tool dated 1/11/21, identified ar diet with mechanical soft liquids. The assessment tool on R18 had weight loss or any event weight loss or to maintain ary Report dated 5/1/21,		the deficient practice will not recur; IDT-team members will review resident weights and meal intake was to identify variances, and ensure a interventions are in place; RD will notified of all residents identified a risk for significant weight loss wee; The Director of Nursing or deswill educate all nursing and culinar on the procedures for Nutrition Risweight Loss How the facility will monitor its corractions to ensure that the deficient practice is being corrected and will recur; The Director of Nursing and/or Registered Dietician or designee wof residents experiencing weight to Resident swho experience a 5% loss will be audited for appropriate interventions weekly for 4 weeks; monthly for 2 months. Audit result reviewed in QAPI for further recommendations. "The date that each deficiency will corrected: July 12, 2021	weekly idequate be s high kly. signee ry staff sk and rective t I not r will audit oss. weight t then ts will be		
	identified R18's died meat texture and re lacked documentati being offered for R	t as a diabetic diet with ground gular liquids. The report on of any type of supplement 18's weight loss.					
	to 4/29/21, identified	onthly weights from 10/29/20, d the following:					
	10/29/20, weight wa	as 170.5 pounds					

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00669	B. WING		05/0) 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00.0	
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 965	11/27/20, weight was 12/31/20, weight was 12/31/20, weight was 2/17/21, weight was 3/25/21, weight was 4/29/21, weight was 4/29/21, weight was Review of R18's regassessment notes identified the follow On 2/25/21, late enhad a significant chearment weight at 16 significant weight loss was not R18's weight continuous significant loss. changes were need continue to monitor dietary interventions. On 5/5/21, at 1:43 precent weight loss. current weight loss. current weight loss current weight loss fron 1/14/21) and 10 months prior (170.0 identified R18 curred clinically significant months. RD identificant months. RD identificant months. RD identificant months. RD identificant months a day given during observation.	as 172.5 pounds as 171.0 pounds as 160.0 pounds as 161.7 pounds as 156.0 pounds as 152.0 pounds gistered dietician (RD) from 2/25/21, to 5/5/21, ing: try at 1:17 p.m. identified R18 ange assessment with R18's	2 965			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
			7. BOILDING.			2
		00669	B. WING		1	6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 965	was not uncommor not get up until 11:0 still be in bed at this if he was ready to go During observation was assisted out to morning cares. NA-nothing to eat. During interview on director (CD)-A idel weights on point cli or at least weekly ir red if there was a c CD-A stated if there would talk to the nuinterventions could a supplement. During confirmed the last of R18's electronic he 5/21/19. CD-A confiest but was not cur supplement or measupplement or measupp	in for R18 to sleep in late and to 20 a.m. R18 was observed to stime when NA-B asked R18 get up for the day. on 5/5/21, at 10:58 a.m., R18 of the day room area after a crown of the day room of t	2 965			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00669	B. WING		1	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	to assess the reside contracted two days assessments. During interview on registered nurse (R intake was a hit or restated direct care si weights and the lice weights into PCC. It was expected to coprior weight and defoccurred. RN-B indidentified, the nurse nurse manager who provider. RN-B comand was not on any During interview on primary medical doubeen aware of R18 communication and R18 recently. MD-A hip fracture with surand the psychiatrist medication changes changes to the recedose related to leth psychiatrist for furth MD-A indicated he weight loss yet agree identified the weigh notifying the dieticiat to obtain an order foconfirmed a supple appropriate interver During interview on	upplement until she was able ent. RD indicated she was only a month to complete her 5/5/21, at 2:25 p.m., N) B identified R18's meal miss if he would eat. RN-B taff obtained resident's ensed nurse entered the RN-B stated the licensed nurse mpare the weight with the termine if a weight loss had icated if a weight loss was a was expected to notify the firmed R18 had lost weight to type of supplement. 5/5/21, at 2:57 p.m., R18's ctor (MD)-A identified he had a weight loss by verbal I had been at the facility to see a indicated R18 had a recent regery, had recent COVID-19, a had recently made some as MD-A stated he had made ent psychoactive medication argy and consulted with the ner monitoring last month. I was not surprised about the end the facility should have a supplement. MD-A ment would have been an	2 965			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00669	B. WING		I	C 06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	·	
TRAVER	SE CARE CENTER		NTH STREE			
	T		N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 15	2 965			
	5/4/21, as she did r cooking. She confir dietician any types	nen she was in the building on not have time since she was med she does not give the of notes or list of residents erns for weight loss.				
	R22					
	2/26/21, identified Fimpairment and dia failure, diabetes me affect how your bod anxiety. R22's MDS extensive assistant dressing and perso indicated R22 requiencouragement or only. R22's MDS identified for nutrition. R22's identified R22's nut	imum Data Set (MDS) dated R22 had significant cognitive gnoses which included: heart ellitus (group of diseases that dy uses blood sugar) and indicated R22 required be with bed mobility, transfers, nal hygiene. The MDS ired supervision/oversight, cueing to eat with set up help dentified R22's weight was 126 ght loss of 5% or more in last 10% or more in the last 6 andicated R22 was not on a red weight-loss regimen.				
	functioning. R22's care plan dat at nutritional risk ar about meals. Upda involuntary weight leappetite and genera COVID-19 infection R22's COVID diagrowith frequent refusa	the current level of seed 5/6/21, identified R22 was ad had a history of complaining ated care plan identified coss related to diminished al decline secondary to a. The care plan indicated coses on 2/1/21, poor appetite al to eat and significant weight see months, dated 5/5/21.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY
		00669	B. WING		1	C 0 6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVERSE CARE CENTER			NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 965	Interventions includ daily for extra prote offering a nutritional due to weight loss a registered dietician recommendation as plan included interved dressing, toilet use, requested and PRN she requested. R22 was independent we up first before eating. Review of R22's Most from 10/1/20, to 5/11. October 2020-weighter 2020-weighter 2021-weighter 2021-w	ed: Offer 2 hard boiled eggs in, offer a trial of supplements, I supplement twice a day (BID) and poor intake, and refer to for evaluation and/or is needed (PRN). R22's care entions to assist R22 with bed mobility when she I assistance with transfers if it's interventions identified R22 ith eating with occasional set g. Onthly Weight Report reviewed /21, identified the following; ight 135.5 eight 137 ight 136 ight 126 it 122 in her meal in front of her and os of chocolate milk through a R22 was encouraged to eat offered fruit and shown her ice need only a few bites of ice few sips of ice water and R22 left the table. R22 had a hard boiled egg or	2 965			
	eyes open, head of delivered a breakfa	bed slightly elevated. Staff st tray to R22 and informed comeone to assist her up. At				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00000	B. WING		05/0	
		00669	B. WING		05/0	6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		303 SEVE	NTH STREE	T SOUTH		
TRAVER	SE CARE CENTER		N, MN 56296			
			4, WIN 30230			
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
0.005	0 " 15	17	0.005			
2 965	Continued From pa	ge 17	2 965			
	9:05 a.m. Interim di	rector of nursing (IDON)				
		and placed head phones on				
		alker attached (hearing				
		OON asked if she could assist				
		chair and R22 refused. IDON				
		of bed up and placed her				
		nt of her. IDON removed the				
	meal cover and info	ormed R22 of her breakfast				
		french toast, sausage, toast				
		ered to cut up her meal which				
		began eating the watermelon				
		o remove her head phones.				
		she did not like them. At 10:01				
		in bed and was not eating at				
		reakfast meal remained in				
	front of her. At 10:2	4 a.m. social service designee				
		's room and asked her to try to				
		per by R18's bedside with				
		on it to communicate to her				
		R22 ate a few bites of fruit and				
	no other foods duri	ng the meal. R22 had not been				
		a hard boiled egg or				
	supplements during					
		•				
	On 5/5/21, at 12:39	p.m. R22 was seated in her				
	wheelchair at a tabl	e in the dining room and had				
	just been served he	er lunch meal. R22 stated she				
	could not eat all of	that. R22 was served a bacon,				
	lettuce and tomato	(BLT) sandwich, macaroni and				
		of sliced cucumbers. R22				
	received a glass of	ice water and chocolate milk.				
		provided a hard boiled egg or				
		the meal. At 1:06 p.m. R22				
		oom, had consumed 3/4 of				
	her BLT sandwich a	and had not eaten anything				
	else.					
		p.m. during a phone				
		ember (FM)-B indicated she				
	was aware of R22's	weight loss and indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING		C		
		00669	D. WING		05/0	6/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 965	R22 had quit eating infection. FM-B stat sometimes she did been giving R22 su not for awhile. FM-was getting a regular modifications made month ago she had when R22 had not in she had reported the stated she attempte and indicated R22 of food onto the silven she was aware R22 lost 15-16 pounds sindicated she had indicated they had indicated they usual only occasionally as indicated the last tire eating was a few was at times had receive nurses. On 5/5/21, at 1:42 processes on the silven she was a few was at times had received in the same shad received it was very hometimes and who at the better. RN-B income the same shad received thought it was on R RN-B checked on Frecord and confirmed records.	when she had COVID ed R22 sometimes ate and not. FM-B indicated staff had pplements however they had B stated she was aware R22 ar diet and had not seen any to her diet. FM-B indicated a caught a couple of times received a tray for meals and at to the administrator. FM-B ed to feed R22 at noon meal did well when she placed the ware for her. FM-B indicated weighed 119 pounds and had since she had COVID. FM-B ot spoken to the registered d was not aware of any	2 965	BELLIGITY STATES OF THE PROPERTY OF THE PROPER			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
		00660			0.5/0	
		00669			05/0	6/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, S NTH STREE	STATE, ZIP CODE T SOUTH		
TRAVERS	SE CARE CENTER		N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	refused meals ofter infection. NA-B stat breakfast meal and unusual for her. NA nurses gave R22 su medications and sh been done for the later of the	o.m. NA-B indicated R22 in since she had COVID ed R22 had not eaten her indicated that was not A-B indicated she thought the supplements with her e had not noticed if this had	2 965	DEFICIENCY)		

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Minnesota Department of Health STATE FORM

On 5/5/21, at 3:30 p.m. during phone interview,

PRINTED: 06/09/2021 FORM APPROVED

Minnesota Department of Health

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_ ر	,
		00000	B. WING		0.5/0	
		00669	B. WING		05/0	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			NTH STREE			
TRAVER	SE CARE CENTER					
		WHEATOI	N, MN 56296	•		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
2 965	Continued From pa	ge 20	2 965			
	RD-A confirmed the	e last time she completed a				
		tary assessment for R22 was				
		nnual assessment. RD-A				
		me she had been in the facility				
		gan was 5/4/21, and				
		e or two times since March				
		ed she was relying on				
		om staff for any concerns.				
		would receive e-mails from				
		or of nursing (DON) and				
		D)-A, which included new				
	admissions and the					
		A indicated in the past she				
		y DON or CD-A regarding				
	9	ht loss. RD-A stated she would				
		y her of any weight loss as				
		ied it. RD-A indicated she was				
		n the facility reviewed weights.				
		•				
	stated now that she	was aware of R22's weight				
		iew R22's record remotely and				
	contact CD-A to init	iate interventions today.				
		o.m. CD-A indicated her usual				
		ing RD-A was by e-mail. CD-A				
	indicated she had s	ent e-mails notifying RD-A				
	regarding things su	ch as new residents, changing				
		ought she may have notified				
		for assessments to RD-A.				
	CD-A confirmed sho	e reviewed residents' weights				
	RD-A pulled up R22 and confirmed R22 RD-A identified R22 lower than her prev R22's weight loss s stated now that she loss, she would rev contact CD-A to init On 5/5/21, at 3:21 process for contact indicated she had s regarding things su diet textures and th RD-A about suppler indicated she though the MDS schedule CD-A confirmed she weekly and indicated system for weight knotify RD-A if she h	2's electronic medical record had a significant weight loss. 2's weight of 119 was much ious weights. RD-A confirmed tarted in February. RD-A was aware of R22's weight iew R22's record remotely and iate interventions today. D.m. CD-A indicated her usual ing RD-A was by e-mail. CD-A ent e-mails notifying RD-A ch as new residents, changing ought she may have notified ments for one resident. CD-A that the administrator e-mailed				

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER	(2) MULTIPLE CONSTRUCTION . BUILDING:	(X3) DATE SURVEY COMPLETED
	. WING	С
00669 B.	. WING	05/06/2021
	ESS, CITY, STATE, ZIP CODE	
TRAVERSE CARE CENTER WHEATON, M	TH STREET SOUTH MN 56296	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO TOT DEFICIENCE)	ION SHOULD BE COMPLETE THE APPROPRIATE DATE
CD-A believed she had sent RD-A an email regarding R22's weight loss and after review of her emails, she confirmed she had not notified RD-A about R22's weight loss. CD-A indicated she was expected to notify RD-A of residents who had lost 5% weight loss in 1 month, or 10% in 6 months or a couple of pounds lost in a week. CD-A stated it was important to notify RD-A of residents with weight loss for their health, eating, and good nutrition. CD-A indicated she would notify both RD-A and IDON so interventions could be put into place for R22. On 5/6/21, at 11:43 a.m. IDON confirmed R22 had weight loss and indicated they were trying to give her supplements and magic cups and R22's family had been coming in to feed R22. IDON indicated they informed R22's PCP every time rounds were made. IDON stated NP-B had discussed R22's weight loss last week with R22's family and had also discussed hospice and family was not ready for that. IDON stated she notified RD-A at times related to concerns with residents. IDON indicated RD-A had access to resident records and was expected to be monitoring resident weights. On 5/6/21, at 4:04 p.m. R22 was re-weighed and her weight was 116. Review of R22's Meal Intake dated 3/20/21 to 5/6/21, identified the following; -3/20/21, to 3/31/21, 13 of a possible 36 meals were recorded. 2 meals identified R22 refused, 9 meals recorded intake of 0-25% and 2 meals recorded intake of 26% to 50%.	2 965	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00669	B. WING	_	l l	C 06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 965	meals recorded intarecorded intake of 2 recorded intake of 3 recorded o-25%, 2 meals recorded o-25%, 2 meals recorded and 2 meals recorded o-25%, 2 meals recorded and 2 meals recorded recorded intake of R22's Megorder of R22's Megorder of R22's Megorder or R22's orders lacked R22's orders lacked R22's weight loss. Review of R22's profoliation of R22's pro	ake of 0-25%, 14 meals 26% to 50%, and 10 meals 51% to 75%, and 4 meals 76% to 100%. O meals of a possible 16 ed. 6 meals recorded intake of corded intake of 26% to 50%, ed intake of 51% to 75%. Redication Review Report 5/21, included: egular texture, regular liquids art date of 6/14/12. If any interventions related to be following: Indication define of R22's tresults this a.m. R22 at to COVID 19 unit. Indication to prevent nausea In R22 still not eating or notified and provided letter to ake medication and drink, not to hospital, returned with edication to prevent nausea In bite of egg for breakfast, and snacks sent in by family, cookie. R22 took meds	2 965			

