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

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00669	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/3/21, to 5/6/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT to be in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have	2 000		

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2 000	Continued From page 1 reviewed these orders and identify the date when they will be completed. Licensing orders were issued at 0302, 0920, 0965, 1015, 1426, 1550, 1805 and 1942. Additionally, complaint investigations were completed. The following complaints were found to be unsubstantiated with no licensing orders issued: H5585017C (MN00069966). H5585018C (MN00069474). H5585019C (MN00056787). The following complaint was found to be substantiated with no licensing orders issued. H5585020C (MN00066440). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 2 Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include:	2 302		7/12/21

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2 302	Continued From page 3 (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 new employees, nursing assistant (NA)-A, trained medication assistant (TMA)-A, and TMA-B received dementia or Alzheimer's training upon hire per the facility on-boarding protocol . This had the potential to affect all 39 residents residing in the facility. Findings include: During record review of annual dementia and Alzheimer's training for 2020 into 2021, nine staff records were selected and reviewed. Records indicated this training had not been completed for new hires NA-A, TMA-A, and TMA-B who provided direct care to residents. During an interview on 5/5/21, at 11:30 a.m., the administrator identified that dementia training was part of the on-boarding process for new hires and completed annually for all staff. The director of	2 302	The Director of Nursing or designee will enroll all direct care staff in the appropriate Alzheimer's training courses and notify them of a timeline for completion. "The date that each deficiency will be corrected: July 12, 2021	

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2 302	Continued From page 4 nursing (DON) was responsible for the dementia and Alzheimer's training but had been out on family medical leave (FML) for approximately two months. He confirmed there had been no system put into place to ensure the new hires received the dementia and Alzheimer's training in the DON's absence. SUGGESTED METHOD OF CORRECTION: The DON or designee could enroll all direct care staff in the appropriate Alzheimer's training courses and notify them of a timeline for completion. The DON could ensure all direct care staff complete the missed courses via an audit, and could develop a regular audit of facility education course completion to be done following new staff orientation and throughout the year as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide shaving assistance for 2 of 3 residents (R9 and R33) and oral care assistance for 1 of 3 residents (R9) who	2 920	How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	7/12/21

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2 920	Continued From page 5 were dependent on staff with activities of daily living (ADL's). Findings include: R9 R9's annual Minimum Data Set (MDS) dated 2/5/21, identified R1 had severe cognitive impairment and had diagnoses which included Alzheimer's disease, dementia, anxiety. R9's MDS further identified she required extensive assistance of one staff for dressing, personal hygiene and limited staff assistance with transfers, eating, toileting. The MDS indicated R9 required supervision with bed mobility. R9's care plan dated 4/10/21, indicated R9 had an ADL self care deficit related to Alzheimer's and required staff assistance with shaving chin hairs if noted. R9's care plan identified R9 required staff assistance with combing hair, nail care, changing soiled clothes and encouraging/cueing her to brush her teeth. R9's Dental/Oral Data Collection Tool dated 2/2/21, indicated R9 had her own teeth and indicated R9 was able to brush her own teeth after staff assistance with set up and cueing.. During observations on 5/3/21, at 3:12 p.m. R9 was seated out in a recliner in the living room area rocking back and forth in the recliner with her eyes closed. R9 was noted to have several long white facial hairs on her lower chin area that were approximately 1/2 inch or longer. During observations on 5/4/21, 9:30 a.m. R9 was seated the dining room area eating breakfast independently and was noted to have several	2 920	¿ R9 received oral hygiene at the time of survey and as directed by their care plan. R9 and R33 were shaved at the time of survey and have been shaved as directed by their care plans. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing in the facility who are dependent on staff for grooming / hygiene including oral care and shaving have the potential to be affected. An audit was completed, and those who required care received those cares during the time of survey. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing will provide education to nursing assistants regarding the importance of offering oral hygiene and shaving as directed by the resident□s care plan. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Director of Nursing or designee will Audit those dependent on staff for shaving and/or oral care daily for 2 weeks; then weekly for 2 months. Audit results will be reviewed at QAPI for recommendations and need to continue audits. " The date that each deficiency will be corrected: July 12, 2021	

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2 920	Continued From page 6 long white facial hairs on her lower chin area that were approximately 1/2 inch or longer. - at 2:51 p.m. R9 was seated out in the living room area looking out the window and R9's facial hair remained on her lower chin area. - at 3:01 p.m. R9 was seated out in the living room area visiting with her family and R9's facial hair remained on her lower chin area. - at 3:12 p.m. R9 facial hair remained while she continued to visit with her family. At no time did staff offer or provide assistance to R9 to remove the long white facial hairs present on her chin. During observations on 5/5/21 at 10:05 a.m. R9 was laying in bed, when nursing assistant (NA)- C and NA-E entered her room and asked her if she was ready to get up for breakfast. NA-E assisted R9 to the bathroom and provided morning cares which included washing R9's face, hands, upper body, applying a clean incontinent brief and dressing R9 while she sat on the toilet. - at 10:26 NA-C had collected the dirty linen and garbage and immediately left R9's room. NA-E assisted R9 to stand up from the toilet using her walker and gait belt, provided peri cares, pulled up her brief and her pants. NA-E proceeded to walk R9 out of her room and down to the dining room area holding on to the back of the gait belt with walker. NA-E had R9 sit down at the dining room table next to the nurses station and removed her gait belt from her waist. NA-E proceeded to get R9's breakfasts for her and R9 began to eat her breakfast independently. R9 had natural teeth present on the top and bottom of her mouth and continued to have several long white facial hairs on her lower chin area that were approximately 1/2 inch or longer. At no time did NA-C or NA-E offer or provide assistance to R9 to remove the long white facial hairs present on her chin or offer to provide oral cares.	2 920		