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00669	B. WING		1	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 23	2 965			
	continues to have le	oss of taste and smell.				
	hesitancy to eat and stated to continue s supplement better a	h family related to R22 d drink at this time. Family supplements. R22 drank after informed facility spoke ank two full glasses of				
	Staff fed R22 with p	not been eating or drinking. boor appetite noted and to with encouragement.				
		t eating or drinking well. R22 ragement and at times needs				
	-2/25/21, R22 conti smell.	nues to have loss of taste and				
		k supplement and chocolate ne day before with family, but				
		nily here for noon meal, eating na. R22 continues to have loss				
		nall bites apple and banana. ered food and drink, R22				
	-3/7/21, R22 ate ap	ple and small malt for family.				
	-3/10/21, R22 conti smell.	nues to have loss of taste and				
	magic cup. R22 ate	ed breakfast but ate part of noodles and drank malt for R22 had chicken soup, magic				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING			
		00669	B. WING		05/0	6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 24	2 965			
	cup and wanted ice	cream for supper.				
	-3/14/21, R22 continues to have loss of taste and smell. R22 drank supplement for noon meal and after meal ate some noodles and malt with family.					
	-3/15/21, R22 ate few bites of apple before noon meal, ate few bits of magic cup then fed herself 1/2 of it and drank 1/4 supplement, refused rest of meal.					
	-3/17/21, R22 conti smell.	nues to have loss of taste and				
	-3/22/21, R22 continues to have loss of taste and smell, intake fluctuates, eats well occasionally and refused to eat at others.					
	-3/30/21, R22 continues to have loss of taste and smell, intake fluctuates, eats well occasionally and refused to eat at others.					
	-4/5/21, R22 continues to have loss of taste and smell, intake fluctuates, eats well occasionally and refused to eat at others.					
	drink chocolate mill brought in food this continues to have le fluctuates, eats wel eat at others. Famil R22 to eat, sometir	tive to eat this morning, did k and 1/2 of egg. Family here afternoon, good appetite. R22 coss of taste and smell, intake I occasionally and refused to by comes often to encourage mes successful with ice cream in small candy bar, will				
	-4/21/21, R22 continues to have loss of taste and smell, intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00669		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED C 05/06/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 965	with ice cream and bar, will continue to -4/28/21, R22's inta occasionally and recomes often to enc successful with ice small candy bar, wi -4/29/21, R22 did not took bites of puddir two bites of chili, mintake fluctuates, earefused to eat at other encourage R22 to exice cream and som will continue to mor -5/4/21, R22's intak occasionally and recomes often to encourage R22 to exice cream and som will continue to mor -5/4/21, R22's intak occasionally and recomes often to encourage R21, Dietary Prosignificant weight locurrent weight 10 current weight 119, ago, 13.1% weight 13.1% weight 13.1% weight loss for notable weight lodining room per fan supervised/encourar R22 continues to has supplements have been accepting of sthe COVID unit, who day. RD-A communitoday and RD-A will	sometimes with small candy monitor. Ike fluctuates, eats well fused to eat at others. Family ourage R22 to eat, sometimes cream and sometimes with Il continue to monitor. It ike chocolate milk tonight, ag till finished, fed brownie ate inimal fluid intake. R22's eats well occasionally and hers. Family comes often to eat, sometimes successful with etimes with small candy bar,	2 965			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		00669	B. WING		05/0	6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 26	2 965			
	to assess for any fu	sident monthly and as needed irther weight loss, to determine ents or further dietary				
	-R2's progress notes lacked a comprehensive dietary assessment completed between 2/1/21, and 5/5/21.					
	R22's Kardex Report dated 5/6/21, included nutritional status interventions; dietary consult for nutritional regimen and ongoing monitoring. Discuss meal times, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. R22's Kardex report interventions included to monitor/document for signs or symptoms of malnutrition.					
	Review of R22's nursing home visit progress notes dated 2/23/21, identified R22 was seen by NP-B. R22's NP-B progress notes identified staff reported R22 was not eating, taking meds and had decreased drive and energy. R22 was recently located to a different room after the COVID infection and was more noncompliant with medications and had decreased nutritional intake. R22's progress note identified a plan to continue present regimen and for R22 to wear hearing device at all times when she was up and about and out of bed and to have her glasses on. R22 ate very easily today once placed at the table and food was in front of her. Review of R22's nursing home visit progress notes dated 3/8/21, identified R22 was seen by PCP, and identified R22 was refusing medications, which had gone on since R22 had coronavirus infection. R22's progress notes identified R22's vitals were reviewed and the plan					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00669	B. WING		05/0	6/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 27	2 965			
	was to continue pre	esent regimen.				
	home visit dated 4/by NP-B, and identi	rogress notes for nursing 15/21, identified R22 was seen fied no current complaints or ogress note plan was to gimen.				
	The facility policy titled Nutrition (General) dated 4/8/2008, identified the facility maintained parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. The policy indicated residents would receive a therapeutic diet and/or modified diet when there was a nutritional need.					
	The facility policy titled Weight Loss, revised 3/1/2014, identified the facility would ensure that residents would not fall below their ideal body weight range, unless the weigh loss was viewed as unavoidable. The policy procedures list included; residents would be assessed for risk, dietary consult would be completed and suggestions would be implemented, care plans would be updated as appropriate and dietary or designee, and nurse's notes would address weight loss issues.					
	The Director of Nu develop and implem to ensure residents appropriate interver determined necess assessment. The Deducate all appropriocedures. The Do	THOD FOR CORRECTION: rsing (DON) or designee could nent policies and procedures at nutritional risk received ntions to maintain nutrition as ary by their individualized ON or her designee could iate staff on the policies and ON could develop monitoring ongoing compliance.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
00669		B. WING		05/06/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 965	Continued From pa	ge 28	2 965			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21015	MN Rule 4658.0610 Requirements- Sai	Subp. 7 Dietary Staff nitary conditi	21015			7/12/21
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain refrigerators and the dishwasher cover in a clean and sanitary manner to prevent contamination and the spread of food borne organisms. This deficient practice had the potential to affect all 39 residents residing in the facility, visitors and staff who consumed food from the kitchen. In addition, the facility failed to ensure refrigerated food items were properly labeled, dated, and closed after the packaging was opened to prevent cross contamination, due to foods in the refrigerators were not stored away from soiled surfaces, packages not sealed or dated. Furthermore, the facility failed to ensure dishwasher temperatures were maintained according to manufacturer's guidelines to assure sanitization of dishware. Findings include: On 5/3/21, at 1:27 p.m. during initial tour of the kitchen with culinary director (CD)-A, the standard refrigerator had multiple tan, brown and red drops of spills on the wire racks. The bottom white			o How corrective action will be accomplished for those residents have been affected by the deficier practice. ¿ Unlabeled food was discarded refrigerators and the dishwasher owere cleaned and sanitized. ¿ Refrigerated food items were labeled, dated, and sealed to previous contamination, ¿ Dishwasher temperatures were maintained according to manufact guidelines to assure sanitization of dishware. o How the facility will identify other residents having the potential to be affected by the same deficient practice will be put into paystemic changes made, to ensure the deficient practice will not recurrently recurrently residing a traverse Care Center have the pet to be impacted.	properly ent re urer's f e ctice. t otential	

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00669		B. WING		C 05/06/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56290			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 29	21015			
	towel was laying an The refrigerator cor cream opened and liquid eggs undated undated and ranch Additionally, one sn approximately 10 st and left open, and obag open was filled first 4-5 slices noted up on them. CD-A threw out all undates the milk which she morning. CD-A concleaned, and had moder, there was a clear in place wrap filled with creamy rinot sure when that was not stored in the threw the creamy rinot sure when the	en bottom area where a white ad a 1/3 full bottle of water lay. Intained 3 bags of whipped undated, one package of d, a plastic carton of milk salad dressing undated. In all sandwich zip lock bag with lices of cheese was undated one large gallon size zip lock d with cheese slices, with the d to be dry with corners curling confirmed the findings and ed and opened items except indicated was from that firmed the refrigerator was not multiple spills. In the walk in metal container with plastic over the top, undated and indicated it in a correct container. CD-A indicated she was was made, and indicated it in a correct container. CD-A indicated it in a correct container. CD-A in the interior station. NA-D in the multiple spills of brown and attom of the refrigerator. There bottles of pop with resident's it NA-D confirmed one of the resided in the facility. NA-D in pop away. There were and magic cups stored in this dent use. NA-D indicated the esponsible to clean the		it is a consistent of the Curbinector or designee(s) will review policies and procedures regarding sanitation, temperature logs, and cleaning. it is The Culinary Director or design will provide training to all dietary states policies and procedures. o How the facility will monitor its cactions to ensure that the deficien practice is being corrected and wirecur. it is The Culinary Director or design will audit cleaning of the kitchen equipment, food is labeled or disc properly, and temperature logs for completeness and within range 3 per week for 1 month, then 1 times week for 2 months. The audit reside be reviewed during the facility QA Meetings and the QAPI Committee provide direction or change when necessary and will dictate the conforcompletion of this monitoring properties on the compliance noted from audits. "The date that each deficiency with corrected: July 12, 2021	the kitchen deep gnee (s) taff on corrective tall not gnee(s) arded times experults will PI e will tinuation rocess m the	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING		0	
		00669	B. WING		05/0	6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	wash cycle temperaran the trays throug cycle reached only indicated the dishwasher was set Thursday or Friday. have plant operation this morning. CD-A dishwasher where the gauge were located a brown fluffy substitution pipes. CD-A confirm was also located all cover overhanging come out and CD-A particles to fall on the she would call the object to the dishwash. The CMA Owners Manual, CMA Dishres pecifications for cywash 155-160 Fahr F. Review of The Tray Record Log Dishrough and wash-150 F, Rirecord wash and rir breakfast, lunch and reviewed from 3/1/2 the following: -March 2021, log id cycle temperature of the condition of the cycle temperature of the cycle te	ature was 140 degrees. CD-A h 2 more times and the wash 140 degrees each time. CD-A asher had run at 150-155 ng. CD-A stated the rviced by a company last CD-A indicated she would ns manager (POA)-A check it a confirmed that above the he pipes and temperature I there were heavy amounts of ance hanging on the the ned the brown fluffy substance I over the inside of the metal where the clean dishes would a indicated could cause ne clean dishes. CD-A stated company that cleaned the ave them come to clean ner. Manual, Model Tall Installation And Operation machines, undated, identified vole temperatures included: renheit (F) and Rinse 180-195 erse Care Center Dishwasher om, which contained dates, inse 180 F, with spaces to ne temperatures for d dinner. The facility logs were 21, to 5/6/21, which identified entified the following wash entries: 1-140 F, no 155 F	21015			
	reviewed from 3/1/2 the following: -March 2021, log id cycle temperature e entries, and all other	21, to 5/6/21, which identified entified the following wash				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00669	B. WING		05/0	; 6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TDAVED	CE CADE CENTED	303 SEVE	NTH STREE	т ѕоитн		
IRAVER	SE CARE CENTER	WHEATON	N, MN 56296	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21015	FApril 2021, log ider temperature entries entry, and all other cycle entries were rMay 2021, log ider 5/1/21 or 5/2/21. Twash cycle tempera 150 F. Rinse cycle 189-200 F. On 5/6/21, at 9:58 a interview, CD-A promanufacture guide they followed the muse of the dishwash expectation was for cleaning and wipe twere made. CD-A were used for sand and were also on thindicated she expediated and kept sea	ntified the following wash cycle at 12-155 F entries, 1-156 entries 150-154 F. Rinse ecorded at 181-200 F. Intified no entries made for the log identified the following ature entries: 7-155 F, and 3 entries were recorded at a.m. during a follow up vided the dishwasher to surveyor and confirmed anufactures instructions for the confirmed anufactures instructions for the confirmed the cheese slices wiches some supper nights the alternative menu. CD-A coted cheese would have been led in the bags. CD-A	21015			
	and foods not store cross contamination packages were left	rigerators were not kept clean d properly, there was a risk of n. CD-A indicated when the open and there were multiple ator, the potential for infection ere increased.				
	checked, cleaned, a heater for the dishw temperatures were washing. POA-A st who cleaned the kit coming to clean ab POA-A confirmed the	o.m. POA-A indicated he had and flushed the kitchen tank vasher and the dishwasher now running at 155 for ated he called the company chen vents and they would be ove the dishwasher next week he company informed him they above the dishwasher and				

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POA-A confirmed it was very dirty. POA-A

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
		00669	B. WING		05/0	6/2021
	PROVIDER OR SUPPLIER SE CARE CENTER	STREET ADI	DRESS, CITY, S NTH STREE N, MN 56296		, 00.0	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	indicated the dishwa 4/30/21. Review of the requeby the facility were forms included the the form titled Cleato be cleaned daily initial. The form wainstructions for cleathe from titled Weestaff to wipe out dain The form was blankthe form Monthly Coneed to be done by had hand written "mincluded all vents. The facility policy for found to be done by had hand written "mincluded all vents. The administrator was recessary the poregarding kitchen sedietary or designee all appropriate staff procedures. The directions of the dishward of the sedietary or designee all appropriate staff procedures. The directions of the sedietary or designee all appropriate staff procedures. The directions of the sedietary or designee all sedietary or designee all appropriate staff procedures. The directions of the sedietary or designee all sedietary or designee all sedietary or designee.	asher was last serviced on ested cleaning logs provided not filled out or dated. The following: uning Schedule, included items with blank areas to fill in or as blank and did not include ning the refrigerators. Ekly Cleaning List, instructed ry fridge-aide on Thursday. Cleaning List, identified all jobs 20th of each month. The form naster" over the month and the form was blank. Dod storage and cleaning of was requested, but not CHOD OF CORRECTION: with the director of dietary e(s) could review and revise colicies and procedures anitation. The director of (s) could provide training for on these policies and rector of dietary or designee assure staff are cleaning the	21015			
21426	MN St. Statute 144A Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			7/12/21

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Minnesota Department of Health		
) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED	
	С	
00669 B. WING	05/06/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
303 SEVENTH STREET SOUTH		
TRAVERSE CARE CENTER WHEATON, MN 56296		
	0.5	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIA		
DEFICIENCY)		
21426 Continued From page 33 21426		
(a) A nursing home provider must establish and		
maintain a comprehensive tuberculosis		
infection control program according to the most		
current tuberculosis infection control guidelines issued by the United States Centers for Disease		
Control and Prevention (CDC), Division of		
Tuberculosis Elimination, as published in CDC's		
Morbidity and Mortality Weekly Report (MMWR).		
This program must include a tuberculosis		
infection control plan that covers all paid and		
unpaid employees, contractors, students,		
residents, and volunteers. The Department of		
Health shall provide technical assistance		
regarding implementation of the guidelines.		
(b) Written compliance with this subdivision must		
be maintained by the nursing home.		
This MN Requirement is not met as evidenced		
by:		
Based on interview and document review the The Director of Nursing or designee w	vill	
facility failed to complete a Tuberculosis (TB) risk ensure the TB risk assessment will be		
assessment according to the current State completed according to the State guid	deline	
guidelines for preventing the transmission of recommendations.		
Tuberculosis. This deficient practice had the		
potential to affect all 39 residents residing in the)	
facility. corrected: July 12, 2021		
Findings include:		
During an interview on FIC/24, at 40:20 m m		
During an interview on 5/6/21, at 12:29 p.m.,		
administrator confirmed the facility had no written		
TB risk assessment completed. He revealed the facility had no policy for TB but the facility was		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
					С	
		00669	B. WING		05/0	6/2021
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56290			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 34	21426			
	Minnesota Health C	Care Settings as their guide.				
	Settings guide identicated should perform an inthe facility is determined assessment should facility is determined year. The guide profrom to conduct a fadirections. SUGGESTED MET	B, Regulations for on in Minnesota Health Care tified heath care settings nitial facility TB assessment. If nined to be medium-risk the be updated yearly or if the d low-risk updated every other vided three options to choose acility assessment and THOD FOR CORRECTION: sing or designee could ensure				
	according to the Starecommendations.	nent would be completed ate guideline R CORRECTION: Fourteen				
	(14) days.					
21550	MN Rule 4658.1325 Medications; Pharm	5 Subp. 1 Adminiatration of nacy Serv.	21550			7/12/21
		cy services. A nursing home e provision of pharmacy				
	by: Based on interview facility failed to obta medication for 1 of	and document review, the ain and administer ordered 1 residents (R190) who were ation administration.		o How corrective action will be accomplished for those residents for have been affected by the deficient practice. ¿ R190 received the medication a ordered without any further concern	as	

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Minneso	<u>ota Department of He</u>	alth				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE	
		00669	B. WING		05/0	; 6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TD AVED	SE CARE CENTER	303 SEVE	NTH STREE	т ѕоитн		
INAVEN	SE CARE CENTER	WHEATON	N, MN 56290	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 35	21550			
	R190 admission recidentified admission Diagnosis included anxiety disorder, obgastroesophageal r R190's hospital dischad been admitted in February sustains which ruptured her went surgery 2/3/21 graft. R190 had an then transferred to complications and with sepsis. Ultimat pain and her wound drainage and R190 R190's admission date of 5/3/21, Fodamilligrams /0.5 millii (0.5 ml subcutaneo blood clots. Review of R190's p 5/5/21, identified the 5/3/21 4:47 p.m., R facility. 5/4/21 7:13 a.m., m and a clarification w Fodaparinux.	cord (face sheet) dated 5/6/21, in to the facility on 5/3/21. heart failure, hypertension, resity, depression, eflux and sleep apnea. Charge notes identified sheet to the hospital following a falling a left knee dislocation popliteal artery. R190 under , and had a synthetic popliteal external fixator placed. R190 a rehab facility and developed was readmitted to the hospital ely, R190 had increasing leg als had to be reopened for required skin grafting. Corders identified original order aparinux Sodium (Arixtra) 2.5 liters (mg/ml) inject 2.5 mg us daily for prevention of a rogress notes from 5/3/21, to be following: 190 was admitted to the dedication review completed was requested for duration of a lacked documentation		o How the facility will identify other residents having the potential to be affected by the same deficient pratice. Residents currently residing a facility have the potential to be affected by a facility have the potential to be affected by the same deficient practice availability. No other issues were identified. o What measures will be put into paystemic changes made, to ensure the deficient practice will not recurted. The Director of Nursing educational Licensed Nursing staff on notifying physician when holding medicational clarification, or should a medicational available. o How the facility will monitor its cactions to ensure that the deficient practice is being corrected and will recur. ¿ Director of Nursing or designer audit medication omissions weekling days, then bi-weekly x 60 days; rebe brought to QAIP for further recommendation. "The date that each deficiency will corrected: July 12, 2021	e ctice. t the ected. nated ation place, or e that t ated the g the n for on is not prective t ll not be will y x 30 sults will	

During an interview on 5/5/21, at 11:02 a.m.,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00669	B. WING			C 06/2021
NAME OF PROVIDER OR	SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	30/2021
TRAVERSE CARE C	ENTER		NTH STREE N, MN 56296			
PREFIX (EACH	DEFICIENC'	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
on 5/3/2. I receive he evening. F medicatio admitted the blood thin after she was pain medication to delivered R190 recember 19:00 p.m. During an stated the pharmacy hours of 9 who are common medication medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication been control of the pharmacy hours of 9 who are common medication because the pharmacy hours of 9 who are common medication hours of 9 who are com	ed she had a set and she had be to the faciner until the was adminimated interview. I nurse (Roman American Ame	ad been admitted to the facility cated the facility did not tions until 10:30 p.m. that utified that not all of her been delivered the day she lity and she did not get her he evening of 5/4/21, the day	21550			