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2 920	Continued From page 7 - at 10:46 a.m. R9 continued to be seated at the dining room table eating her breakfast independently when trained medication aid (TMA)-C approached R9 and sat down at the table visiting with her while providing her a supplement to drink. R9 finished her supplement drink and TMA-C immediately got up from the table and left while R9 continued to eat breakfast. R9's facial hair remained and TMA-C did not offer or provide assistance to R9 to remove the long white facial hairs on her chin or to provide oral cares. On 5/4/21, at 3:41 p.m. family member (FM)-A indicated staff assisted R9 with cares and personal hygiene. FM-A indicated R9 would hate it if she knew she had long hairs on her face and stated "I wish they would take care of it." On 5/6/21, at 10:10 a.m. NA-E confirmed R9 needed assistance with personal hygiene and grooming and shaving. NA-E indicated the bath aid was the one who usually shaved the residents. NA-E confirmed neither she or NA-C offered to shave R9's chin hairs or offered to provide oral cares. NA-E stated they should have offered it to her. R33 R33's quarterly MDS dated 3/12/21, identified R33 had severe cognitive impairment and had diagnoses which included dementia, depression and renal insufficiency. R33's MDS further identified she required extensive assistance of one staff for personal hygiene and limited staff assistance with bed mobility, transfers, toileting and dressing.	2 920		

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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 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		

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2 920	Continued From page 9 and shaving. NA-E indicated the bath aid should have been completing the cares on her bath day and staff should have been offering to shave her daily. On 5/6/21, at 1:59 p.m. the director of nursing (DON) confirmed the above findings and indicated she would expect staff to shave the residents daily. The DON stated she expected staff to provide or offer dental care and follow the residents care plans. Review of facility policy titled, Shaving revised on 3/1/2014, indicated residents will be provided care and services daily which included shaving as per resident needs and/or care plan. Review of facility policy titled, Oral Hygiene dated 4/1/2008, indicated residents who are unable to perform daily oral hygiene will receive assistance. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents unable to carry out activities of daily living to assure they are receiving the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality improvement for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		7/12/21

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2 965	Continued From page 10 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete ongoing nutritional assessment, address risk factors for impaired nutritional status and implement approaches to maintain acceptable nutrition parameters for 2 of 4 resident (R18, R22), who had a significant weight loss of 10.8% and 13.1%, reviewed for nutrition. Findings include: R18 R18's significant change Minimum Data Set (MDS) dated 2/22/21, identified R18 had diagnoses which included right hip fracture, dementia with behavioral disturbance, major depression and heart failure. The MDS indicated R18 required extensive assistance with bed mobility, dressing, personal hygiene, and eating. The MDS identified R18 required total assistance for transfers and locomotion. R18's MDS identified R18's weight at 162 and indicated no weight loss. The MDS indicated R18 coughed or choked during meals or when swallowing medications.	2 965	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R18, and R22 were reviewed for scheduled monitoring of weekly weights; appropriate nutritional supplements, nutritional interventions, and resident preferences to address significant weight loss. ¿ Registered dietitian has completed a dietary risk assessment on R18, R22 for further recommendations to modified plan of care. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents residing in the facility have the potential to be affected. The Director of Nursing and Registered Dietician will review current residents for significant weight loss, and care plans updated with appropriate interventions. What measures will be put into place, or systemic changes made, to ensure that	

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2 965	Continued From page 11 R18's care plan undated, identified R18 required assistance of one staff with bed mobility, transfers, toileting, bathing, dressing and personal hygiene. The care plan indicated R18 exhibited adequate intake related to usual good appetite as evidenced by stable body wight, healthy range and good oral intake at most meals. The care plan instructed staff to monitor labs, monitor meal intakes, monitor weights, offer routine house snacks between meals, provide diet as ordered, use a clothing protector,and serve meals in the main dining room as recommended by therapy. R18's Comprehensive Care Area Assessment (CAA) dated 2//22/21, indicated R18 had a mechanically altered diet and a therapeutic diet. The CAA identified R18 had a potential problem for nutrition. The CAA indicated R18 had a swallowing problem and had an inability to perform activities of daily living (ADL's) without assistance. R18's Dietary Profile Tool dated 1/11/21, identified R18 was on a regular diet with mechanical soft texture and regular liquids. The assessment tool lacked documentation R18 had weight loss or any interventions to prevent weight loss or to maintain a stable weight. R18's Order Summary Report dated 5/1/21, identified R18's diet as a diabetic diet with ground meat texture and regular liquids. The report lacked documentation of any type of supplement being offered for R18's weight loss. Review of R18's monthly weights from 10/29/20, to 4/29/21, identified the following: 10/29/20, weight was 170.5 pounds	2 965	the deficient practice will not recur. ¿ IDT-team members will review resident weights and meal intake weekly to identify variances, and ensure adequate interventions are in place; RD will be notified of all residents identified as high risk for significant weight loss weekly. ¿ The Director of Nursing or designee will educate all nursing and culinary staff on the procedures for Nutrition Risk and Weight Loss How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ¿ The Director of Nursing and/or Registered Dietician or designee will audit of residents experiencing weight loss. Resident□s who experience a 5% weight loss will be audited for appropriate interventions weekly for 4 weeks; then monthly for 2 months. Audit results will be reviewed in QAPI for further recommendations. " The date that each deficiency will be corrected: July 12, 2021	

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2 965	Continued From page 12 11/27/20, weight was 172.5 pounds 12/31/20, weight was 171.0 pounds 1/14/21, weight was 160.0 pounds 2/17/21, weight was 161.7 pounds 3/25/21, weight was 156.0 pounds 4/29/21, weight was 152.0 pounds Review of R18's registered dietician (RD) assessment notes from 2/25/21, to 5/5/21, identified the following: On 2/25/21, late entry at 1:17 p.m. identified R18 had a significant change assessment with R18's current weight at 161.7 (on 2/17/21) with no significant weight loss, yet a small and recent weight loss was noted. The plan identified that R18's weight continued to be relatively stable with no significant loss. The note indicated no changes were needed at the time, yet would continue to monitor for need for modifications in dietary interventions. On 5/5/21, at 1:43 p.m. identified R18 showed a recent weight loss. The note identified R18's current weight was 152.0 (on 4/29/21), which showed a 2.5% weight loss from one month prior, a 5% weight loss from three months prior (160.0 on 1/14/21) and 10.8% weight loss from six months prior (170.0 on 10/29/20). The note identified R18 currently was presenting with a clinically significant weight loss for the last 6 months. RD identified recent history and conditions with R18's weight loss and recommended a nutritional supplement to be offered to help support his decreased intake. RD recommended four ounces of Glucerna three times a day given during medication times. During observation and interview on 5/5/21, at 10:14 a.m., nursing assistant(NA)-B identified it	2 965		

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2 965	Continued From page 13	2 965		

was not uncommon for R18 to sleep in late and to not get up until 11:00 a.m. R18 was observed to still be in bed at this time when NA-B asked R18 if he was ready to get up for the day.

During observation on 5/5/21, at 10:58 a.m., R18 was assisted out to the day room area after morning cares. NA-C offered him a drink but nothing to eat.

During interview on 5/5/21, at 1:00 p.m., culinary director (CD)-A identified she reviewed the weights on point click care (PCC) each morning or at least weekly indicating the weights were in red if there was a change for quick identification. CD-A stated if there was a weight change she would talk to the nurse manager to see what interventions could be placed which would include a supplement. During record review, CD-A confirmed the last dietician notes documented in R18's electronic health record (EHR) were from 5/21/19. CD-A confirmed R18 was encouraged to eat but was not currently on any type of supplement or meal modification to increase his weight. CD-A confirmed R18 did have a weight loss and indicated there were no dietary interventions implemented.

During interview on 5/5/21, at 1:58 p.m., registered dietician (RD) identified she had just finished the assessment for the significant change from back in February 2021 for R18 which should of been completed in February 2021. RD stated she had just been given an updated MDS schedule when she was there on 5/4/21. RD confirmed she had not been notified of any weight loss for R18 even though she had been to the facility on 5/4/21. RD stated she expected someone to be monitoring the weights, to notify her of weight loss and to notify nursing to

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2 965	Continued From page 14	2 965		

start a temporary supplement until she was able to assess the resident. RD indicated she was only contracted two days a month to complete her assessments.

During interview on 5/5/21, at 2:25 p.m., registered nurse (RN) B identified R18's meal intake was a hit or miss if he would eat. RN-B stated direct care staff obtained resident's weights and the licensed nurse entered the weights into PCC. RN-B stated the licensed nurse was expected to compare the weight with the prior weight and determine if a weight loss had occurred. RN-B indicated if a weight loss was identified, the nurse was expected to notify the nurse manager who usually contacted the provider. RN-B confirmed R18 had lost weight and was not on any type of supplement.

During interview on 5/5/21, at 2:57 p.m., R18's primary medical doctor (MD)-A identified he had been aware of R18's weight loss by verbal communication and had been at the facility to see R18 recently. MD-A indicated R18 had a recent hip fracture with surgery, had recent COVID-19, and the psychiatrist had recently made some medication changes. MD-A stated he had made changes to the recent psychoactive medication dose related to lethargy and consulted with the psychiatrist for further monitoring last month. MD-A indicated he was not surprised about the weight loss yet agreed the facility should have identified the weight loss and acted on it by notifying the dietician for an evaluation or nursing to obtain an order for a supplement. MD-A confirmed a supplement would have been an appropriate intervention for R18.

During interview on 5/6/21, at 11:10 a.m., CD-A confirmed R18's weight loss was not addressed

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2 965	Continued From page 15 with the dietician when she was in the building on 5/4/21, as she did not have time since she was cooking. She confirmed she does not give the dietician any types of notes or list of residents with identified concerns for weight loss. R22 R22's quarterly Minimum Data Set (MDS) dated 2/26/21, identified R22 had significant cognitive impairment and diagnoses which included: heart failure, diabetes mellitus (group of diseases that affect how your body uses blood sugar) and anxiety. R22's MDS indicated R22 required extensive assistance with bed mobility, transfers, dressing and personal hygiene. The MDS indicated R22 required supervision/oversight, encouragement or cueing to eat with set up help only. R22's MDS identified R22's weight was 126 and she had a weight loss of 5% or more in last month or a loss of 10% or more in the last 6 months. The MDS indicated R22 was not on a physician-prescribed weight-loss regimen. R22's Care Area Assessment (CAA) dated 10/29/20, identified R22 had a potential problem for nutrition. R22's weight was 137. R22's CAA identified R22's nutrition needs would be care planned to maintain her current level of functioning. R22's care plan dated 5/6/21, identified R22 was at nutritional risk and had a history of complaining about meals. Updated care plan identified involuntary weight loss related to diminished appetite and general decline secondary to COVID-19 infection. The care plan indicated R22's COVID diagnoses on 2/1/21, poor appetite with frequent refusal to eat and significant weight loss of 13% for three months, dated 5/5/21.	2 965		