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00669	B. WING		05/0	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21550	During an interview Care pharmacist ide facility to contact the anytime a medicatic administer as order facility should have primary provider wh unavailable for adm During an interview administrator identif to contact the on-ca resident's medicatic A policy was reques SUGGESTED MET The director of nurs review and revise p pharmacy services, ordered, transcribed the pharmacy. The designee could dev about pharmacy set the medication. The could monitor to ens	on 5/6/21, at 3:09 p.m., Omnientified he would expect the erprovider for direction on was unavailable to ed. The pharmacist stated the contacted the on-call or nen R190's medication was inistration as ordered. on 5/6/21, at 4:00 p.m., fied he would expect the nurse all or primary physician if a on was unavailable as ordered. Sted but not provided. CHOD OF CORRECTION: Sing (DON) or designee could olicies and procedures for and how medication is d, delivered and dispensed by director of nursing or elop a system to educate staff rivices and the disposition of equality assurance committee	21550			
21805	MN St. Statute 144. Residents of HC Fa	651 Subd. 5 Patients & ac.Bill of Rights	21805			7/12/21
	residents have the courtesy and respec	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	-ETED
					l c	·
		00669	B. WING		05/0	6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			NTH STREE			
TRAVER	SE CARE CENTER		I, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 38	21805			
	by: Based on observati review the facility fa utilizing gait belts fo 3 of 3 residents (RS assistance with acti Findings include:	on, interview and document illed to promote dignity while or extended periods of time for 0, R33 and R24) who received vities of daily living (ADL's).		How corrective action will be accomplished for those residents thave been affected by the deficient practice. ¿ R9, R33, and R24 will have garemoved when not in use to promoin a dignified manner.	it belts ote care	
	R9's annual Minimum Data Set (MDS) dated 2/5/21, identified R1 had diagnoses which included Alzheimer's disease, dementia, anxiety and was severely cognitively impaired. R9's MDS further identified she required extensive assistance of one staff for dressing personal hygiene, limited staff assistance with transfers, eating, toileting and supervision with bed mobility. R9's care plan dated 4/10/21, indicated R9 was at high risk for falls related to confusion and was okay to ambulate in room /hallways with a four wheeled walker independently and required no staff assistance with transfers. R9's care plan did not include interventions for gait belt use.			How the facility will identify other rehaving the potential to be affected same deficient practice. ¿ Residents currently residing in facility who utilize gait belts have the potential to be affected. A review of completed for the lack of removal gait belt and no other residents we affected. What measures will be put into plasystemic changes made, to ensure the deficient practice will not recur in the Director of Nursing / designed and dignity with the focus on remogait belts when not in use.	the ne was of the ere ace, or e that . gnee will at Rights	
	was seated in the nother residents eati and had a white gai waist. R9 got up indindependently with the main dining roo (NA)-C came over a to walk with R9 whithe gait belt into the	s on 5/4/21, at 9:28 a.m. R9 nain dining room area with ng breakfast independently it belt fastened around her dependently and began to walk her four wheeled walker out of m area. Nursing assistant a few minutes later and began le she held onto the back of a living room area. NA-C own in the recliner in the living		How the facility will monitor its corractions to ensure that the deficient practice is being corrected and wil recur. ¿ Director of Nursing or designe complete daily audits for 2 weeks; weekly audits for 1 month to ensur appropriate gait belt utilization. Audresults and the data collected will I presented to the QAPI Committee by the Direct of Nursing or designed.	e will then re dit be monthly	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:) DATE SURVEY COMPLETED
7. BOILBING.	С
00669 B. WING	05/06/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TRAVERSE CARE CENTER 303 SEVENTH STREET SOUTH WHEATON, MN 56296	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
Continued From page 39 room area and immediately left. R9 continued to have the white gait belt fastened around her waist while she rocked in the recilinerat 12:30 p.m. R9 was seated in the main dining room area with other residents eating lunch independently and had a white gait belt fastened around her waist while she ate at 2:51 p.m. R9 was seated at a table in the living room area by the main entrance looking out the window and had a white gait belt fastened around her waist with her four wheeled walker sitting in front of her at 3:01 p.m. R9 continued to be seated at a table in the living room area by the main entrance and was visiting with her daughters and continued to have the gait belt fastened around her waist at 3:12 p.m. R9 continued to visit with her daughters while she had the gait belt fastened around her waist. NA-C had R9 sit down on chair in the dining room with other residents and placed a clothing protector across her chest area and immediately left leaving the gait belt fastened around her waist while she waited for lunchat 12:51 p.m. R9 received her lunch and began to eat lunch independently while she continued to have the gait belt fastened around her waist availe she waited for lunchat 12:51 p.m. R9 received her lunch and began to eat lunch independently while she continued to have the gait belt fastened around her waist while out in the common areas of the nursing home when R9 was not being assisted with her transfers or ambulation. On 5/4/21 at 3:41 p.m. family member (FM) -A	ng

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00669	B. WING		II	C 06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	·	
TRAVER	SE CARE CENTER		NTH STREET N, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 40	21805			
	she never used to the facility used it fo	wear a gait belt and indicated wear one before and thought or safety. FM-A indicated R9 referred not to have the gait				
	R33					
	R33 had diagnoses depression, renal in cognitively impaired she required extens personal hygiene, li	S dated 3/12/21, identified which included dementia, asufficiency and was severely I. R33's MDS further identified sive assistance of one staff for mited staff assistance with ers, toileting and dressing.				
	an ADL self care de required staff super encouragement ass wheeled walker with R33 does self trans	sist, a gait belt and four n transferring and ambulation. fer and ambulates with her r independently in her room				
	was seated in a recher husband and har around her waist at 4:59 p.m. R33 value in the main direction independently eating	s on 5/3/21, at 2:54 p.m. R33 diner in her room visiting with ad a white gait belt fastened was seated at the dining room ning room with her husband g supper and she continued to let fastened around her waist.				
	was seated at the d breakfast independ her walker located i	on 5/4/21, at 9:25 a.m. R33 lining room table eating ently with other residents with next to her. R33 had a white round her waist while she ate.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00669	B. WING		05/0	D 06/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			NTH STREE			
IRAVER	SE CARE CENTER	WHEATO	N, MN 56296	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 41	21805			
	routinely left R33's waist while out in th	s from 5/4/21, to 5/6/21, staff gait belt fastened around her e common areas of the R33 was not being assisted r ambulation.				
	finding and indicate supposed to be left have been removed	m. NA-E confirmed the above d gait belts were not on the residents and should d. NA-E also indicated leaving s a dignity issue and was he resident				
	(DON) confirmed the indicated staff should on due to a dignity is would expect staff to	o.m. the director of nursing ne above findings and Id not be leaving the gait belts issue. The DON indicated she to remove the gait belts when used to assist the residents.				
	R24					
	6/29/20, identified F impairment, and ha heart failure, demei of diseases that affi sugar), and arthritis identified he require and walking in his r	inimum Data Set (MDS) dated R24 had severe cognitive d diagnoses which included: ntia, diabetes mellitus (group ect how your body uses blood at R24's quarterly MDS further ed limited assist with transfers, oom and supervision walking IDS identified he used no				
	required supervision	S dated 3/1/21, identified R24 n with transfers and walking in or. R24's MDS identified R24 nobility.				
	R24's care plan dat	ed 5/6/21, identified R24 was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				C	
	00669	D. WING		05/0	6/2021
NAME OF PROVIDER OR SUPPLIE			STATE, ZIP CODE		
TRAVERSE CARE CENTER		NTH STREE N, MN 56296			
PREFIX (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
(ADL) self care podementia and disidentified R24 recon and off the toil transfers. R24's conterventions for QUALTH CONTENT CON	d had an activity of daily living erformance deficit related to ease process. R24's care planuired assistance with transfers et and was independent with are plan did not include ait belt use. a.m. R24 was sitting on the nd nursing assistant (NA)-B complete morning cares. NA-B se the bathroom, completed and dressed R24. At 8:27 a.m. ait belt and assisted R24 to chair with the use of his front had assisted him to walk to the 40 a.m. R24 was seated in a next to the table eating his were other residents and staffing room at this time. R24 the gait belt around his waist. It confirmed she had assisted the dining room. At 9:12 a.m. be seated in the dining room remained around his waist. B8 p.m. R24 was in the dining chair next to a table with two able and other residents and R24 had a gait belt around his waist. p.m. NA-D indicated once a end in the dining room, her usual ace the gait belt onto the walker the resident's room. NA-D to the dining room, because the din the dining room, because	21805			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00669	B. WING		05/0	6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56296			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21805	Continued From pa	ge 43	21805			
	On 5/5/21, at 2;12 progotten to take R2 was seated in the difference the facility had a his residents in the passes remove them for digresident. NA-B indicated have been removed On 5/6/21, at 11:49 nursing (IDON) states for transfers and was not steady. IDON into have their gait be behaviors or if they IDON indicated she resident's care plant.	o.m. NA-B stated she had 24's gait belt off of him once he lining room. NA-B indicated story of leaving gait belts on st and stated it was better to gnity and comfort for the cated R24's gait belt should d and hung over his walker. a.m. interim director of ted gait belts were to be used alking of residents if they were ndicated a resident may need belt left on if they were having became upset by removing it. If would expect this to be in the a if the gait belt was to be left at R24 should not have his gait				
	belt left on after use and confirmed this was a dignity issue. Review of facility policy titled Dignity Quality of Life dated 4/1/2008, indicated in full recognition of his or her individuality, the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.					
	SUGGESTED MET The administrator of implement systems maintained. The fact these systems. Rar be done to ensure of administrator or desiresults to the quality and further recommend.	THOD OF CORRECTION: or designee could develop and is to ensure resident dignity is cility could educate all staff on indom audits for dignity could congoing compliance. The signee could take that audit y assurance group for review				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
					С		
		00669	B. WING		05/0	6/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TRAVERSE CARE CENTER			NTH STREE N, MN 56296				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21942	Resident and Famil Resident advisory of boarding care home advisory council and fewer than three per participating. If one function, the nursing home shall docume council or councils a year. This subdivision	council. Each nursing home or e shall establish a resident d a family council, unless rsons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of es provided by section	21942			7/12/21	
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year. This had the potential to affect all 39 residents in the facility Findings include: On 5/6/21, at 2:23 p.m. the facility's efforts to establish a family council was reviewed with the administrator and he confirmed no attempts had been made to contact resident's families regarding the desire to form a family council within the past year. The administrator confirmed the finding and indicated he expected an attempt would have been made to establish a family council.			The Executive Director or designed review facility systems for family county and work on promotion and encouragement of this group on arbasis. "The date that each deficiency will corrected: July 12, 2021	ouncil n annual		
	Council/Family Cou the resident's family	olicy titled, Resident ncil dated 4/1/2008, indicated has the right to meet in the dies of other facility residents.					

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
				P. WING		С
		00669	B. WING		05/0	06/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRAVER	SE CARE CENTER		NTH STREE N, MN 56290			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21942	Continued From pa	ge 45	21942			
	The Administrator a facility systems for t	THOD OF CORRECTION: and/or designee could review family council and work on ouragement of this group on				
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen				

6899

PRINTED: 06/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING				E SURVEY IPLETED	
		0.45505				С	
		245585	B. WING			05/	06/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TRAVERSE CARE CENTER				B SEVENTH STREET SOUTH HEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	with Appendix Z, Er Requirements, §48: during a standard refacility was NOT in The facility's plan of as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Upon receipt of an aconsite revisit of you validate substantial regulation has been Policies/Procedures CFR(s): 483.73(b)(6), §483.73(b)(6), §48	f correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 acceptable electronic POC, an refacility may be conducted to compliance with the next attained.	E 0	24			7/12/21
		cilities]. At a minimum, the ures must address the					

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

Electronically Signed (X6) DATE

06/03/2021

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245585	B. WING _		I	C 06/2021
	NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP O 303 SEVENTH STREET SOUTH WHEATON, MN 56296		00/2021
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 024	(6) [or (4), (5), or (7) volunteers in an en staffing strategies, for integration of St health care profess during an emergen *[For RNHCIs at §4 procedures. (6) The emergency and oth strategies to addre emergency. *[For Hospice at §4 procedures. (4) Than emergency and strategies, including integration of State health care profes needs during an er This REQUIREMED by: Based on interview facility failed to devithe use of voluntee facility during an er	7) as noted above] The use of hergency or other emergency including the process and role rate and Federally designated sionals to address surge needs cy. 403.748(b):] Policies and e use of volunteers in an her emergency staffing as surge needs during an 418.113(b):] Policies and he use of hospice employees in other emergency staffing g the process and role for and Federally designated sionals to address surge hergency. NT is not met as evidenced and document review, the relop policy and procedure for ers or other personnel in the mergency. This deficient	E 02	o How corrective action will accomplished for those reshave been affected by the opractice.	idents found to deficient	
	who currently resid Findings include: On 5/6/21, at 10:15 Emergency Policy revised 5/2020, wa	5 a.m. review of the facility's and Procedure manual, s conducted with the		¿ The use of volunteers i emergency or other emerge strategies, including the profor integration of State and designated healthcare profoaddress surge needs during emergency was developed the facility's Emergency Profos	ency staffing ocess and role Federally essionals to g an and added to	
	findings. The manuassociated with em	ent and he confirmed the ual included various topics ergency preparedness, all lacked documentation of a		o How the facility will identification residents having the potent		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245585	B. WING		C 05/06/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2021	
TRAVER	SE CARE CENTER			303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
E 024	Continued From pa policy for use of vol	_	E 02	affected by the same deficient praction. No residents were affected. Residents residing in the facility has potential to be affected. o What measures will be put into pleasystemic changes made, to ensure the deficient practice will not recur. The Plant Operations Director of designee will educate staff on the performance of Volunteers During Emergencies. o How the facility will monitor its confactions to ensure that the deficient	ve the ace, or that or olicy	
				practice is being corrected and will recur. ¿ The Director of Plant Operation designee will engage in community Disaster Drill annually, will conduct internal drills, and will conduct "Tab discussion to include a scenario of alternative care site and challenge questions and use of volunteers an professionals to test the revised Emergency Preparedness Plan. Roof the drills will be brought to the Sa and QAPI committee for further recommendations.	le Top" d other esults afety	
	EP Testing Require CFR(s): 483.73(d)(E 0	corrected: July 12, 2021	7/12/21	
	§460.84(d)(2), §482	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2),				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING		05	C / 06/2021
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	§485.625(d)(2), §496.4 §491.12(d)(2), §496.4 *[For ASCs at §416.6 "Organizations" und §485.920, RHCs/Fe Facilities at §494.6 (2) Testing. The [fato test the emerger must do all of the formust do all	35.727(d)(2), §485.920(d)(2), 4.62(d)(2). 5.54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD 2]: cility] must conduct exercises acy plan annually. The [facility] bellowing: ull-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based for individual facility-based facility-	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING			C / 06/2021
	NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	designed to challer (iii) Analyze the [fac maintain document exercises, and eme [facility's] emergence *[For Hospices at 4 (2) Testing for hos patient's home. The exercises to test th annually. The hosp (i) Participate in a community based of (A) When a community based of (A) When a community community-based of functional exercise (B) If the hospice e man-made emerge the emergency plan engaging in its next community-based functionset of the emerg (ii) Conduct an ado opposite the year the exercise under part is conducted, that in to the following: (A) A second full-s community-based of exercise; or (B) A mock disaste (C) A tabletop exercise a facilitator and inca a narrated, clinicalliscenario, and a set directed messages	age an emergency plan. cility's] response to and cation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] pices that provide care in the de hospice must conduct de emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not at an individual facility based every 2 years; or experiences a natural or ency that requires activation of an, the hospital is exempt from at required full scale exercise or individual conal exercise following the ency event. ditional exercise every 2 years, agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	EO	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245585	B. WING		05	C / 06/2021
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 039	(3) Testing for hosp care directly. The exercises to test the year. The hospice (i) Participate in aris community-base (A) When a community-based funct (B) If the hospice eman-made emerge the emergency planengaging in its next based or facility-based following the onset (ii) Conduct an adding include, but is (A) A second full-scommunity-based exercise; or (B) A mock disaste (C) A tabletop exercise facilitator that inclunarrated, clinically-and a set of problemessages, or prepichallenge an emerging in Analyze the homaintain document exercises, and emergen hospice's emergen *[For PRFTs at §44 §482.15(d), CAHs	pices that provide inpatient hospice must conduct be emergency plan twice per must do the following: an annual full-scale exercise that ad; or unity-based exercise is not at an annual individual ional exercise; or experiences a natural or ency that requires activation of an, the hospice is exempt from at required full-scale community sed functional exercise of the emergency event. In ditional annual exercise that not limited to the following: acale exercise that is or a facility based functional er drill; or recise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. In a spice's response to and tation of all drills, tabletop ergency events and revise the act plan, as needed. 41.184(d), Hospitals at at §485.625(d):]	EO	39		
	(2) Testing. The [Pl	RTF, Hospital, CAH] must to test the emergency plan				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING			C 05/06/2021
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER				STREET ADDRESS, CIT 303 SEVENTH STRE WHEATON, MN 56	TY, STATE, ZIP CODE EET SOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	twice per year. The do the following: (i) Participate in an is community-base (A) When a commu accessible, conduct facility-based functi (B) If the [PRTF, He actual natural or ma requires activation [facility] is exempt for the required full-scale of facility-based functionset of the emerg (ii) Conduct an and that may include following: (A) A second full-scommunity-based of functional exercises (B) A mock (C) A tabletop of led by a facilitator a discussion, using a emergency scenari statements, directe questions designed plan. (iii) Analyze the maintain document exercises, and eme [facility's] emergence *[For PACE at §460 (2) Testing. The PA exercises to test the	e [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. a [additional] annual exercise or de, but is not limited to the cale exercise that is or individual, a facility-based or a disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared d to challenge an emergency e [facility's] response to and ation of all drills, tabletop ergency events and revise the exp plan, as needed.	E	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING		I	C / 06/2021
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	(i) Participate in an is community-base (A) When a community-based (A) When a community-based function (B) If the PACE expression of the emergency planengaging in its next based or individual, exercise following the exercise following the exercise under participation of the following: (ii) Conduct an years opposite the exercise under participation of the following: (A) A second full-scommunity-based of functional exercise; (B) A mock disaste (C) A tabletop exercise a facilitator and inclusing a narrated, of scenario, and a set directed messages designed to challen (iii) Analyze the PA maintain document exercises, and emergancy including unannour in	annual full-scale exercise that d; or unity-based exercise is not than annual individual, onal exercise; or periences an actual natural or noty that requires activation of any the PACE is exempt from a required full-scale community facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited to cale exercise that is or individual, a facility based or er drill; or roise or workshop that is led by undes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. (CE's response to and action of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):] The [LTC facility,	EO	39		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245585	B. WING		I	C / 06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 039	(i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the [LTC facility-based function actual natural or marequires activation of LTC facility is exemined a full-scale individual, facility-based individual, facility-based (ii) Conduct an additional exercise; (B) A mock disasted (C) A tabletop exert a facilitator includes narrated, clinically-rand a set of problem messages, or preparticity and a set of problem messages, or preparticity and maintain documexercises, and emergical maintain documexercises, and emergical transport of the ICF/IIDs at §4 (2) Testing. The ICF to test the emergent The ICF/IID must document in an is community-based (A) When a community-based (A) When a community-based (A)	annual full-scale exercise that d; or unity-based exercise is not that an annual individual, onal exercise. Tyly facility experiences an en-made emergency that of the emergency plan, the exterior end functional exercise of the emergency event. The exercise of the emergency event. The exercise that the exercise that the exercise that is or an individual, facility based or exercise or workshop that is led by a group discussion, using a relevant emergency scenario, or statements, directed exercise that exercise depends and questions designed to gency plan. To facility facility's response to mentation of all drills, tabletop expense events, and revise the exercise second exercise that exercises the exercise that disconditional exercises and revise the exercise that disconditional exercise is not the following: annual full-scale exercise is not the annual individual,	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245585	B. WING			C / 06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	(B) If the ICF/IID exman-made emerge the emergency plarengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-so community-based of functional exercises (B) A mock disaste (C) A tabletop exerca facilitator and inclusing a narrated, of scenario, and a set directed messages designed to challer (iii) Analyze the ICF maintain document exercises, and emerger increases (B) Testing. The to test the emerger	speriences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the sitional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or an ind	EO	39		
	(i) Participate in a frommunity-based; (A) When a correct accessible, conduct facility-based function. (B) If the HHA or man-made emer	mmunity-based exercise is not tan annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation blan, the HHA is exempt from				

NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES WHATON, MN 56296	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
TRAVERSE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			245585	B. WING		05	C 5/06/2021
E 039 Continued From page 10 community-based or individual, facility based functional exercise or limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Canduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and					303 SEVENTH STREET SOUTH		
community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency plan, the OPO is exempt from	E 039	community-based functional exercise emergency event. (ii) Conduct an add opposite the year the exercise under partise conducted, that limited to the follow (A) A second functional exercise (B) A mock dise (C) A tabletopoled by a facilitator addiscussion, using a emergency scenar statements, directed questions designed plan. (iii) Analyze the Hedocumentation of a emergency events emergency plan, a *[For OPOs at §48 (d)(2) Testing. The to test the emergency following: (i) Conduct a pape workshop at least a led by a facilitator addiscussion, using a emergency scenar statements, directed questions designed plan. If the OPO examples of the open and	or individual, facility based following the onset of the litional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ving: ull-scale exercise that is or an individual, facility-based; or aster drill; or exercise or workshop that is and includes a group a narrated, clinically-relevant io, and a set of problem and messages, or prepared at to challenge an emergency lA's response to and maintain all drills, tabletop exercises, and and revise the HHA's and revise or annually. A tabletop exercise or annually. A tabletop exercise is and includes a group an narrated, clinically relevant io, and a set of problem and messages, or prepared at to challenge an emergency experiences an actual natural or ency that requires activation of	EC	039		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	COMI	(X3) DATE SURVEY COMPLETED	
		245585	B. WING _			06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
E 039	engaging in its next following the onset (ii) Analyze the OP documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the following (i) Conduct a paper least annually. A tare discussion led by a clinically-relevant exprepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency plan, as This REQUIREMED by: Based on interview facility failed to concommunity based exercise, a table to emergency prepare per year. This had residents who currealong with staff who the findings included the concommunity based of the concommun	of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct e emergency plan. The RNHCl ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCl's response to and ation of all tabletop exercises, ents, and revise the RNHCl's is needed. NT is not met as evidenced of and document review, the duct a second full-scale exercise, a facility based p, or a facility drill to test their edness program at least twice the potential to affect all 39 ently resided in the facility, of work in the facility.	E 03	o How corrective action will accomplished for those residuave been affected by the dipractice. ¿ The community has scheommunity disaster plan dril (the specific date pending corganizers). A "Table Top" of scheduled for 9/21/2021, to scenarios to prepare for an The plan was developed and facility's Emergency Prepare of How the facility will identify residents having the potential	dents found to eficient neduled a all in June 2021 community discussion is discuss emergency. d added to the edness Plan.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		245585	B. WING				06/ 2021	
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	30/2021	
					SEVENTH STREET SOUTH			
TRAVER	SE CARE CENTER				ATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE) BE	(X5) COMPLETION DATE	
E 039	emergency prepare COVID-19 began.	edness exercises since ency Preparedness was	EC	at is R prices of the state of	ffected by the same deficient pra No residents were affected. esidents residing in the facility had be provided in the facility Provided in the provided in t	or corrective to a the cor		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING		05	C / 06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296		700,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 041	S482.15(e) Condition (e) Emergency and hospital must imple power systems base forth in paragraph (policies and proced paragraphs (b)(1)(i) §483.73(e), §485.6 (e) Emergency and [LTC facility and the emergency and state emergency plant this section. §482.15(e)(1), §483. Emergency general must be located in requirements found Code (NFPA 99 and Amendments TIA 112-5, and TIA 12-6) and Tentative Interingular the section (PFPA 99) and Amendments TIA 112-5, and TIA 12-6) and Tentative Interingular the section (PFPA 99) and Amendments TIA 112-5, and TIA 12-6) and Tentative Interingular the section (PFPA 99) and Tentative Inte	on for Participation: standby power systems. The ement emergency and standby ed on the emergency plan set a) of this section and in the lures plan set forth in) and (ii) of this section. 25(e) standby power systems. The e CAH] must implement ndby power systems based on a set forth in paragraph (a) of 3.73(e)(1), §485.625(e)(1) tor location. The generator accordance with the location I in the Health Care Facilities d Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA a, Life Safety Code (NFPA 101 m Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, ure is built or when an existing	E O E O			7/12/21	
	and [maintenance]	ver system inspection, testing, requirements found in the es Code, NFPA 110, and Life					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245585	B. WING_			C / 06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296		.00,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 041	Emergency general LTC facilities] that it to power emergency for how it will keep operational during evacuates. *[For hospitals at § and CAHs §485.62 The standards inconsection are approvereference by the Diffederal Register in 552(a) and 1 CFR material from the sinspect a copy at the Center, 7500 Seculor at the National Administration (NA availability of this in 202-741-6030, or good the changes in the changes in the changes in the changes. (1) National Fire Prester Course of the Center, MA 02169, 1.617.770.3000. (i) NFPA 99, Healthedition, issued Aug (ii) Technical interir NFPA 99, issued A (iii) TIA 12-3 to NFI in the change of the	and tor fuel. [Hospitals, CAHs and maintain an onsite fuel source by generators must have a plan emergency power systems the emergency, unless it 482.15(h), LTC at §483.73(g), 25(g):] by proported by reference in this ed for incorporation by irector of the Office of the accordance with 5 U.S.C. part 51. You may obtain the ources listed below. You may be CMS Information Resource rity Boulevard, Baltimore, MD archives and Records RA). For information on the naterial at NARA, call go to: a.gov/federal_register/code_of ins/ibr_locations.html. his edition of the Code are derence, CMS will publish a dederal Register to announce rotection Association, 1, www.nfpa.org, a. Care Facilities Code, 2012 just 11, 2011. The amendment (TIA) 12-2 to	E 04	11		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
		245585	B. WING _		l	06/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 041	(v) TIA 12-5 to NFF (vi) TIA 12-6 to NF (vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-2 to NF 2012. (x) TIA 12-3 to NFF 2013. (xi) TIA 12-4 to NF 2013. (xii) NFPA 110, Sta Standby Power Sy TIAs to chapter 7, This REQUIREME by: Based on interview facility failed to imp standby power sys generator safety ch had the potential to in the facility. Findings include: On 5/6/21, at 10:15 the facility Emerge with surveyor. Ad safety survey had I problems noted wit unaware of the det On 5/5/21, the stat facility tour, review maintenance docu interview with the p (POM), which reve	PA 99, issued August 1, 2013. PA 99, issued March 3, 2014. PA 101, issued August 11, PA 101, issued October 30, PA 101, issued October 22, PA 101, issued October 30, PA 101, iss	E 04	o How corrective action will accomplished for those residhave been affected by the depractice. ¿ No residents were affect o How the facility will identify residents having the potential affected by the same deficient. Residents residing in the the potential to be affected. o What measures will be put systemic changes made, to the deficient practice will not. ¿ Plant Operations Directore-educated on the 2012 edit Life Safety Code (NFPA 101) 9.1.3.1 and the 2010 edition section 8.4.2. ¿ Plant Operations Directore-educated on the Generatore-educated on	dents found to efficient ed. other al to be nt practice. facility have into place, or ensure that recur. or was tion of the section of NFPA 110,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245585	B. WING_			06/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 303 SEVENTH STREET SOUTH WHEATON, MN 56296		····
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 041	Continued From pagenerator in the last confirmed these firms	st 12 months. The POM	E 04	Policy and Procedure. o How the facility will monitor i actions to ensure that the definition practice is being corrected and recur. ¿ The Executive Director will Plant Operations Generator lo for 3 months to assure complications of the audits will be breauther and QAPI Committee for recommendations.	cient d will not ll audit the g monthly ance. ought to the or further	
F 000	survey was conduction investigation was a was found to be Not requirements of 42 Requirements for L. The following compunity UNSUBSTANTIAT H5585017C (MNOT H5585019C (MNOT H5585019C (MNOT H5585020C (MNOT H6 facility's plan of as your allegation of Departments acce.	21, a standard recertification cted at your facility. A complaint also conducted. Your facility OT in compliance with the CFR 483, Subpart B, Long Term Care Facilities. colaints were found to be ED: 10069966). 10069474). 10056787).	F 00	o The date that each deficience corrected: July 12, 2021	cy will de	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
		245585	B. WING				06/ 2021
	PROVIDER OR SUPPLIER SE CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 03 SEVENTH STREET SOUTH VHEATON, MN 56296	00/	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	at the bottom of the form. Your electroni be used as verificat	e first page of the CMS-2567 ic submission of the POC will	F (000			
	validate that substa regulations has bee Resident Rights/Ex CFR(s): 483.10(a)(ercise of Rights	F t	550			7/12/21
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and dig resident in a manne promotes maintena her quality of life, re	cility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca severity of condition must establish and practices regarding provision of service	facility must provide equal are regardless of diagnosis, a, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all s of payment source.					
		e right to exercise his or her of the facility and as a citizen					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245585	B. WING			05/0)6/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 03 SEVENTH STREET SOUTH VHEATON, MN 56296	0070	7072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	§483.10(b)(1) The resident can exerci interference, coerc from the facility. §483.10(b)(2) The free of interference reprisal from the farights and to be supexercise of his or his subpart. This REQUIREMED by: Based on observative the facility factilizing gait belts for 3 of 3 residents (RS assistance with active Findings include: R9 R9's annual Minimum 2/5/21, identified Rincluded Alzheimer and was severely of further identified shassistance of one shygiene, limited states.	facility must ensure that the se his or her rights without ion, discrimination, or reprisal resident has the right to be coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced tion, interview and document ailed to promote dignity while or extended periods of time for 2, R33 and R24) who received ivities of daily living (ADL's).	F 5	550	How corrective action will be accomplished for those residents for have been affected by the deficient practice. ¿ R9, R33, and R24 will have gair removed when not in use to promotin a dignified manner. How the facility will identify other rehaving the potential to be affected became deficient practice. ¿ Residents currently residing infacility who utilize gait belts have the potential to be affected. A review we completed for the lack of removal or gait belt and no other residents were affected.	t belts te care sidents by the the e vas of the	
	high risk for falls re okay to ambulate ir wheeled walker ind staff assistance wit	ed 4/10/21, indicated R9 was at lated to confusion and was a room /hallways with a four lependently and required no h transfers. R9's care plan didutions for gait belt use.			What measures will be put into place systemic changes made, to ensure the deficient practice will not recur. ¿ The Director of Nursing / designed re-educate Nursing staff regarding Resident Rights and dignity with the on removal of gait belts when not in	that nee will e focus	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
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		245585	B. WING			05/0	06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	During observations was seated in the nother residents eati and had a white gawaist. R9 got up indindependently with the main dining roo (NA)-C came over ato walk with R9 whith the gait belt into the assisted R9 to sit do room area and immhave the white gait while she rocked in at 12:30 p.m. R9 wroom area with other independently and around her waist which will will be window and had around her waist wisitting in front of he at 3:01 p.m. R9 co table in the living roand was visiting with to have the gait belt at 3:12 p.m. R9 co daughters while she around her waist. During observations was walking to the wheeled walker and back of the gait belt NA-C had R9 sit do with other residents.	s on 5/4/21, at 9:28 a.m. R9 nain dining room area with ng breakfast independently it belt fastened around her dependently and began to walk her four wheeled walker out of m area. Nursing assistant a few minutes later and began le she held onto the back of e living room area. NA-C own in the recliner in the living nediately left. R9 continued to belt fastened around her waist the recliner. vas seated in the main dining er residents eating lunch had a white gait belt fastened hile she ate. as seated at a table in the the main entrance looking out d a white gait belt fastened ith her four wheeled walker	F	5550	How the facility will monitor its correactions to ensure that the deficient practice is being corrected and will recur. ¿ Director of Nursing or designed complete daily audits for 2 weeks; weekly audits for 1 month to ensure appropriate gait belt utilization. Aud results and the data collected will be presented to the QAPI Committee monthly by the Direct of Nursing or designee. The QAPI committee will and make any necessary recommendations regarding audits • The date that each deficiency will corrected: July 12, 2021	not will then e it e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
245585 B. WING	C 05/06/2021
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER STREET ADDRESS, CITY 303 SEVENTH STREE WHEATON, MN 562	Y, STATE, ZIP CODE ET SOUTH
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
left leaving the gait belt fastened around her waist while she waited for lunchat 12:51 p.m. R9 received her lunch and began to eat lunch independently while she continued to have the gait belt fastened around her waist area. During observations from 5/4/21 to 5/6/21 staff routinely left R9's gait belt fastened around her waist while out in the common areas of the nursing home when R9 was not being assisted with her transfers or ambulation. On 5/4/21 at 3:41 p.m. family member (FM) -A confirmed R9 does wear a gait belt and indicated she never used to wear one before and thought the facility used it for safety. FM-A indicated R9 did not like it and preferred not to have the gait belt on. R33 R33's quarterly MDS dated 3/12/21, identified R33 had diagnoses which included dementia, depression, renal insufficiency and was severely cognitively impaired. R33's MDS further identified she required extensive assistance of one staff for personal hygiene, limited staff assistance with bed mobility, transfers, toileting and dressing. R33's care plan dated 5/6/21, indicated R33 had an ADL self care deficit related to dementia and required staff supervision, cueing, encouragement assist, a gait belt and four wheeled walker with transferring and ambulation. R33 does self transfer and ambulates with her four wheeled walker independently in her room	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		COM	(X3) DATE SURVEY COMPLETED	
	245585	B. WING			C / 06/2021	
		,	STREET ADDRESS, CITY, STATE, ZIP C 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
During observations was seated in a receiver her husband and her around her waist. - at 4:59 p.m. R33 table in the main districted in the main districted and the components of the components	siner in her room visiting with ad a white gait belt fastened was seated at the dining room ning room with her husband g supper and she continued to left fastened around her waist. on 5/4/21, at 9:25 a.m. R33 dining room table eating ently with other residents with next to her. R33 had a white round her waist while she ate. Is from 5/4/21, to 5/6/21, staff gait belt fastened around her her waist while she ate. Is from 5/4/21, to 5/6/21, staff gait belt fastened around her her waist while she ate. In R33 was not being assisted or ambulation. In NA-E confirmed the above and gait belts were not on the residents and should do. NA-E also indicated leaving as a dignity issue and was the resident In the director of nursing the gait belts issue. The DON indicated she to remove the gait belts when	F 5	50			
	inimum Data Set (MDS) dated					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa During observations was seated in a rece her husband and he around her waist at 4:59 p.m. R33 y table in the main di independently eatin have a white gait be During observation was seated at the co breakfast independ her walker located gait belt fastened a During observations routinely left R33's waist while out in th nursing home wher with her transfers of On 5/6/21,10:10 a.r finding and indicate supposed to be left have been removed the gait belts on wa uncomfortable for to On 5/6/21, at 1:59 p (DON) confirmed th indicated staff shou on due to a dignity would expect staff to they are not being to	SE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room visiting with her husband and had a white gait belt fastened around her waist. - at 4:59 p.m. R33 was seated at the dining room table in the main dining room with her husband independently eating supper and she continued to have a white gait belt fastened around her waist. During observation on 5/4/21, at 9:25 a.m. R33 was seated at the dining room table eating breakfast independently with other residents with her walker located next to her. R33 had a white gait belt fastened around her waist while she ate. During observations from 5/4/21, to 5/6/21, staff routinely left R33's gait belt fastened around her waist while out in the common areas of the nursing home when R33 was not being assisted with her transfers or ambulation. On 5/6/21,10:10 a.m. NA-E confirmed the above finding and indicated gait belts were not supposed to be left on the residents and should have been removed. NA-E also indicated leaving the gait belts on was a dignity issue and was uncomfortable for the resident On 5/6/21, at 1:59 p.m. the director of nursing (DON) confirmed the above findings and indicated staff should not be leaving the gait belts on due to a dignity issue. The DON indicated she would expect staff to remove the gait belts when they are not being used to assist the residents.	PROVIDER OR SUPPLIER SE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room visiting with her husband and had a white gait belt fastened around her waist. - at 4:59 p.m. R33 was seated at the dining room table in the main dining room with her husband independently eating supper and she continued to have a white gait belt fastened around her waist. During observation on 5/4/21, at 9:25 a.m. R33 was seated at the dining room table eating breakfast independently with other residents with her walker located next to her. R33 had a white gait belt fastened around her waist while she ate. During observations from 5/4/21, to 5/6/21, staff routinely left R33's gait belt fastened around her waist while out in the common areas of the nursing home when R33 was not being assisted with her transfers or ambulation. On 5/6/21,10:10 a.m. NA-E confirmed the above finding and indicated gait belts were not supposed to be left on the residents and should have been removed. NA-E also indicated leaving the gait belts on was a dignity issue and was uncomfortable for the resident On 5/6/21, at 1:59 p.m. the director of nursing (DON) confirmed the above findings and indicated staff should not be leaving the gait belts on due to a dignity issue. The DON indicated she would expect staff to remove the gait belts when they are not being used to assist the residents.	TO DENTIFICATION NUMBER: 245585 245585 ROVIDER OR SUPPLIER SE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room visiting with her husband and had a white gait belt fastened around her waist. —at 4:59 p.m. R33 was seated at the dining room table in the main dining room with her husband independently eating supper and she continued to have a white gait belt fastened around her waist. During observations on 5/4/21, at 9:25 a.m. R33 was seated at the dining room table eating breakfast independently with other residents with her walker located next to her. R33 had a white gait belt fastened around her waist while out in the common areas of the nursing home when R33 was not being assisted with her transfers or ambulation. On 5/6/21,10:10 a.m. NA-E confirmed the above finding and indicated gait belts were not supposed to be left on the residents and should have been removed. NA-E also indicated leaving the gait belt son was a dignity issue and was uncomfortable for the residents of the resi	ROVIDER OR SUPPLIER SE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 During observations on 5/3/21, at 2:54 p.m. R33 was seated in a recliner in her room visiting with her husband and had a white gait belf fastened around her waist. During observation on 5/4/21, at 9:25 a.m. R33 was seated at the dining room table eating breakfast independently with other residents with her walker located next to her. R33 had a white gait belf fastened around her waist. During observation on 5/4/21, at 9:25 a.m. R33 was seated at the dining room table eating breakfast independently with other residents with her walker located next to her. R33 had a white gait belf fastened around her waist while out in the common areas of the nursing home when R33 was not being assisted with her transfers or ambulation. On 5/6/21, 10:10 a.m. NA-E confirmed the above finding and indicated gait belts were not supposed to be left on the residents and should have been removed. NA-E also indicated leaving the gait belts on was a dignity issue and was uncomfortable for the resident to be leaving the gait belts affs should not be leaving the gait belts on was a dignity issue and was uncomfortable for the resident belts when they are not being used to assist the residents.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245585	B. WING _		05	5/06/2021		
	PROVIDER OR SUPPLIER SE CARE CENTER	-		STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 550	6/29/20, identified impairment, and had heart failure, demond of diseases that af sugar), and arthriticidentified he required and walking in his in corridor. R24's mobility devices. R24's quarterly MI required supervision his room and corriused a walker for a walk	R24 had severe cognitive ad diagnoses which included: entia, diabetes mellitus (group fect how your body uses blood s. R24's quarterly MDS further red limited assist with transfers, room and supervision walking MDS identified he used no DS dated 3/1/21, identified R24 on with transfers and walking in dor. R24's MDS identified R24 mobility. Atted 5/6/21, identified R24 was d had an activity of daily living rformance deficit related to ase process. R24's care planuired assistance with transfers t and was independent with are plan did not include	F 55	50				
	edge of his bed, an was in his room to assisted R24 to us personal hygiene a NA-B applied a gatransfer from his c wheeled walker and dining room. At 8:4 dining room chair is breakfast. There we present in the dining continued to have At 8:41 a.m. NA-B	a.m. R24 was sitting on the and nursing assistant (NA)-B complete morning cares. NA-B e the bathroom, completed and dressed R24. At 8:27 a.m. it belt and assisted R24 to hair with the use of his front id assisted him to walk to the 40 a.m. R24 was seated in a next to the table eating his were other residents and staffing room at this time. R24 the gait belt around his waist. confirmed she had assisted the dining room. At 9:12 a.m.						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245585	B. WING_		0.5	C / 06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP O 303 SEVENTH STREET SOUTH WHEATON, MN 56296		70072021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 550	R24 continued to be while his gait belt recommendated in a cother men at his tal staff in the room. Recommendate waist. On 5/5/21, at 1:26 president was seated process was to place or bring it back to the stated the gait belt resident while seated that was a dignity is on 5/5/21, at 2;12 forgotten to take R2 was seated in the cothe facility had a his residents in the pasternove them for direction. NA-B indivate been removed on 5/6/21, at 11:49 nursing (IDON) stafor transfers and we not steady. IDON in to have their gait be behaviors or if they IDON indicated she resident's care plar on. IDON confirmed belt left on after used dignity issue.	e seated in the dining room emained around his waist. B p.m. R24 was in the dining thair next to a table with two ole and other residents and 24 had a gait belt around his o.m. NA-D indicated once a d in the dining room, her usual ce the gait belt onto the walker he resident's room. NA-D should not be kept on a ed in the dining room, because	F 5	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED	
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	245585	B. WING			/06/2021	
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
his or her individua care for residents in	B, indicated in full recognition of lity, the facility will promote n a manner and in an naintains or enhances each and respect.	F 5			7/12/21	
SS=C CFR(s): 483.10(g)(§483.10(g)(4) The receive notices ora writing (including B language he or she (i) Required notices The facility must fu description of legal (A) A description of personal funds, une section; (B) A description of procedures for estaincluding the right to resources under security Act. (C) A list of names, email), and telephots State regulatory and resident advocacy Survey Agency, the State Long-Term Coprotection and advocacy services where stain long-term care faagency for informatic community and the and (D) A statement that complaint with the services or services with the services with the services in the services with the s					7712/21	