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2 965	Continued From page 16 Interventions included: Offer 2 hard boiled eggs daily for extra protein, offer a trial of supplements, offering a nutritional supplement twice a day (BID) due to weight loss and poor intake, and refer to registered dietician for evaluation and/or recommendation as needed (PRN). R22's care plan included interventions to assist R22 with dressing, toilet use, bed mobility when she requested and PRN assistance with transfers if she requested. R22's interventions identified R22 was independent with eating with occasional set up first before eating. Review of R22's Monthly Weight Report reviewed from 10/1/20, to 5/1/21, identified the following; -October 2020-weight 135.5 -November 2020-weight 134.5 -December 2020-weight 137 -January 2021-weight 136 -February 2021-weight 126 -March 2021-weight 122 -April 2021-weight 119 On 5/3/21, at 4:58 p.m. R22 was in the dining room seated in her wheelchair. At 5:17 p.m. R22 was at her table with her meal in front of her and R22 drank a few sips of chocolate milk through a straw. At 5:30 p.m. R22 was encouraged to eat by a staff member, offered fruit and shown her ice cream. R22 consumed only a few bites of ice cream and drank a few sips of ice water and chocolate milk and R22 left the table. R22 had not been provided a hard boiled egg or supplements during this meal. On 5/5/21, at 9:02 a.m. R22 was lying in her bed, eyes open, head of bed slightly elevated. Staff delivered a breakfast tray to R22 and informed her she would get someone to assist her up. At	2 965		

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2 965	Continued From page 17 9:05 a.m. Interim director of nursing (IDON) entered R22's room and placed head phones on R22 with a pocket talker attached (hearing assistive device). IDON asked if she could assist R22 into her wheelchair and R22 refused. IDON raised R22's head of bed up and placed her bedside table in front of her. IDON removed the meal cover and informed R22 of her breakfast which consisted of french toast, sausage, toast and fruit. IDON offered to cut up her meal which R22 declined. R22 began eating the watermelon and IDON offered to remove her head phones. R22 stated yes as she did not like them. At 10:01 a.m. R22 remained in bed and was not eating at the time while her breakfast meal remained in front of her. At 10:24 a.m. social service designee (SSD) entered R22's room and asked her to try to eat. SSD used a paper by R18's bedside with different messages on it to communicate to her and left the room. R22 ate a few bites of fruit and no other foods during the meal. R22 had not been provided or offered a hard boiled egg or supplements during the meal. On 5/5/21, at 12:39 p.m. R22 was seated in her wheelchair at a table in the dining room and had just been served her lunch meal. R22 stated she could not eat all of that. R22 was served a bacon, lettuce and tomato (BLT) sandwich, macaroni and cheese, and a cup of sliced cucumbers. R22 received a glass of ice water and chocolate milk. R22 had not been provided a hard boiled egg or supplements during the meal. At 1:06 p.m. R22 had left the dining room, had consumed 3/4 of her BLT sandwich and had not eaten anything else. On 5/5/21, at 12:50 p.m. during a phone interview, family member (FM)-B indicated she was aware of R22's weight loss and indicated	2 965		

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2 965	Continued From page 18 R22 had quit eating when she had COVID infection. FM-B stated R22 sometimes ate and sometimes she did not. FM-B indicated staff had been giving R22 supplements however they had not for awhile. FM-B stated she was aware R22 was getting a regular diet and had not seen any modifications made to her diet. FM-B indicated a month ago she had caught a couple of times when R22 had not received a tray for meals and she had reported that to the administrator. FM-B stated she attempted to feed R22 at noon meal and indicated R22 did well when she placed the food onto the silverware for her. FM-B indicated she was aware R22 weighed 119 pounds and had lost 15-16 pounds since she had COVID. FM-B indicated she had not spoken to the registered dietician (RD)-A and was not aware of any changes they had made to R22's diet. On 5/5/21, at 1:29 p.m. nursing assistant (NA)-D stated R22 had not been eating very well and her family was coming in to help her eat. NA-D indicated they usually encouraged her to eat and only occasionally assisted R22 to eat. NA-D indicated the last time she had assisted R22 with eating was a few weeks ago. NA-D indicated R22 at times had received supplements from the nurses. On 5/5/21, at 1:42 p.m. registered nurse (RN)-B stated it was very hard to get R22 to eat sometimes and when her family was here R22 ate better. RN-B indicated she thought R22 used to receive supplements, and indicated she thought it was on R22's orders to receive them. RN-B checked on R22's electronic medical record and confirmed R22 did not have orders for supplements. RN-B indicated she had not worked with R22 for awhile.	2 965		

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2 965	Continued From page 19 On 5/5/21, at 2:20 p.m. NA-B indicated R22 refused meals often since she had COVID infection. NA-B stated R22 had not eaten her breakfast meal and indicated that was not unusual for her. NA-B indicated she thought the nurses gave R22 supplements with her medications and she had not noticed if this had been done for the last couple of days. On 5/5/21, at 2:24 p.m. trained medication aide (TMA)-C stated she was not aware R22 had a supplement order and indicated it was difficult to get her to eat food and drink liquids. TMA-C indicated R22 did not have an appetite anymore and stated she was not aware of any changes with her diet or orders related to her weight loss. TMA-C indicated a few times they tried to get R22 to drink a chocolate supplement drink and she would spit it out. TMA-C indicated they did not have orders to give supplements and did not believe R22 ever had any orders for them. TMA-C stated at times she would try to give supplements or attempt to give R22 a magic cup. On 5/5/21, at 2:38 p.m. R22 stated she has never ate very much and denied losing any weight. R22 confirmed FM-B came in and assisted her with eating lunch. On 5/5/21, at 2:55 p.m. during phone interview nurse practitioner (NP)-A identified R22's weight loss was related to her dementia and behaviors. NP-A indicated she would expect the facility staff to encourage R22 to eat, help her eat, and provide nutritional supplements and increase protein. NP-A confirmed she would expect those recommendations were to be made by the facility dietician. On 5/5/21, at 3:30 p.m. during phone interview,	2 965		

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2 965	Continued From page 20 RD-A confirmed the last time she completed a comprehensive dietary assessment for R22 was 12/19/20, for her annual assessment. RD-A indicated the first time she had been in the facility since COVID-19 began was 5/4/21, and additionally only one or two times since March 2020. RD-A indicated she was relying on communications from staff for any concerns. RD-A indicated she would receive e-mails from the previous director of nursing (DON) and culinary director (CD)-A, which included new admissions and the MDS schedule for assessments. RD-A indicated in the past she would be notified by DON or CD-A regarding residents with weight loss. RD-A stated she would expect staff to notify her of any weight loss as soon as they identified it. RD-A indicated she was not aware how often the facility reviewed weights. RD-A pulled up R22's electronic medical record and confirmed R22 had a significant weight loss. RD-A identified R22's weight of 119 was much lower than her previous weights. RD-A confirmed R22's weight loss started in February. RD-A stated now that she was aware of R22's weight loss, she would review R22's record remotely and contact CD-A to initiate interventions today. On 5/5/21, at 3:21 p.m. CD-A indicated her usual process for contacting RD-A was by e-mail. CD-A indicated she had sent e-mails notifying RD-A regarding things such as new residents, changing diet textures and thought she may have notified RD-A about supplements for one resident. CD-A indicated she thought the administrator e-mailed the MDS schedule for assessments to RD-A. CD-A confirmed she reviewed residents' weights weekly and indicated they were flagged by the system for weight loss. CD-A stated she would notify RD-A if she had concerns with residents or if the nurses brought concerns to her attention.	2 965		

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2 965	Continued From page 21 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%. -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	2 965		

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2 965	Continued From page 22	2 965		

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 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 5/6/21, identified the following:

-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 encourage R22 to take medication and drink, not effective. R22 went to hospital, returned with order for Zofran (medication to prevent nausea and vomiting).

-2/17/21, R22 ate one bite of egg for breakfast, and refused lunch and snacks sent in by family, except one bite of cookie. R22 took meds crushed in supplement and drank one supplement at breakfast and at noon. R22

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2 965	Continued From page 23 continues to have loss of taste and smell. -2/20/21, spoke with family related to R22 hesitancy to eat and drink at this time. Family stated to continue supplements. R22 drank supplement better after informed facility spoke with family. R22 drank two full glasses of supplement. -2/21/21, R22 has not been eating or drinking. Staff fed R22 with poor appetite noted and to drink supplements with encouragement. -2/23/21, R22 is not eating or drinking well. R22 needs much encouragement and at times needs to be fed as allows. -2/25/21, R22 continues to have loss of taste and smell. -2/26/21, R22 drank supplement and chocolate milk, ate popcorn the day before with family, but did not eat today. -2/28/21, R22's family here for noon meal, eating an apple and banana. R22 continues to have loss of taste and smell. -3/5/21, R22 ate small bites apple and banana. Staff frequently offered food and drink, R22 refused more. -3/7/21, R22 ate apple and small malt for family. -3/10/21, R22 continues to have loss of taste and smell. -3/12/21, R22 refused breakfast but ate part of magic cup. R22 ate noodles and drank malt for lunch with family. R22 had chicken soup, magic	2 965		

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2 965	Continued From page 24 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 continues to have loss of taste and smell. -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. -4/15/21, R22 resistive to eat this morning, did drink chocolate milk and 1/2 of egg. Family here brought in food this afternoon, good appetite. 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 with ice cream and sometimes with small candy bar, will continue to monitor. -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	2 965		

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2 965	Continued From page 25 with ice cream and sometimes with small candy bar, will continue to monitor. -4/28/21, R22's intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor. -4/29/21, R22 did not like chocolate milk tonight, took bites of pudding till finished, fed brownie ate two bites of chili, minimal fluid intake. R22's intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor. -5/4/21, R22's intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor. -5/5/21, Dietary Progress note-included: R22 significant weight loss in the last 3 months, current weight 119, 2.5% weight loss 1 month ago, 13.1% weight loss from 90 days ago, and 13.1% weight loss from 6 months ago. R22 diagnosed with COVID-19 2/1/21, likely reason for notable weight loss. R22 now eating in main dining room per family request, and R22 can be supervised/encouraged and assisted as needed. R22 continues to have very little appetite and supplements have been offered at times, not been accepting of supplements like she was on the COVID unit, when drank 5-6 supplements a day. RD-A communicated with dietary manager today and RD-A will recommend supplements to be trialed twice a day and will monitor. RD-A will	2 965		