CLIVILI	13 I OIT MEDICAILE	. & WILDICAID SLIVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	СОМІ	E SURVEY PLETED
		245585	B. WING			05/0	06/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	03 SEVENTH STREET SOUTH		
TRAVER	SE CARE CENTER			V	VHEATON, MN 56296		
(VA) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREF	IX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP	RIATE	DATE
					DEFICIENCY)		
F 574	Continued From pa	ige 25	F t	574			
	federal nursing faci	lity regulations, including but					
	not limited to reside	ent abuse, neglect,					
	exploitation, misap	propriation of resident property					
	in the facility, non-c	compliance with the advance					
	directives requirem	ents and requests for					
		ng returning to the community.					
		contact information for State					
		organizations including but					
		tate Survey Agency, the State					
	Long-Term Care Ombudsman program						
	(established under section 712 of the Older						
		965, as amended 2016 (42					
) and the protection and					
		as designated by the state, and					
		er the Developmental					
		nce and Bill of Rights Act of					
	2000 (42 U.S.C. 15						
		arding Medicare and Medicaid					
	eligibility and cover						
		ation for the Aging and • Center (established under					
		(B)(iii) of the Older Americans					
		rong Door Program;					
		ition for the Medicaid Fraud					
	Control Unit; and	alon for the Medicala Fraud					
	'	I contact information for filing					
		plaints concerning any					
		of state or federal nursing					
		including but not limited to					
	resident abuse, neg						
		resident property in the					
		ance with the advance					
		ents and requests for					
		ng returning to the community.					
		NT is not met as evidenced					
	by:						
		tion, interview, and document			How corrective action will be		
		ailed to provide information to			accomplished for those residents f	ound to	
	5 of 5 residents (R2	23, R27, R17, R10, R31) who			have been affected by the deficien	t	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		245585	B. WING _		1	C 06/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 303 SEVENTH STREET SOUTH		50/2021
TRAVER	SE CARE CENTER			WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 574	Continued From pa	age 26	F 57	4		
	attended the reside regarding the Omb for residents residing potential to affect a facility.	ent council group meeting udsman services as advocates ng in the facility. This had the Ill 39 residents residing in the		practice. ¿ R23, R27, R17, R10, R31 received a copy of Ombudsman notification. The Ombudsman prominently displayed in reside easy viewing.	n posters are	
	05/05/21, at 1:37 p R27, R17, R10 and Upon asking, R23, indicated they were	group meeting held on .m. state surveyors and R23, I R31 were in attendance. R27, R17, R10 and R31 e not aware of where to find the to contact the Ombudsman if		How the facility will identify oth having the potential to be affect same deficient practice. ¿ Residents currently residir facility have received a copy combudsmen notification and not the location of this posted infor	eted by the ng in the of otified of	
	During observation Ombudsman inforr the wall by the Res by the main entran- Review of the resid 1/1/2021, to 5/1/21	lent council minutes from , revealed no information ontact the Ombudsman was		What measures will be put into systemic changes made, to en the deficient practice will not read to be provided in the Admission of the Admiss	sure that ecur. vill continue n Packet. vill be Council	
	confirmed the above fairly new in her polar had not informed the the contact information on 5/6/21, at 12:06 confirmed the above would expect staff the Ombudsman contact within the building.	s a.m. the activity director (AD) we findings and stated she was sition. The AD indicated she he residents of where to find ation for the Ombudsmen. S p.m. the administrator we finding and indicated he to inform the residents where contact information was located ty policy titled, Resident		How the facility will monitor its actions to ensure that the deficience is being corrected and recur. ¿ The Executive Director will Resident Council Notes on an basis for 3 (three) months to ediscussion was held regarding of the survey results. 10% of residents will be randomly aud days for knowledge of the offic Ombudsman, and where this control of the survey results.	cient I will not I monitor nonthly nsure a the location current ited x 90	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING				0
NAMEOF	DOVIDED OD SUDDUED	243303	B: *******	CTDEET ADDRESS OFF STATE 7	ID CODE	05/0	06/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
TRAVER	SE CARE CENTER			303 SEVENTH STREET SOUTH			
				WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD E THE APPROPRI	3E	(X5) COMPLETION DATE
F 574	the resident has the	ge 27 incil dated 4/1/2008, indicated e right to organize and ent groups in the facility.	F 5	information can be locate committee will review an necessary recommendar audits	d make any	/	
	Right to Survey Res CFR(s): 483.10(g)(sults/Advocate Agency Info 10)(11)	F 5	•The date that each defice corrected: July 12, 2021	ciency will b	e	7/12/21
	(i) Examine the resident of the facility condusurveyors and any respect to the facility (ii) Receive information.	ition from agencies acting as and be afforded the opportunity					
	and family member residents, the result the facility. (ii) Have reports with certifications, and correspecting the facility years, and any plan respect to the facility to review upon reques (iii) Post notice of the areas of the facility accessible to the post (iv) The facility shall information about to This REQUIREMENTS.	eadily accessible to residents, is and legal representatives of its of the most recent survey of the respect to any surveys, complaint investigations made ity during the 3 preceding of correction in effect with ity, available for any individual uest; and the availability of such reports in that are prominent and lablic. I not make available identifying omplainants or residents. NT is not met as evidenced		How corrective action w	ill he		
	Based on observat	tion, interview and document		How corrective action w	III be		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	COMF	
		245585	B. WING _		05/0)6/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 577	review the facility fa (R23, R27, R17, R) attended resident of the state agency (Spotential to affect at the facility. Findings include: During the resident 05/05/21, at 1:37 p R17, R10 and R31 asking, R23, R27, Ithey did not know were located within During observation SA survey results wentrance of the buil On 5/6/21, at 11:58 confirmed the above fairly new in her pohad not reviewed the identified the locatic council meetings. On 5/6/21, at 12:06 confirmed the above survey results were front entrance. The expected staff to in survey results were Review of facility per Review of facility	ailed to ensure 5 of 5 residents 10, R31), who routinely council, were made aware of SA) survey results. This had the II 39 residents who resided in	F 57	,	deficient and R31 were action of survey other residents affected by the iding at d be potentially into place, or o ensure that of recur. notice to all o the facility arvey Results. e center otice on the and state location of the ouncil on a sting regarding n area o the public ne facility. er staff will be survey results. its corrective	
	preceding years of complaint investiga	surveys, certifications and titions completed by the state eyors were available for		practice is being corrected recur. ¿ The Executive Director	and will not	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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		245585	B. WING			05/0	06/2021
NAME OF F	PROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
TD AVED	SE CARE CENTER			30	3 SEVENTH STREET SOUTH		
IKAVEK	SE CARE CENTER			W	/HEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 577	availability of the locareas of the facility accessible to the pu	would post notices of the cation of survey results in that are prominent and	F 5		audit 10% of current residents for knowledge of the location of survey results. Weekly for 1 month; them r for 2 months. ¿ Executive Director will monitor Resident Council Minutes on a mor basis for 3 (three) months to ensure discussion was held regarding the I of the survey results. The audit results be reviewed during the facility QAP Meetings. The QAPI Committee will provide direction or change when necessary. •The date that each deficiency will be corrected: July 12, 2021	nonthly e a ocate ults will I	7/12/21
	CFR(s): 483.15(d)(§483.15(d) Notice of §483.15(d) (1) Notice of §483.15(d)(1) Notice of the resident goes of the resident goes of the resident or resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing fact bed-hold periods, where the paragraph (e)(1) of resident to return; as	of bed-hold policy and returnate before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the trovide written information to dent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing I payment policy in the state to of this chapter, if any; illity's policies regarding which must be consistent with this section, permitting a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		MPLETED C	
		245585	B. WING			, 6/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 625	of this section. §483.15(d)(2) Bedden the time of transfer hospitalization or the facility must provid resident represents specifies the duration described in parage This REQUIREME by: Based on interview facility failed to profor 2 of 2 residents hospitalization. The and update their bedden the findings include: R18 R18's significant of (MDS) dated 2/22/2 extensive assistant personal hygiene and locomotion. The fall with fracture and identified R18 had right hip fracture, carteriosclerosis. R18's progress not identified R18 was complained of right local emergency refound to have a frat transferred and ad progress note identified.	-hold notice upon transfer. At	F 625	How corrective action will be accomplished for those residents for have been affected by the deficient practice. ¿ R18, R20 and/or their represent will be sent bed hold notices for the hospitalizations. How the facility will identify other restaving the potential to be affected be same deficient practice. ¿ Residents who require transfer hospital or take a therapeutic leave the facility have the potential to be affected. An audit was completed a other resident and/or responsible pawas affected. What measures will be put into place systemic changes made, to ensure the deficient practice will not recur. ¿ The Director of Nursing / Busing Office Manager will educate license nursing staff on the need to provide bed hold notification for all residents leave the facility for a hospitalization take a therapeutic leave from the facility for the series of the facility for the facility facility for the facility for the facility for the facility for the facility facility for the faci	tative ir sidents by the to the from and no arty ce, or that ess ed e the s that n or		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	l ` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245585	B. WING _		1	C 06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296		00/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPORT OF TH	OULD BE	(X5) COMPLETION DATE	
F 625	identified the daugh for an update and the abed hold had been R20 R20's quarterly MD R20 had severe cool diagnoses which inde (TBI), heart failure at MDS indicated R20 bed mobility and drawith transfers, eating and bathing. R20's progress note had been seen at the and was admitted to indicated the family admission. The note hold had been discontinuous discontinuous and interview administrator confirmated hold notice to representatives. His resident was dischart staff would provide Review of November Re-Admission policity of a hospital a writte would be provided to representative. A confirmation of the confirmation of t	Iditional note at 3:56 p.m., after called back to the facility the note lacked documentation in discussed S dated 2/24/21, identified gnitive impairment and had cluded Traumatic Brain Injury and a seizure disorder. The required extensive assist with essing tasks and total assisting, toileting, personal hygiene de dated 4/27/21, identified R20 the local ER to be suctioned to the hospital. The note had been notified of the lacked documentation a bed cussed. on 5/6/21, at 3:44 p.m., the med the facility had not given to either R18 or R20 or their sexpectation was anytime a larged with a return anticipated information about a bed hold. Der 2016, Bed Hold and by identified at time of transfer ten notice of the bed hold to the resident and/or resident opy of the notice would be	F 62	How the facility will monitor its of actions to ensure that the defic practice is being corrected and recur. ¿ The Director of Nurses or of will complete audits on resident have been hospitalized or take therapeutic leave from the facility weekly basis for 4 weeks.; there for 2 months ¿ Audit results will be reviewed the facility QAPI Meetings and the continuation or completion monitoring process base on the "The date that each deficiency corrected: July 12, 2021	ent will not lesignee s who a tty on a monthly ed during will dictate of this e results		
	•	ent's medical record. for Dependent Residents 2)	F 67	77		7/12/21	

	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245585	B. WING		05/06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 677	out activities of dai services to maintai personal and oral if This REQUIREME by: Based on observareview the facility fassistance for 2 of oral care assistance were dependent or living (ADL's). Findings include: R9 R9's annual Minim 2/5/21, identified R impairment and ha Alzheimer's disease MDS further identifiassistance of one shygiene and limited transfers, eating, to required supervision R9's care plan date an ADL self care do required staff assistance with consoiled clothes and brush her teeth.	sident who is unable to carry ly living receives the necessary n good nutrition, grooming, and	F 677	How corrective action will be accomplished for those residents for have been affected by the deficient practice. ¿ R9 received oral hygiene at the of survey and as directed by their caplan. R9 and R33 were shaved at the time of survey and have been shave directed by their care plans. How the facility will identify other reshaving the potential to be affected by same deficient practice. ¿ Residents currently residing in the facility who are dependent on staffing grooming / hygiene including oral cand shaving have the potential to be affected. An audit was completed, at those who required care received the cares during the time of survey. What measures will be put into place systemic changes made, to ensure the deficient practice will not recur. ¿ The Director of Nursing will proveducation to nursing assistants regathe importance of offering oral hygie and shaving as directed by the residicare plan.	time re ne nd as idents y the he or re and ose e, or hat ride rding ne
	2/2/21, indicated R	9 had her own teeth and ble to brush her own teeth		How the facility will monitor its correct actions to ensure that the deficient	ctive

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED C		
		245585	B. WING _			06/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 303 SEVENTH STREET SOUTH WHEATON, MN 56296		00,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 677	During observation was seated out in a area rocking back her eyes closed. R long white facial hawere approximately During observation seated the dining rindependently and long white facial hawere approximately and long white facial hawere approximately at 2:51 p.m. R9 w room area looking hair remained on h at 3:01 p.m. R9 w room area visiting hair remained on h at 3:12 p.m. R9 facontinued to visit w staff offer or provide the long white facial During observation was laying in bed, and NA-E entered was ready to get up R9 to the bathroom which included was body, applying a cludressing R9 while at 10:26 NA-C hagarbage and immed assisted R9 to star walker and gait bel up her brief and here	ce with set up and cueing Is on 5/3/21, at 3:12 p.m. R9 a recliner in the living room and forth in the recliner with 9 was noted to have several airs on her lower chin area that by 1/2 inch or longer. Is on 5/4/21, 9:30 a.m. R9 was been area eating breakfast by 1/2 inch or longer chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on her lower chin area that by 1/2 inch or longer. It is on 5/3/21, at 3:12 p.m. R9 It is on 5/4/21, at 3:12	F 67	practice is being corrected recur. ¿ The Director of Nursing will Audit those dependent shaving and/or oral care dathen weekly for 2 months. will be reviewed at QAPI for recommendations and nee audits. "The date that each deficie corrected: July 12, 2021	g or designee on staff for aily for 2 weeks; Audit results r d to continue	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245585	B. WING_		05	C / 06/2021	
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP						
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	room area holding with walker. NA-E I room table next to removed her gait b proceeded to get R began to eat her brinatural teeth prese mouth and continue facial hairs on her I approximately 1/2 i NA-C or NA-E offeremove the long which or offer to provible of the continuity of the c	on to the back of the gait belt had R9 sit down at the dining the nurses station and elt from her waist. NA-E 19's breakfasts for her and R9 reakfast independently. R9 had not on the top and bottom of her ed to have several long white lower chin area that were nch or longer. At no time did or or provide assistance to R9 to hite facial hairs present on her	F 67	77			

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 245585 B. WING		COM	COMPLETED		
		245585	B. WING_		l l	06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH APPOSE TO THE	OULD BE	(X5) COMPLETION DATE
F 677	Continued From pa	age 35	F 67	77		
	R33					
	R33 had severe co diagnoses which in and renal insufficie identified she requi one staff for persor	OS dated 3/12/21, identified agnitive impairment and had acluded dementia, depression ncy. R33's MDS further ired extensive assistance of hal hygiene and limited staff d mobility, transfers, toileting				
	an ADL self care de required staff assis hygiene/oral care.	ted 5/6/21, indicated R33 had eficit related to dementia and stance with personal The Care plan indicated staff with shaving her chin hairs, oral cares.				
	was seated in a rec puzzle book. R33 v white facial hairs of	es on 5/3/21, at 2:54 p.m. R33 cliner in her room working on a was noted to have several long in her lower chin area and the lip that were approximately 1/4				
	was seated in the r breakfast. R33 was white facial hairs of sides of her upper inch or longer. - at 2:46 p.m. R33 room working on a remained on her lo her upper lip.	as on 5/4/21, at 9:27 a.m. R33 main dining room eating sonoted to have several long in her lower chin area and the lip that were approximately 1/4 was seated in a recliner in her puzzle book and her facial hair wer chin area and the side of remained seated in her room				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I			E SURVEY IPLETED
		245585	B. WING			C 06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296	1 03/	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	and her facial hair rarea and the side of During observations was seated at a tab with other residents have several long with chin area and the sapproximately 1/4 in staff offer or provide the long white facial sides of her upper I On 5/6/21, at 2:17 pneeded staff assistand shaving. NA-E have been complet and staff should had aily. On 5/6/21, at 1:59 provide or or sidents daily. The staff to provide or or residents care plant. Review of facility possible and services or per resident needs. Review of facility possible and services or per resident needs.	emained on her lower chin f her upper lip. s on 5/5/21, at 12:37 p.m. R33 ble in the main dining room a present. R33 was noted to white facial hairs on her lower ides of her upper lip that were nich or longer. At no time did a assistance to R33 to remove I hair on her chin and the ip. b.m. NA-E confirmed R33 ance with personal hygiene indicated the bath aid should ing the cares on her bath day we been offering to shave her b.m. the director of nursing he above findings and I expect staff to shave the DON stated she expected ffer dental care and follow the scholicy titled, Shaving revised on residents will be provided laily which included shaving as	F 67	77		
	Quality of Care CFR(s): 483.25		F 68	34		7/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245585	B. WING _			C 06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER	I		STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	§ 483.25 Quality of Quality of care is a applies to all treatm facility residents. B assessment of a rethat residents recei accordance with propractice, the complicate plan, and the This REQUIREMED by: Based on observation review, the facility fassess, implement 1 of 1 residents (Ratear.) Findings include: R27's admission M 3/13/21, identified I included Alzheimer pulmonary disease progressive lung di increasing breathle R27's MDS further tears, and no specimum MDS indicated R27 with bed mobility, the hygiene, and toilet identify R27's cognitive reamonary models.	care fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure eve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview and document failed to comprehensively interventions, and monitor, for early who had obtained a skin inimum Data Set (MDS) dated R27 had diagnoses which 's disease, chronic obstructive (COPD) (a group of sorders characterized by essness) and other fracture. identified R27 had no skin fall treatment for skin. R27's required extensive assistance ransfers, dressing, personal use. R27's MDS failed to itive level.	F 68	How corrective action will be accomplished for those reside have been affected by the depractice. ¿ The skin tear on R27 we documented, orders obtaine at the time of survey. The Newere notified. A skin tool was implemented on R27 to more healing process. R27 scale updated to reflect changes in the How the facility will identify a having the potential to be affected. The potential to be affected. The potential to be affected. Comprehensive skin assessing completed for all current Transported for all current Transported for all current to the deficient practice will not the deficient practice will no	dents found to eficient as assessed, id, and treated ID and family as nitor the re plan was n care. Other residents fected by the efacility have A ment is everse Care ges or er facility Into place, or ensure that a recur. Will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING			1	C 06/2021	
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 03 SEVENTH STREET SOUTH VHEATON, MN 56296	1 00.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 684	outer elbow on top closely together. The brown spots on the had struck her elbounable to remember cloth elbow protect. On 5/5/21, at 10:30 chair in her room. Her right elbow. R2 spots in the center around the area was R27 indicated the ato have an elbow point of the properties of the progress of the progress notes and facility's usual process for skin tear. In process for skin tear.	of the other criss-crossed The top Steri-strip had a few e center. R27 indicated she ow on a door frame and was er when it occurred. R27 had a for on her left elbow. If a.m. R27 was seated in a R27's Steri-strips remained on the continued to have brown and approximately one inch as slightly pink/red in color. Area was sore. R27 continued forotector on her left arm. If p.m. NA-B indicated she was skin tear and was not sure how stated she had heard about it extered nurse (RN)-B. NA-B mot noticed the skin tear mot believe R27 had the skin If p.m. licensed practical nurse e was not aware R27 had a andicated if R27 had a skin tear, in documented in R27's If reported. LPN-A stated the effice was to complete a skin	F6	684	care process per facility policy and procedure and reporting requirement alterations to skin integrity. How the facility will monitor its corractions to ensure that the deficient practice is being corrected and will recur. ¿ The Director of Nursing or des will conduct 2 resident wound care 2 times per week for 4 weeks. The monthly for 2 additional months Rewill be reviewed in QAPI for further recommendations. "The date that each deficiency will corrected: July 12, 2021	ents for ective not ignee audits en esults		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	l` '	(X3) DATE SURVEY COMPLETED	
			A. BUILD			С	
		245585	B. WING		05	/06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 303 SEVENTH STREET SOUTH WHEATON, MN 56296)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	residents should had on their bath day. It is she could assess IDON slowly pulled side and confirmed discharge, the wou and was not closing Steri-strips center in noted over wound approximately one color. IDON informarea, apply a non-stee area depending IDON confirmed the was pink/red in color had not been monit deteriorated. IDON expected R27's ski skin assessed proper R27's SNF Weekly identified no skin is Review of R27's Markeyiew of R27's profe/21, identified the -3/6/21, at 10:28 profe/23/31/21, at 10:28 profe-no new or wor -4/1/21, at 3:55 a.m.	At 2:46 p.m. IDON asked R27 is her skin tear and she agreed. I back the Steri-strips on one If the area had some light tan and bed was still pink and moisting up. The area under the was dime sized with tan slough and the area surrounding inch diameter was pink/red in a hed R27 she would clean the stick Telfa dressing and wrap in the wound was weeping. It is a rea around the skin tear for. IDON confirmed the wound to red and looked like it had a indicated she would have in tear to be monitored and her berly on her bath day. The Skin Check Tool dated 5/2/21, is uses noted. The sues noted and orders to region of the words and orders to be monitored and her berly on her bath day. The sues noted and orders to region of the words and orders to be monitored and her berly on her bath day. The sues noted and orders to region of the skin orders and any orders to region of the skin bloom	F 6	84			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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		245585	B. WING			05/0	06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 103 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 40	F 6	84			
		. comprehensive nursing sening skin concerns.					
		m. comprehensive nursing sening skin concerns.					
		. comprehensive nursing sening skin concerns.					
		. comprehensive nursing sening skin concerns.					
		. comprehensive nursing sening skin concerns.					
		. comprehensive nursing sening skin concerns.					
		. comprehensive nursing sening skin concerns.					
		m. comprehensive nursing sening skin concerns					
	note-new or worser on bilateral lower sk antibiotic for urinary	. comprehensive nursing ning skin conditions; yes, red kins, provider faxed, on tract infection (UTI). Red rea under breasts-Nystatin fabric.					
		m. comprehensive nursing sening skin concerns.					
		m. comprehensive nursing sening skin concerns.					
	-4/11/21, at 10:33 a	.m. comprehensive nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING			1	06/ 2021
	PROVIDER OR SUPPLIER SE CARE CENTER			303	SEVENTH STREET SOUTH SEVENTH STREET SOUTH SEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	-4/12/21, at 1:46 p.mote-no new or wor -4/12/21, at 3:20 p.mhad whirlpool bath woondition noted4/13/21, at 4:34 p.mote-no new or wor -4/14/21, at 3:43 p.mote-no new or wor -4/15/21, at 12:58 p.mote-no new or wor -4/16/21, at 3:57 p.mote-no new or wor -4/19/21, at 9:12 a.mote-no new or wor -4/20/21, at 11:49 p.mote-no new or wor -4/21/21, at 5:19 p.mote-no new or wor -4/22/21, at 12:10 p.mote-no new or wor -4/23/21, at 4:11 p.mote-no new or wor -4/23/21, at 4:11 p.mote-no new or wor -4/23/21, at 10:01 p.mote-no new or	ge 41 sening skin concerns. m. comprehensive nursing sening skin concerns. m. nurse progress note- R27 with no change in skin m. comprehensive nursing sening skin concerns. m. comprehensive nursing sening skin concerns.	F6	584			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		COV	MPLETED
		245585	B. WING				C / 06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS 303 SEVENTH S WHEATON, MM		1 00	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	-4/24/21, at 11:35 p note-no new or wor -4/26/21, at 3:03 p. note-no new or wor R27's progress note when R27 received provided and any mear was obtained. The facility policy tit (General) dated 4/1 provided to the resi physician and docu/procedures include following: reasons f progress or decline needed (PRN) treat Nutrition/Hydration CFR(s): 483.25(g) (S483.25(g) Assisted (Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas comprehensive assensure that a reside \$483.25(g)(1) Main of nutritional status.	.m. comprehensive nursing sening skin concerns. m. comprehensive nursing sening skin concerns. es lacked identification of a skin tear, any treatment nonitoring of the site after skin eled Treatment Record /2008, indicated all treatments dent must be ordered by the mented. The policy of instructions to record the for refusal of treatments and of condition for which as timents were given. Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's ressment, the facility must tent- tains acceptable parameters, such as usual body weight or	F 6				7/12/21
	balance, unless the demonstrates that t preferences indicate	ght range and electrolyte resident's clinical condition this is not possible or resident e otherwise; ered sufficient fluid intake to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTR		(X3) DATE SURVEY COMPLETED				
		245585	B. WING		05/0	; 6/2021
	PROVIDER OR SUPPLIER SE CARE CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296	00/0	0,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	there is a nutritional provider orders at the This REQUIREMED by: Based on observative, the facility for nutritional assessmit impaired nutritional approaches to main parameters for 2 of had a significant were viewed for nutrition for the findings include: R18 R18's significant check (MDS) dated 2/22/2 diagnoses which in dementia with behade pression and head R18 required extending mobility, dressing, In the MDS identified for transfers and loid identified R18's we weight loss. The M choked during mead medications. R18's care plan unassistance of one significant at the mobility of the MDS identified for transfers and loid identified R18's we weight loss. The M choked during mead medications.	dration and health; fered a therapeutic diet when I problem and the health care herapeutic diet. NT is not met as evidenced tion, interview and document ailed to complete ongoing hent, address risk factors for status and implement hatain acceptable nutrition 4 resident (R18, R22), who eight loss of 10.8% and 13.1%, on. I ange Minimum Data Set 21, identified R18 had cluded right hip fracture, avioral disturbance, major art failure. The MDS indicated sive assistance with bed bersonal hygiene, and eating. R18 required total assistance comotion. R18's MDS and indicated no DS indicated R18 coughed or alls or when swallowing dated, identified R18 required total assistance dated, identified R18 required total with bed mobility,	F 692	How corrective action will be accomplished for those residents fo have been affected by the deficient practice. ¿ R18, and R22 were reviewed for scheduled monitoring of weekly weir appropriate nutritional supplements nutritional interventions, and resider preferences to address significant whose. ¿ Registered dietitian has compled dietary risk assessment on R18, R2 further recommendations to modifier of care. How the facility will identify other reshaving the potential to be affected be same deficient practice. ¿ Residents residing in the facility the potential to be affected. The Direction of Nursing and Registered Dietician review current residents for signification weight loss, and care plans updated appropriate interventions. What measures will be put into place systemic changes made, to ensure the deficient practice will not recur. ¿ IDT-team members will review	or ghts; nt veight sted a 22 for ed plan sidents by the rector will ant d with	
	personal hygiene.	bathing, dressing and The care plan indicated R18 intake related to usual good		resident weights and meal intake we to identify variances, and ensure adequate interventions are in place;		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245585	B. WING			06/ 2021	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP		00/2021	
TRAVER	SE CARE CENTER			303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	healthy range and meals. The care plabs, monitor mearoutine house snadiet as ordered, us serve meals in the recommended by R18's Comprehent (CAA) dated 2//22 mechanically alter The CAA identified for nutrition. The Camperform activities assistance. R18's Dietary Profe R18 was on a regulated documentation interventions to professed documentation intervential texture and regulated texture and regulated documentation intervential texture and regulated texture and regulated documentation intervential texture and regulated documentation intervential regulated texture and regulated documentation intervential regulated texture and regulated texture and regulated for Figure 1 in the regulated for Figure 2 in the regulated for Figure 2 in the care place of the regulated for Figure 2 in the care place of the regulated for Figure 2 in the care place of the regulated for Figure 2 in the care place of the care	liced by stable body wight, good oral intake at most blan instructed staff to monitor I intakes, monitor weights, offer cks between meals, provide se a clothing protector, and a main dining room as therapy. Issive Care Area Assessment /21, indicated R18 had a red diet and a therapeutic diet. If R18 had a potential problem CAA indicated R18 had a mand had an inability to of daily living (ADL's) without file Tool dated 1/11/21, identified ular diet with mechanical soft ar liquids. The assessment tool ation R18 had weight loss or any event weight loss or to maintain mary Report dated 5/1/21, et as a diabetic diet with ground regular liquids. The report ation of any type of supplement R18's weight loss. Inonthly weights from 10/29/20, ed the following: Was 170.5 pounds was 171.0 pounds as 160.0 pounds	Fé	will be notified of all reside high risk for significant we is. The Director of Nursin will educate all nursing and on the procedures for Nutr Weight Loss How the facility will monito actions to ensure that the practice is being corrected recur. The Director of Nursin Registered Dietician or de of residents experiencing Resident who experience loss will be audited for appointerventions weekly for 4 monthly for 2 months. Aud reviewed in QAPI for further recommendations. "The date that each deficit corrected: July 12, 2021	ight loss weekly. g or designee d culinary staff rition Risk and r its corrective deficient I and will not g and/or signee will audit weight loss. ce a 5% weight propriate weeks; then dit results will be er		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245585	B. WING _		05	C 5/ 06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP OF STATE, Z			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	assessment notes identified the follow. On 2/25/21, late enhad a significant character weight at 10 significant weight loss was no R18's weight continuous significant loss. Changes were need continue to monitor dietary intervention. On 5/5/21, at 1:43 recent weight loss. Current weight loss. Current weight loss. Current weight loss fron 1/14/21) and 10 months prior (170.0 identified R18 current clinically significant months. RD identificant months. RD identificant months. RD identificant months and a nu offered to help sup recommended a nu offered to help sup recommended four times a day given of During observation 10:14 a.m., nursing was not uncommon not get up until 11:0	s 156.0 pounds s 152.0 pounds gistered dietician (RD) from 2/25/21, to 5/5/21, ring: atry at 1:17 p.m. identified R18 hange assessment with R18's 61.7 (on 2/17/21) with no loss, yet a small and recent ted. The plan identified that hued to be relatively stable with The note indicated no ded at the time, yet would for need for modifications in s. p.m. identified R18 showed a The note identified R18's 152.0 (on 4/29/21), which ight loss from one month prior, om three months prior (160.0 .8% weight loss from six 0 on 10/29/20). The note ently was presenting with a weight loss for the last 6 ided recent history and	F 69				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245585	B. WING				06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			303	REET ADDRESS, CITY, STATE, ZIP CODE 3 SEVENTH STREET SOUTH HEATON, MN 56296	1 00/	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	was assisted out to morning cares. NAnothing to eat. During interview on director (CD)-A ider weights on point cliror at least weekly ir red if there was a c CD-A stated if there would talk to the nuinterventions could a supplement. During confirmed the last of R18's electronic he 5/21/19. CD-A confieat but was not cur supplement or mea weight. CD-A confir loss and indicated to interventions impled During interview on registered dietician finished the assess change from back in which should of bee 2021. RD stated shupdated MDS sche 5/4/21. RD confirmed fany weight loss from the control of any weight loss from the control of th	on 5/5/21, at 10:58 a.m., R18 the day room area after C offered him a drink but 5/5/21, at 1:00 p.m., culinary ntified she reviewed the ck care (PCC) each morning adicating the weights were in hange for quick identification. It was a weight change she rese manager to see what be placed which would include a record review, CD-A dietician notes documented in alth record (EHR) were from a rently on any type of I modification to increase his med R18 did have a weight here were no dietary	F 6	92			
	to notify her of weig start a temporary s	to be monitoring the weights, tht loss and to notify nursing to applement until she was able ent. RD indicated she was only					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING				C / 06/2021
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIF 303 SEVENTH STREET SOUTH WHEATON, MN 56296			00/2021
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F 692	contracted two day assessments. During interview or registered nurse (intake was a hit of stated direct care weights and the lieweights into PCC, was expected to oprior weight and doccurred. RN-B in identified, the nurse manager with provider. RN-B country medical documents and was not on an	on 5/5/21, at 2:25 p.m., RN) B identified R18's meal or miss if he would eat. RN-B staff obtained resident's censed nurse entered the RN-B stated the licensed nurse compare the weight with the etermine if a weight loss had adicated if a weight loss was se was expected to notify the tho usually contacted the infirmed R18 had lost weight my type of supplement. on 5/5/21, at 2:57 p.m., R18's octor (MD)-A identified he had 8's weight loss by verbal and had been at the facility to see A indicated R18 had a recent urgery, had recent COVID-19, st had recently made some es. MD-A stated he had made cent psychoactive medication chargy and consulted with the ther monitoring last month. E was not surprised about the reed the facility should have which loss and acted on it by cian for an evaluation or nursing for a supplement. MD-A ement would have been an		692			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION NG		C (X3) DATE SURVEY		
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F 692	cooking. She confi dietician any types	age 48 not have time since she was rmed she does not give the of notes or list of residents cerns for weight loss.	F 6	92				
	2/26/21, identified impairment and dia failure, diabetes m affect how your bo anxiety. R22's MDS extensive assistan dressing and persoindicated R22 requencouragement or only. R22's MDS i and she had a weigmonth or a loss of months. The MDS	nimum Data Set (MDS) dated R22 had significant cognitive agnoses which included: heart ellitus (group of diseases that dy uses blood sugar) and S indicated R22 required ce with bed mobility, transfers, anal hygiene. The MDS hired supervision/oversight, cueing to eat with set up help dentified R22's weight was 126 ght loss of 5% or more in last 10% or more in the last 6 indicated R22 was not on a led weight-loss regimen.						
	10/29/20, identified for nutrition. R22's identified R22's nu	ssessment (CAA) dated I R22 had a potential problem weight was 137. R22's CAA trition needs would be care n her current level of						
	at nutritional risk a about meals. Upd involuntary weight appetite and gener COVID-19 infection R22's COVID diag	ted 5/6/21, identified R22 was nd had a history of complaining ated care plan identified loss related to diminished ral decline secondary to n. The care plan indicated noses on 2/1/21, poor appetite al to eat and significant weight						