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2 965	Continued From page 26 begin monitoring resident monthly and as needed to assess for any further weight loss, to determine scheduled supplements or further dietary inventions. -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	2 965		

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2 965	Continued From page 27 was to continue present regimen. Review of R22's progress notes for nursing home visit dated 4/15/21, identified R22 was seen by NP-B, and identified no current complaints or concerns. R22's progress note plan was to continue present regimen. 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. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritional risk received appropriate interventions to maintain nutrition as determined necessary by their individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance.	2 965		

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2 965	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi 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 plastic shelf was covered in red spillage which	21015	o How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ Unlabeled food was discarded, refrigerators and the dishwasher cover were cleaned and sanitized. ¿ Refrigerated food items were properly labeled, dated, and sealed to prevent contamination, ¿ Dishwasher temperatures were maintained according to manufacturer's 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. ¿ Residents currently residing at Traverse Care Center have the potential to be impacted. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.	7/12/21

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21015	Continued From page 29 ran down to the open bottom area where a white towel was laying and a 1/3 full bottle of water lay. The refrigerator contained 3 bags of whipped cream opened and undated, one package of liquid eggs undated, a plastic carton of milk undated and ranch salad dressing undated. 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 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	21015	¿ The Administrator with the Culinary Director or designee(s) will review the policies and procedures regarding kitchen sanitation, temperature logs, and deep cleaning. ¿ The Culinary Director or designee (s) will provide training to all dietary staff on these policies and procedures. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Culinary Director or designee(s) will audit cleaning of the kitchen equipment, food is labeled or discarded properly, and temperature logs for completeness and within range 3 times per week for 1 month, then 1 time per week for 2 months. The audit results will be reviewed during the facility QAPI Meetings and the QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process base on the compliance noted from the audits. " The date that each deficiency will be corrected: July 12, 2021	

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21015	Continued From page 30	21015		

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 degrees that morning. CD-A stated the dishwasher was serviced by a company last Thursday or Friday. CD-A indicated she would have plant operations manager (POA)-A check it this morning. CD-A confirmed that above the dishwasher where the pipes and temperature gauge were located there were heavy amounts of a brown fluffy substance hanging on the the pipes. CD-A confirmed the brown fluffy substance was also located all over the inside of the metal cover overhanging where the clean dishes would come out and CD-A indicated could cause particles to fall on the clean dishes. CD-A stated she would call the company that cleaned the kitchen vents and have them come to clean above the dishwasher.

The CMA Owners Manual, Model CMA-180VL/180VL Tall Installation And Operation Manual, CMA Dishmachines, undated, identified specifications for cycle temperatures included: wash 155-160 Fahrenheit (F) and Rinse 180-195 F.

Review of The Traverse Care Center Dishwasher Record Log Dishroom, which contained dates, and wash-150 F, Rinse 180 F, with spaces to record wash and rinse temperatures for breakfast, lunch and dinner. The facility logs were reviewed from 3/1/21, to 5/6/21, which identified the following:

-March 2021, log identified the following wash cycle temperature entries: 1-140 F, no 155 F entries, and all other entries were from 150-154 F. Rinse cycle entries were recorded at 180-200

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21015	Continued From page 31 F. -April 2021, log identified the following wash cycle temperature entries: 12-155 F entries, 1-156 entry, and all other entries 150-154 F. Rinse cycle entries were recorded at 181-200 F. -May 2021, log identified no entries made for 5/1/21 or 5/2/21. The log identified the following wash cycle temperature entries: 7-155 F, and 3 150 F. Rinse cycle entries were recorded at 189-200 F. On 5/6/21, at 9:58 a.m. during a follow up interview, CD-A provided the dishwasher manufacture guide to surveyor and confirmed they followed the manufactures instructions for use of the dishwasher. CD-A indicated her expectation was for staff to minimally do weekly cleaning and wipe up any spills as soon as they were made. CD-A confirmed the cheese slices were used for sandwiches some supper nights and were also on the alternative menu. CD-A indicated she expected cheese would have been dated and kept sealed in the bags. CD-A confirmed if the refrigerators were not kept clean and foods not stored properly, there was a risk of cross contamination. CD-A indicated when the packages were left open and there were multiple spills in the refrigerator, the potential for infection control concerns were increased. On 5/6/21, at 3:17 p.m. POA-A indicated he had checked, cleaned, and flushed the kitchen tank heater for the dishwasher and the dishwasher temperatures were now running at 155 for washing. POA-A stated he called the company who cleaned the kitchen vents and they would be coming to clean above the dishwasher next week. POA-A confirmed the company informed him they had never cleaned above the dishwasher and POA-A confirmed it was very dirty. POA-A	21015		

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21015	Continued From page 32 indicated the dishwasher was last serviced on 4/30/21. Review of the requested cleaning logs provided by the facility were not filled out or dated. The forms included the following: -the form titled Cleaning Schedule, included items to be cleaned daily with blank areas to fill in or initial. The form was blank and did not include instructions for cleaning the refrigerators. -the from titled Weekly Cleaning List, instructed staff to wipe out dairy fridge-aide on Thursday. The form was blank. -the form Monthly Cleaning List, identified all jobs need to be done by 20th of each month. The form had hand written "master" over the month and included all vents. The form was blank. A facility policy for food storage and cleaning of kitchen equipment was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		7/12/21