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F 692	loss of 13% for the Interventions included aily for extra prote offering a nutritional due to weight loss registered dieticiar recommendation a plan included interdressing, toilet use requested and PRI she requested. R2 was independent vup first before eatin Review of R22's M from 10/1/20, to 5/-October 2020-wei-November 2020-v-January 2021-wei-February 2021-wei-February 2021-wei-February 2021-weight 2021-weigh	ree months, dated 5/5/21. ded: Offer 2 hard boiled eggs ein, offer a trial of supplements, al supplement twice a day (BID) and poor intake, and refer to a for evaluation and/or as needed (PRN). R22's care ventions to assist R22 with bed mobility when she N assistance with transfers if 2's interventions identified R22 with eating with occasional set ang. Ionthly Weight Report reviewed 1/21, identified the following; ght 135.5 veight 134.5 veight 136 eight 126 at 122 119 p.m. R22 was in the dining wheelchair. At 5:17 p.m. R22 th her meal in front of her and a R22 was encouraged to eat a offered fruit and shown her ice med only a few bites of ice a few sips of ice water and a R22 left the table. R22 had a hard boiled egg or g this meal.	F	692			
		a.m. R22 was lying in her bed,					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	her she would get significant with a pocket the assistive device). It R22 into her wheeld raised R22's head obedside table in fromeal cover and information which consisted of and fruit. IDON offer R22 declined. R22 and IDON offered to R22 stated yes as a.m. R22 remained the time while her befront of her. At 10:2 (SSD) entered R22 eat. SSD used a padifferent messages and left the room. Fino other foods during provided or offered supplements during On 5/5/21, at 12:39 wheelchair at a tablitust been served he could not eat all of lettuce and tomato cheese, and a cup received a glass of R22 had not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not been supplements during had left the dining residual control of the could not be an account of the could not be an account of the could not be an account of the could not be a co	st tray to R22 and informed someone to assist her up. At rector of nursing (IDON) and placed head phones on alker attached (hearing DON asked if she could assist chair and R22 refused. IDON of bed up and placed her not of her. IDON removed the ormed R22 of her breakfast french toast, sausage, toast ered to cut up her meal which began eating the watermelon or remove her head phones. She did not like them. At 10:01 in bed and was not eating at oreakfast meal remained in 4 a.m. social service designee is room and asked her to try to oper by R18's bedside with on it to communicate to her R22 ate a few bites of fruit and ang the meal. R22 had not been a hard boiled egg or	F	692				

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F 692	interview, family me was aware of R22's R22 had quit eating infection. FM-B sta sometimes she did been giving R22 sunot for awhile. FM-was getting a regul modifications made month ago she had when R22 had not she had reported the stated she attempted and indicated R22 food onto the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she had recommended to the silver she was aware R22 lost 15-16 pounds indicated she was aware R23 lost 15-16 pounds indicated she was aware R23 lost 15-16 pounds indicated she was aware R23	o p.m. during a phone ember (FM)-B indicated she is weight loss and indicated gwhen she had COVID ted R22 sometimes ate and not. FM-B indicated staff had applements however they had applements however they had a stated she was aware R22 ar diet and had not seen any eto her diet. FM-B indicated a dicaught a couple of times received a tray for meals and nat to the administrator. FM-B and to feed R22 at noon meal did well when she placed the tware for her. FM-B indicated 2 weighed 119 pounds and had since she had COVID. FM-B not spoken to the registered did was not aware of any	F 69	2			
	stated R22 had not family was coming indicated they usua only occasionally a indicated the last ti eating was a few w	p.m. nursing assistant (NA)-D been eating very well and her in to help her eat. NA-D ally encouraged her to eat and ssisted R22 to eat. NA-D me she had assisted R22 with reeks ago. NA-D indicated R22 red supplements from the					
	stated it was very had sometimes and whate better. RN-B into receive supplement thought it was on R	p.m. registered nurse (RN)-B hard to get R22 to eat en her family was here R22 dicated she thought R22 used ents, and indicated she R22's orders to receive them.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MUL		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SE CARE CENTER			303	REET ADDRESS, CITY, STATE, ZIP CODE SEVENTH STREET SOUTH HEATON, MN 56296	1 00/	00/2021
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F 692	record and confirm supplements. RN-worked with R22 for On 5/5/21, at 2:20 prefused meals often infection. NA-B state breakfast meal and unusual for her. Natures gave R22 semedications and shapeen done for the last of the following of the supplement order and stated she was with her diet or order the following of the supplement order and stated she was with her diet or order TMA-C indicated a to drink a chocolate would spit it out. The have orders to give believe R22 ever have ordered at time supplements or attention of the supplements of the supplements or attention of the supplements of t	ed R22 did not have orders for B indicated she had not or awhile. o.m. NA-B indicated R22 on since she had COVID ted R22 had not eaten her I indicated that was not A-B indicated she thought the upplements with her ne had not noticed if this had	F6	92			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245585	B. WING		05	C / 06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
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F 692	protein. NP-A confirrecommendations of dietician. On 5/5/21, at 3:30 pRD-A confirmed the comprehensive die 12/19/20, for her arindicated the first tis since COVID-19 be additionally only on 2020. RD-A indicate communications for RD-A indicated she the previous director (C admissions and the assessments. RD-would be notified by residents with weig expect staff to notif soon as they identifinot aware how ofte RD-A pulled up R22 and confirmed R22 RD-A identified R22 lower than her prev R22's weight loss is stated now that she loss, she would rev contact CD-A to inition of 5/5/21, at 3:21 process for contact indicated she had segarding things su	o.m. during phone interview, e last time she completed a tary assessment for R22 was mual assessment. RD-A me she had been in the facility egan was 5/4/21, and e or two times since March ed she was relying on om staff for any concerns. E would receive e-mails from or of nursing (DON) and D)-A, which included new	F 6	92		
	RD-A about supple	ought sne may have notified ments for one resident. CD-A pht the administrator e-mailed				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 692	CD-A confirmed si weekly and indicate system for weight notify RD-A if she if the nurses broug CD-A believed she regarding R22's wher emails, she con RD-A about R22's she was expected had lost 5% weigh months or a coupl CD-A stated it was residents with weight and good nutrition notify both RD-A abe put into place from the put into place fr	e for assessments to RD-A. The reviewed residents' weights he ted they were flagged by the loss. CD-A stated she would had concerns with residents or ght concerns to her attention. The had sent RD-A an email reight loss and after review of confirmed she had not notified weight loss. CD-A indicated to notify RD-A of residents who at loss in 1 month, or 10% in 6 to for pounds lost in a week. The important to notify RD-A of ght loss for their health, eating, and IDON so interventions could for R22. The indicated they were trying to ents and magic cups and R22's coming in to feed R22. IDON remed R22's PCP every time to each of the indicated hospice and family that. IDON stated NP-B had weight loss last week with R22's o discussed hospice and family that. IDON stated she notified the to concerns with residents. D-A had access to resident expected to be monitoring The provided the provided and family that access to resident expected to be monitoring. The format is a provided to RD-A had access to resident expected to be monitoring.	Fé	692			

NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	I \ /	COMPLETED		
TRAVERSE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			245585	B. WING		05		
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 692 Continued From page 55 were recorded. 2 meals identified R22 refused, 9 meals recorded intake of 0-25% and 2 meals recorded intake of 26% to 50%. -4/1/21, to 4/30/21, 43 of a possible of 90 meals were recorded. 1 meal identified R22 was not available, 4 meals identified R22 refused, 10 meals recorded intake of 0-25%, 14 meals recorded intake of 50%, and 10 meals recorded intake of 56% to 100%. -5/1/21, to 5/6/21, 10 meals of a possible 16 meals were recorded. 6 meals recorded intake of 26% to 50%, and 2 meals recorded intake of 51% to 75%. Review of R22's Medication Review Report (orders) signed 4/15/21, included: -small portion diet regular texture, regular liquids consistency, with start date of 6/14/12. R22's orders lacked any interventions related to R22's weight loss. Review of R22's progress notes from 2/1/21, to					303 SEVENTH STREET SOUTH			
were recorded. 2 meals identified R22 refused, 9 meals recorded intake of 0-25% and 2 meals recorded intake of 26% to 50%. -4/1/21, to 4/30/21, 43 of a possible of 90 meals were recorded. 1 meal identified R22 was not available, 4 meals identified R22 refused, 10 meals recorded intake of 0-25%, 14 meals recorded intake of 26% to 50%, and 10 meals recorded intake of 51% to 75%, and 4 meals recorded intake of 51% to 75%, and 4 meals recorded intake of 76% to 100%. -5/1/21, to 5/6/21, 10 meals of a possible 16 meals were recorded. 6 meals recorded intake of 0-25%, 2 meals recorded intake of 26% to 50%, and 2 meals recorded intake of 51% to 75%. Review of R22's Medication Review Report (orders) signed 4/15/21, included: -small portion diet regular texture, regular liquids consistency, with start date of 6/14/12. R22's orders lacked any interventions related to R22's weight loss. Review of R22's progress notes from 2/1/21, to	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE	
-2/1/21, Provider and family notified of R22's COVID positive test results this a.m. R22 immediately brought to COVID 19 unit. -2/6/21, R22 refused to eat or drink much of anything. -2/7/21, R22 this a.m. R22 still not eating or drinking, daughter notified and provided letter to	F 692	were recorded. 2 meals recorded in recorded intake of -4/1/21, to 4/30/21 were recorded. 1 mavailable, 4 meals meals recorded intake of recorded i	meals identified R22 refused, 9 take of 0-25% and 2 meals 26% to 50%. , 43 of a possible of 90 meals meal identified R22 was not identified R22 refused, 10 take of 0-25%, 14 meals 26% to 50%, and 10 meals 51% to 75%, and 4 meals 76% to 100%. 10 meals of a possible 16 ded. 6 meals recorded intake of corded intake of 26% to 50%, ded intake of 51% to 75%. Medication Review Report 15/21, included: regular texture, regular liquids start date of 6/14/12. Red any interventions related to rogress notes from 2/1/21, to be following: and family notified of R22's st results this a.m. R22 that to COVID 19 unit. Red to eat or drink much of	F6	92			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SU COMPLET	
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F 692	and vomiting). -2/17/21, R22 ate of and refused lunch a except one bite of or crushed in supplem supplement at breat continues to have leaded to continue a supplement better awith family. R22 drawink supplement. -2/21/21, R22 has a Staff fed R22 with a grink supplements. -2/23/21, R22 is not needs much encount be fed as allows. -2/25/21, R22 continued as allows. -2/26/21, R22 continued and in the supplement. -2/28/21, R22 drawing lik, at epoporn the did not eat today. -2/28/21, R22's fam an apple and banar of taste and smell.	edication to prevent nausea one bite of egg for breakfast, and snacks sent in by family, cookie. R22 took meds nent and drank one akfast and at noon. R22 oss of taste and smell. th family related to R22 d drink at this time. Family supplements. R22 drank after informed facility spoke ank two full glasses of not been eating or drinking. coor appetite noted and to with encouragement. t eating or drinking well. R22 laragement and at times needs	F 6	92			

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F 692	Continued From pa	age 57	F 69	92		
	-3/7/21, R22 ate ap	ople and small malt for family.				
	-3/10/21, R22 cont smell.	inues to have loss of taste and				
	magic cup. R22 ate	sed breakfast but ate part of e noodles and drank malt for R22 had chicken soup, magic e cream for supper.				
	smell. R22 drank s	inues to have loss of taste and upplement for noon meal and e noodles and malt with family.				
	meal, ate few bits	ew bites of apple before noon of magic cup then fed herself 1/4 supplement, refused rest				
	-3/17/21, R22 cont smell.	inues to have loss of taste and				
		inues to have loss of taste and ates, eats well occasionally at others.				
	,	inues to have loss of taste and ates, eats well occasionally at others.				
		nues to have loss of taste and ates, eats well occasionally at others.				
	drink chocolate mil brought in food this	stive to eat this morning, did k and 1/2 of egg. Family here s afternoon, good appetite. R22 loss of taste and smell. intake				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
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F 692	eat at others. Familiand sometimes with continue to monito -4/21/21, R22 contismell, intake flucturand refused to eat to encourage R22 with ice cream and bar, will continue to -4/28/21, R22's into occasionally and recomes often to encourage Side and to bites of pudding two bites of chili, mintake fluctuates, erefused to eat at of encourage R22 to ice cream and som will continue to mo -5/4/21, R22's intal occasionally and recomes often to encourage R22 to ice cream and som will continue to mo -5/4/21, R22's intal occasionally and recomes often to encourage R22 to ice cream and som will continue to mo -5/4/21, R22's intal occasionally and recomes often to encourage R22 to ice cream and som will continue to mo -5/4/21, R22's intal occasionally and recomes often to encourage R21, Dietary Prosignificant weight licurrent weight 119 ago, 13.1% weight	Ill occasionally and refused to illy comes often to encourage mes successful with ice cream the small candy bar, will r. inues to have loss of taste and ates, eats well occasionally at others. Family comes often to eat, sometimes successful I sometimes with small candy o monitor. ake fluctuates, eats well efused to eat at others. Family courage R22 to eat, sometimes or cream and sometimes with ill continue to monitor. not like chocolate milk tonight, and tilke chocolate milk tonight, and till finished, fed brownie ate aninimal fluid intake. R22's eats well occasionally and thers. Family comes often to eat, sometimes successful with netimes with small candy bar,	F 69				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED C
		245585	B. WING		05	5/06/2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
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F 692	for notable weight I dining room per far supervised/encoura R22 continues to h supplements have been accepting of sthe COVID unit, who day. RD-A community to a supplement of the trialed twice and begin monitoring restorated assess for any for scheduled supplement inventions. R2's progress noted dietary assessment and 5/5/21. R22's Kardex Reponditional status in nutritional regiment Discuss meal times restrictions, snacks plan, compliance with Kardex report intermonitor/document malnutrition. Review of R22's nunotes dated 2/23/2 NP-B. R22's NP-B reported R22 was and decreased driving recently located to COVID infection are	age 59 aVID-19 2/1/21, likely reason oss. R22 now eating in main mily request, and R22 can be aged and assisted as needed. ave very little appetite and been offered at times, not supplements like she was on nen drank 5-6 supplements a nicated with dietary manager Il recommend supplements to ay and will monitor. RD-A will esident monthly and as needed urther weight loss, to determine nents or further dietary es lacked a comprehensive trompleted between 2/1/21, ort dated 5/6/21, included terventions; dietary consult for and ongoing monitoring. So, portion sizes, dietary so allowed in daily nutritional with nutritional regimen. R22's ventions included to for signs or symptoms of the symptoms of the symptoms of the symptoms of the symptoms and eating, taking meds and we and energy. R22 was a different room after the different room after	F 6	92		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION NG	I \ /	(X3) DATE SURVEY COMPLETED	
		245585	B. WING_		05	C 5/06/2021	
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP O 303 SEVENTH STREET SOUTH WHEATON, MN 56296			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 692	device at all times and out of bed and ate very easily toda food was in front of Review of R22's nunotes dated 3/8/21 PCP, and identified medications, which coronavirus infectic identified R22's vita was to continue present results of Review of R22's phome visit dated 4/by NP-B, and ident concerns. R22's prontinue present results of Review of R22's prontinue present results of R22's prominue present results of R22's prontinue presen	and for R22 to wear hearing when she was up and about to have her glasses on. R22 by once placed at the table and f her. Aursing home visit progress, identified R22 was seen by the R22 was refusing a had gone on since R22 had fon. R22's progress notes als were reviewed and the plantesent regimen. Aursing home visit progress, identified R22 was seen by the R22 was refusing and the plantesent regimen. Aursing home visit progress, identified R22 was seen by the R22 was refusing and the plantesent regimen. Aursing home visit progress, identified R22 was seen by the regimen. Aursing home visit progress, identified R22 was seen by the regimen. Aursing home visit progress, identified R22 was seen by the regimen. Aursing home visit progress, identified R22 was seen by the regimen. Aursing home visit progress, identified R22 was seen by the plantesent regimen.	F 69	92			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296		00,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 755	Continued From pa weight loss issues. Pharmacy Srvcs/Pr CFR(s): 483.45(a)(l	ocedures/Pharmacist/Records	F 6			7/12/21
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	Services ovide routine and emergency als to its residents, or obtain ement described in cility may permit unlicensed ister drugs if State law ander the general supervision of				
	pharmaceutical ser that assure the acc dispensing, and adi	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.				
		Consultation. The facility ain the services of a licensed				
		ides consultation on all ision of pharmacy services in				
		olishes a system of records of tion of all controlled drugs in nable an accurate				
	order and that an aris maintained and p This REQUIREMEN by:	rmines that drug records are in count of all controlled drugs periodically reconciled. NT is not met as evidenced and document review, the		o How corrective action will be		
	Dasca on litter view	and document review, the		o now conceive action will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C C		PLETED				
		245585	B. WING		I) 06/2021
	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 755	facility failed to obta medication for 1 of reviewed for medic. Findings include: R190 admission reidentified admission Diagnosis included anxiety disorder, obgastroesophageal in R190's hospital dishad been admitted in February sustain which ruptured her went surgery 2/3/2 graft. R190 had an then transferred to complications and with sepsis. Ultimate pain and her wound drainage and R190 R190's admission date of 5/3/21, Fod milligrams /0.5 m	ain and administer ordered 1 residents (R190) who were ation administration. cord (face sheet) dated 5/6/21, in to the facility on 5/3/21. heart failure, hypertension, besity, depression, reflux and sleep apnea. charge notes identified she to the hospital following a falling a left knee dislocation popliteal artery. R190 under 1, and had a synthetic popliteal external fixator placed. R190 a rehab facility and developed was readmitted to the hospital tely, R190 had increasing leg ds had to be reopened for required skin grafting. orders identified original order aparinux Sodium (Arixtra) 2.5 liters (mg/ml) inject 2.5 mg aus daily for prevention of progress notes from 5/3/21, to	F 75	accomplished for those reside have been affected by the defi practice. ¿ R190 received the medical ordered without any further co 05/04/2021. o How the facility will identify or residents having the potential affected by the same deficient is Residents currently residing facility have the potential to be the Director of Nursing and delicensed nurse audited the meavailability. No other issues with identified. o What measures will be put in systemic changes made, to enthe deficient practice will not receive the deficient practice of pharmacy services to take when medication unavailable. o How the facility will monitor is actions to ensure that the deficience is being corrected and recur. ¿ Director of Nursing or desiduit medication omissions we days, then bi-weekly x 60 days be brought to QAIP for further recommendation.	cient Ition as incerns on ther to be practice. In affected. It is affected in the court. It is affected in the court intered in the court in the court in the court in the court in the	
		vas requested for duration of		corrected: July 12, 2021	y will be	

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	PROVIDER OR SUPPLIER SE CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 03 SEVENTH STREET SOUTH VHEATON, MN 56296	1 03/	00/2021
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F 755	,	age 63	F 7	55			
	Fodaparinux was n administered.						
	R190 stated she had on 5/3/2. R190 indirective her medical evening. R190 iden medications had be admitted to the faciliary.	on 5/5/21, at 11:02 a.m., ad been admitted to the facility cated the facility did not tions until 10:30 p.m. that ntified that not all of her een delivered the day she lity and she did not get her he evening of 5/4/21, the day tted.					
	registered nurse (R pharmacy Omni Ca for Medicare A and not deliver medicat p.m., normally. RN- come from the Who delivered earlier in R190 received med most likely those di	on 5/5/21, at 12:42 p.m., RN)-B who confirmed that the are who delivered medications managed care residents did ion until 9:00 p.m., or 10:00 -B stated medications that eaton pharmacy were the day. RN-B confirmed that dication from Omni Care and d not get delivered until after ay of admission.					
	9:00 p.m. on the day of admission. During an interview on 5/5/21, at 4:49 p.m., RN-A stated the Omni Care's contract identified the pharmacy would deliver medication between the hours of 9:00 p.m. and 10:00 p.m. for residents who are currently on Medicare skilled services or managed care skilled service. RN-A confirmed if there was a medication needed (for example a pain medication) the facility was able to use standing orders or use medication out of the emergency kit after authorization.						
	During a follow-up i	interview on 5/6/21, at 9:18					

PAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER TRAVERSE CARE CENTER TRAVERSE CARE CENTER DESCRIPTION OF SUPPLIER 303 SEVENTH STREET SOUTH WHEATON, MN 56296		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	1 ' '	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			245585				-
TRAVERSE CARE CENTER WHEATON, MN 56296	NAME OF I	PROVIDER OR SUPPLIER	240000	1		05/	/06/2021
WHEATON, MN 56296	TDAVED	SE CADE CENTED			303 SEVENTH STREET SOUTH		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	IRAVER	SE CARE CENTER			WHEATON, MN 56296		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
F 755 Continued From page 64 a.m., RN-A confirmed R190 had not received the Fodaparinux Sodium injection the night she was admitted as the pharmacy had not delivered the medication. RN-A confirmed no provider had been contacted for direction when the medication was unavailable to administer as ordered. During an interview on 5/6/21, at 3:09 p.m., Omni Care pharmacist identified he would expect the facility to contact the provider for direction anytime a medication was unavailable to administer as ordered. The pharmacist stated the facility should have contacted the on-call or primary provider when R190's medication was unavailable for administration as ordered. During an interview on 5/6/21, at 4:00 p.m., administrator identified he would expect the nurse to contact the on-call or primary physician if a resident's medication was unavailable as ordered. A policy was requested but not provided. F 812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812	a.m., RN-A confirm Fodaparinux Sodiu admitted as the phamedication. RN-A confirm Fodaparinux Sodiu admitted as the phamedication. RN-A cobeen contacted for was unavailable to During an interview Care pharmacist id facility to contact the anytime a medicatical administer as order facility should have primary provider who unavailable for administrator identition contact the on-caresident's medication. A policy was requested Food Procurement. CFR(s): 483.60(i) Food sate The facility must - \$483.60(i)(1) - Procapproved or considing state or local authority in the provision defacilities from using gardens, subject to	ed R190 had not received the minjection the night she was armacy had not delivered the confirmed no provider had direction when the medication administer as ordered. If on 5/6/21, at 3:09 p.m., Omnifentified he would expect the exprovider for direction on was unavailable to red. The pharmacist stated the contacted the on-call or nen R190's medication was ministration as ordered. If on 5/6/21, at 4:00 p.m., fied he would expect the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21, at 4:00 p.m., fied he would expect the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the contacted the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined to primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the nurse all or primary physician if a con was unavailable as ordered. If on 5/6/21 is defined the nurse all or primary physician if a con was unavailable as ordered.				7/12/21

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F 812	from consuming for §483.60(i)(2) - Stors serve food in according serve food in according standards for food This REQUIREME by: Based on observareview, the facility fand the dishwasher manner to prevent of food borne orgath had the potential to in the facility, visito food from the kitch failed to ensure referoperly labeled, dispackaging was opecontamination, due were not stored award packages not seale facility failed to ensure maintained arguidelines to assure Findings include: On 5/3/21, at 1:27 kitchen with culinarefrigerator had must of spills on the wire plastic shelf was cordinated and spills on the optowel was laying and The refrigerator cocream opened and liquid eggs undated	does not preclude residents ods not procured by the facility. re, prepare, distribute and rdance with professional	F8	o How corrective action will be accomplished for those resid have been affected by the depractice. ¿ Unlabeled food was discarefrigerators and the dishwas were cleaned and sanitized. ¿ Refrigerated food items were cleaned and sealed to contamination, ¿ Dishwasher temperatures maintained according to man guidelines to assure sanitizated dishware. o How the facility will identify residents having the potential affected by the same deficient. ¿ Residents currently residents currently residents having the potential affected by the same deficient. O What measures will be put systemic changes made, to each the deficient practice will not in the deficient practice will not	lents found to efficient arded, sher cover were properly prevent s were nufacturer's tion of other all to be not practice. ling at the potential into place, or ensure that recur. The Culinary eview the arding kitchen and deep	

Facility ID: 00669

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F 812 Continued From page 66 Additionally, one small sandwich zip lock bag with approximately 10 slices of cheese was undated and left open, and one large gallon size zip lock bag open was filled with cheese slices, with the first 4-5 slices noted to be dry with corners curling up on them. CD-A confirmed the findings and threw out all undated and opened items except the milk which she indicated was from that morning. CD-A confirmed the refrigerator was not cleaned, and had multiple spills. In the walk in cooler, there was a metal container with plastic clear in place wrap over the top, undated and filled with creamy rice. CD-A indicated she was not sure when that was made, and indicated it was not stored in the correct container. CD-A threw the creamy rice into the trash. On 5/4/21, at 2:57 p.m. nursing assistant (NA)-D and surveyor inspected the refrigerator in the kitchenette by the nursing station. NA-D confirmed there were multiple spills of brown and	CLIVILI	10 I OIL MEDICAILE	A MEDICAID SERVICES			0	VID INO.	0930-0391
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER X44 ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 66 Additionally, one small sandwich zip lock bag with approximately 10 slices of cheese was undated and left open, and one large gallon size zip lock bag open was filled with cheese slices, with the first 4-5 slices noted to be dry with corners curling up on them. CD-A confirmed the findings and threw out all undated and opened items except the milk which she indicated was from that morning. CD-A confirmed the refrigerator was not cleaned, and had multiple spills. In the walk in cooler, there was a metal container with plastic clear in place wrap over the top, undated and filled with creamy rice. CD-A indicated she was not sure when that was made, and indicated it was not stored in the correct container. CD-A threw the creamy rice into the trash. No 15/296 PROVIDER'S TATE, ZIP CODE 30 SEVENTH STREET SOUTH WHEATON, MN 56296				` ′			COMI	PLETED
TRAVERSE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SEVENTH STREET SOUTH WHEATON, MN 56296			245585	B. WING				
TRAVERSE CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 66 Additionally, one small sandwich zip lock bag with approximately 10 slices of cheese was undated and left open, and one large gallon size zip lock bag open was filled with cheese slices, with the first 4-5 slices noted to be dry with corners curling up on them. CD-A confirmed the refrigerator was not cleared, and had multiple spills. In the walk in cooler, there was a metal container with plastic clear in place wrap over the top, undated and filled with creamy rice. CD-A indicated she was not sure when that was made, and indicated it was not stored in the correct container. CD-A threw the creamy rice into the trash. On 5/4/21, at 2:57 p.m. nursing assistant (NA)-D and surveyor inspected the refrigerator in the kitchenette by the nursing station. NA-D confirmed there were multiple spills of brown and	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS CITY STATE ZIP CODE		
CALCIDITION OF LOCATION OF L	10 101 1	TO VIDEN ON GOLF EIEN						
WHEATON, MN 56296 (X4) ID REFUX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 66 Additionally, one small sandwich zip lock bag with approximately 10 slices of cheese was undated and left open, and one large gallon size zip lock bag open was filled with cheese slices, with the first 4-5 slices noted to be dry with corners curling up on them. CD-A confirmed the findings and threw out all undated and opened items except the milk which she indicated was from that morning. CD-A confirmed the refrigerator was not cleaned, and had multiple spills. In the walk in cooler, there was a metal container with plastic clear in place wrap over the top, undated and filled with creamy rice. CD-A indicated she was not sure when that was made, and indicated it was not stored in the correct container. CD-A threw the creamy rice into the trash. On 5/4/21, at 2:57 p.m. nursing assistant (NA)-D and surveyor inspected the refrigerator in the kitchenette by the nursing station. NA-D confirmed there were multiple spills of brown and	TRAVER	SE CARE CENTER						
F 812 Continued From page 66 Additionally, one small sandwich zip lock bag with approximately 10 slices of cheese was undated and left open, and one large gallon size zip lock bag open was filled with cheese slices, with the first 4-5 slices noted to be dry with corners curling up on them. CD-A confirmed the findings and threw out all undated and opened items except the milk which she indicated was from that morning. CD-A confirmed the refrigerator was not cleaned, and had multiple spills. In the walk in cooler, there was a metal container with plastic clear in place wrap over the top, undated and filled with creamy rice. CD-A indicated she was not sure when that was made, and indicated it was not stored in the correct container. CD-A threw the creamy rice into the trash. On 5/4/21, at 2:57 p.m. nursing assistant (NA)-D and surveyor inspected the refrigerator in the kitchenette by the nursing station. NA-D confirmed there were multiple spills of brown and					W	/HEATON, MN 56296		
Additionally, one small sandwich zip lock bag with approximately 10 slices of cheese was undated and left open, and one large gallon size zip lock bag open was filled with cheese slices, with the first 4-5 slices noted to be dry with corners curling up on them. CD-A confirmed the findings and threw out all undated and opened items except the milk which she indicated was from that morning. CD-A confirmed the refrigerator was not cleaned, and had multiple spills. In the walk in cooler, there was a metal container with plastic clear in place wrap over the top, undated and filled with creamy rice. CD-A indicated she was not stored in the correct container. CD-A threw the creamy rice into the trash. On 5/4/21, at 2:57 p.m. nursing assistant (NA)-D and surveyor inspected the refrigerator in the kitchenette by the nursing station. NA-D confirmed there were multiple spills of brown and	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
tan spots on the bottom of the refrigerator. There were opened quart bottles of pop with resident's initials on them and NA-D confirmed one of the residents no longer resided in the facility. NA-D threw the bottles of pop away. There were supplement drinks and magic cups stored in this refrigerator for resident use. NA-D indicated the kitchen staff were responsible to clean the refrigerator. On 5/6/21, at 9:51 a.m. CD-A ran a rack of trays through the dishwasher. CD-A confirmed the wash cycle temperature was 140 degrees. CD-A ran the trays through 2 more times and the wash cycle reached only 140 degrees each time. CD-A indicated the dishwasher had run at 150-155	F 812	Additionally, one snapproximately 10 s and left open, and obag open was filled first 4-5 slices note up on them. CD-A threw out all undate the milk which she morning. CD-A concleaned, and had not cooler, there was a clear in place wrap filled with creamy rinot sure when that was not stored in the threw the creamy rinot sure when the confirmed there we tan spots on the bowere opened quart initials on them and residents no longer threw the bottles of supplement drinks refrigerator for residents no longer threw the bottles of supplement drinks refrigerator. On 5/6/21, at 9:51 at through the dishway wash cycle temperaran the trays through cycle reached only	mall sandwich zip lock bag with lices of cheese was undated one large gallon size zip lock I with cheese slices, with the d to be dry with corners curling confirmed the findings and ed and opened items except indicated was from that firmed the refrigerator was not multiple spills. In the walk in metal container with plastic over the top, undated and ce. CD-A indicated she was was made, and indicated it ne correct container. CD-A ice into the trash. D.m. nursing assistant (NA)-D cted the refrigerator in the nursing station. NA-D ere multiple spills of brown and attom of the refrigerator. There bottles of pop with resident's I NA-D confirmed one of the resided in the facility. NA-D inpop away. There were and magic cups stored in this dent use. NA-D indicated the esponsible to clean the	F 8	312	will provide training to all dietary stathese policies and procedures. o How the facility will monitor its concions to ensure that the deficient practice is being corrected and will recur. The Culinary Director or design will audit cleaning of the kitchen equipment, food is labeled or discar properly, and temperature logs for completeness and within range 3 tiper week for 1 month, then 1 time week for 2 months. The audit resure be reviewed during the facility QAP Meetings and the QAPI Committee provide direction or change when necessary and will dictate the contion or completion of this monitoring probase on the compliance noted from audits. "The date that each deficiency will	rrective not nee(s) rded mes per lts will l will nuation ocess the	

degrees that morning. CD-A stated the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP O 303 SEVENTH STREET SOUTH WHEATON, MN 56296		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 812	Thursday or Friday have plant operation this morning. CD-A dishwasher where gauge were located a brown fluffy subspipes. CD-A confirmas also located all cover overhanging come out and CD-A particles to fall on the she would call the kitchen vents and habove the dishwas. The CMA Owners If CMA-180VL/180VL Manual, CMA Diships specifications for change wash 155-160 Fahrer. Review of The Transpector Log Dishround wash-150 F, Record Log Dishround wash-150 F, Record wash and rib breakfast, lunch an reviewed from 3/1/2 the following: -March 2021, log is cycle temperature of entries, and all other entries, and all other contents.	erviced by a company last c. CD-A indicated she would on manager (POA)-A check it a confirmed that above the the pipes and temperature distance hanging on the the med the brown fluffy substance of lover the inside of the metal where the clean dishes would a indicated could cause the clean dishes. CD-A stated company that cleaned the nave them come to clean ther.	F 81	2		
	temperature entries	ntified the following wash cycle s: 12-155 F entries, 1-156 entries 150-154 F. Rinse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245585	B. WING			1	06/2021
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER				303	EET ADDRESS, CITY, STATE, ZIP CODE SEVENTH STREET SOUTH EATON, MN 56296	1 00.	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
F 812	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F8	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245585	B. WING		05	C / 06/2021	
NAME OF PROVIDER OR SUPPLIER TRAVERSE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIF 303 SEVENTH STREET SOUTH WHEATON, MN 56296		700/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 812	by the facility were forms included the the form titled Cleato be cleaned daily initial. The form wainstructions for cleathe from titled Weestaff to wipe out dain The form was blankthe form Monthly Coneed to be done by had hand written "mincluded all vents." A facility policy for form	ested cleaning logs provided not filled out or dated. The following: aning Schedule, included items with blank areas to fill in or as blank and did not include uning the refrigerators. Ekly Cleaning List, instructed ry fridge-aide on Thursday.	F 8	12			