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	00669	A. BUILDING: _____ B. WING _____	C 05/06/2021

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21426	Continued From page 33 (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 facility failed to complete a Tuberculosis (TB) risk assessment according to the current State guidelines for preventing the transmission of Tuberculosis. This deficient practice had the potential to affect all 39 residents residing in the facility. Findings include: 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 using the Regulations for Tuberculosis Control in	21426	The Director of Nursing or designee will ensure the TB risk assessment will be completed according to the State guideline recommendations. " The date that each deficiency will be corrected: July 12, 2021	

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21426	Continued From page 34 Minnesota Health Care Settings as their guide. Review of July 2013, Regulations for Tuberculosis Control in Minnesota Health Care Settings guide identified heath care settings should perform an initial facility TB assessment. If the facility is determined to be medium-risk the assessment should be updated yearly or if the facility is determined low-risk updated every other year. The guide provided three options to choose from to conduct a facility assessment and directions. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could ensure the TB risk assessment would be completed according to the State guideline recommendations. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to obtain and administer ordered medication for 1 of 1 residents (R190) who were reviewed for medication administration. Findings include:	21550	o How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R190 received the medication as ordered without any further concerns on	7/12/21

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21550	Continued From page 35 R190 admission record (face sheet) dated 5/6/21, identified admission to the facility on 5/3/21. Diagnosis included heart failure, hypertension, anxiety disorder, obesity, depression, gastroesophageal reflux and sleep apnea. R190's hospital discharge notes identified she had been admitted to the hospital following a fall in February sustaining a left knee dislocation which ruptured her popliteal artery. R190 under went surgery 2/3/21, and had a synthetic popliteal graft. R190 had an external fixator placed. R190 then transferred to a rehab facility and developed complications and was readmitted to the hospital with sepsis. Ultimately, R190 had increasing leg pain and her wounds had to be reopened for drainage and R190 required skin grafting. R190's admission orders identified original order date of 5/3/21, Fodaparinux Sodium (Arixtra) 2.5 milligrams /0.5 milliliters (mg/ml) inject 2.5 mg (0.5 ml subcutaneous daily for prevention of blood clots. Review of R190's progress notes from 5/3/21, to 5/5/21, identified the following: 5/3/21 4:47 p.m., R190 was admitted to the facility. 5/4/21 7:13 a.m., medication review completed and a clarification was requested for duration of Fodaparinux. The progress notes lacked documentation Fodaparinux was not available to be administered. During an interview on 5/5/21, at 11:02 a.m.,	21550	05/04/2021. o How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing at the facility have the potential to be affected. The Director of Nursing and designated licensed nurse audited the medication availability. No other issues were identified. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing educated the Licensed Nursing staff on notifying the physician when holding medication for clarification, or should a medication is not available. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ Director of Nursing or designee will audit medication omissions weekly x 30 days, then bi-weekly x 60 days; results will be brought to QAIP for further recommendation. " The date that each deficiency will be corrected: July 12, 2021	

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21550	Continued From page 36 R190 stated she had been admitted to the facility on 5/3/2. R190 indicated the facility did not receive her medications until 10:30 p.m. that evening. R190 identified that not all of her medications had been delivered the day she admitted to the facility and she did not get her blood thinner until the evening of 5/4/21, the day after she was admitted. During an interview on 5/5/21, at 12:42 p.m., registered nurse (RN)-B who confirmed that the pharmacy Omni Care who delivered medications for Medicare A and managed care residents did not deliver medication until 9:00 p.m., or 10:00 p.m., normally. RN-B stated medications that come from the Wheaton pharmacy were delivered earlier in the day. RN-B confirmed that R190 received medication from Omni Care and most likely those did not get delivered until after 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 interview on 5/6/21, at 9:18 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.	21550		

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21550	Continued From page 37 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		7/12/21

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21805	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to promote dignity while utilizing gait belts for extended periods of time for 3 of 3 residents (R9, R33 and R24) who received assistance with activities of daily living (ADL's). Findings include: R9 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. During observations on 5/4/21, at 9:28 a.m. R9 was seated in the main dining room area with other residents eating breakfast independently and had a white gait belt fastened around her waist. R9 got up independently and began to walk independently with her four wheeled walker out of the main dining room area. Nursing assistant (NA)-C came over a few minutes later and began to walk with R9 while she held onto the back of the gait belt into the living room area. NA-C assisted R9 to sit down in the recliner in the living	21805	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R9, R33, and R24 will have gait belts removed when not in use to promote care in a dignified manner. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing in the facility who utilize gait belts have the potential to be affected. A review was completed for the lack of removal of the gait belt and no other residents were affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing / designee will re-educate staff regarding Resident Rights and dignity with the focus on removal of gait belts when not in use. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ Director of Nursing or designee will complete daily audits for 2 weeks; then weekly audits for 1 month to ensure appropriate gait belt utilization. Audit results and the data collected will be presented to the QAPI Committee monthly by the Direct of Nursing or designee. The	

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21805	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 recliner. -at 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. During observations on 5/5/21 at 12:43 p.m. R9 was walking to the main dining room with her four wheeled walker and NA-C was holding onto the back of 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 lunch. -at 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	21805	QAPI committee will review and make any necessary recommendations regarding audits " The date that each deficiency will be corrected: July 12, 2021	

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21805	Continued From page 40 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 and in the halls at times. 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.	21805		

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21805	Continued From page 41 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. R24 R24's admission Minimum Data Set (MDS) dated 6/29/20, identified R24 had severe cognitive impairment, and had diagnoses which included: heart failure, dementia, diabetes mellitus (group of diseases that affect how your body uses blood sugar), and arthritis. R24's quarterly MDS further identified he required limited assist with transfers, and walking in his room and supervision walking in corridor. R24's MDS identified he used no mobility devices. R24's quarterly MDS dated 3/1/21, identified R24 required supervision with transfers and walking in his room and corridor. R24's MDS identified R24 used a walker for mobility. R24's care plan dated 5/6/21, identified R24 was	21805		

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21805	Continued From page 42	21805		

at risk for falls, and had an activity of daily living (ADL) self care performance deficit related to dementia and disease process. R24's care plan identified R24 required assistance with transfers on and off the toilet and was independent with transfers. R24's care plan did not include interventions for gait belt use.

On 5/5/21, at 7:44 a.m. R24 was sitting on the edge of his bed, and nursing assistant (NA)-B was in his room to complete morning cares. NA-B assisted R24 to use the bathroom, completed personal hygiene and dressed R24. At 8:27 a.m. NA-B applied a gait belt and assisted R24 to transfer from his chair with the use of his front wheeled walker and assisted him to walk to the dining room. At 8:40 a.m. R24 was seated in a dining room chair next to the table eating his breakfast. There were other residents and staff present in the dining room at this time. R24 continued to have the gait belt around his waist. At 8:41 a.m. NA-B confirmed she had assisted R24 to his chair in the dining room. At 9:12 a.m. R24 continued to be seated in the dining room while his gait belt remained around his waist.

On 5/5/21, at 12:38 p.m. R24 was in the dining room, seated in a chair next to a table with two other men at his table and other residents and staff in the room. R24 had a gait belt around his waist.

On 5/5/21, at 1:26 p.m. NA-D indicated once a resident was seated in the dining room, her usual process was to place the gait belt onto the walker or bring it back to the resident's room. NA-D stated the gait belt should not be kept on a resident while seated in the dining room, because that was a dignity issue.

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21805	Continued From page 43 On 5/5/21, at 2;12 p.m. NA-B stated she had forgotten to take R24's gait belt off of him once he was seated in the dining room. NA-B indicated the facility had a history of leaving gait belts on residents in the past and stated it was better to remove them for dignity and comfort for the resident. NA-B indicated R24's gait belt should have been removed and hung over his walker. On 5/6/21, at 11:49 a.m. interim director of nursing (IDON) stated gait belts were to be used for transfers and walking of residents if they were not steady. IDON indicated a resident may need to have their gait belt left on if they were having behaviors or if they became upset by removing it. IDON indicated she would expect this to be in the resident's care plan if the gait belt was to be left on. IDON confirmed 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 METHOD OF CORRECTION: The administrator or designee could develop and implement systems to ensure resident dignity is maintained. The facility could educate all staff on these systems. Random audits for dignity could be done to ensure ongoing compliance. The administrator or designee could take that audit results to the quality assurance group for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. 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. Review of facility policy titled, Resident Council/Family Council dated 4/1/2008, indicated the resident's family has the right to meet in the facility with the families of other facility residents.	21942	The Executive Director or designee will review facility systems for family council and work on promotion and encouragement of this group on an annual basis. " The date that each deficiency will be corrected: July 12, 2021	7/12/21

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	00669	A. BUILDING: _____ B. WING _____	C 05/06/2021

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

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21942	Continued From page 45 SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review facility systems for family council and work on promotion and encouragement of this group on an annual basis. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21942		

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	245585	A. BUILDING _____ B. WING _____	C 05/06/2021

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E 000	Initial Comments On 5/3/21, to 5/6/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 024		7/12/21

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

Electronically Signed | 06/03/2021

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E 024	Continued From page 1 (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policy and procedure for the use of volunteers or other personnel in the facility during an emergency. This deficient practice had the potential to affect all 39 resident who currently resided in the facility. Findings include: On 5/6/21, at 10:15 a.m. review of the facility's Emergency Policy and Procedure manual, revised 5/2020, was conducted with the administrator present and he confirmed the findings. The manual included various topics associated with emergency preparedness, however, the manual lacked documentation of a	E 024	o How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated healthcare professionals to address surge needs during an emergency was developed and added to the facility's Emergency Preparedness Plan. o How the facility will identify other residents having the potential to be	

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E 024	Continued From page 2 policy for use of volunteers.	E 024	affected by the same deficient practice. ¿ No residents were affected. Residents residing in the facility have the potential to be affected. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Plant Operations Director or designee will educate staff on the policy for Use of Volunteers During Emergencies. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Director of Plant Operations or designee will engage in community Disaster Drill annually, will conduct internal drills, and will conduct "Table Top" discussion to include a scenario of alternative care site and challenge questions and use of volunteers and other professionals to test the revised Emergency Preparedness Plan. Results of the drills will be brought to the Safety and QAPI committee for further recommendations. o The date that each deficiency will be corrected: July 12, 2021	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2),	E 039		7/12/21

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E 039	Continued From page 3 §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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E 039	Continued From page 4 designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 5 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan	E 039		

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E 039	Continued From page 6 twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:	E 039		

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E 039	Continued From page 7 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:	E 039		

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E 039	Continued From page 8 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.	E 039		

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E 039	Continued From page 9 (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale	E 039		

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E 039	Continued From page 10 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 emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from	E 039		

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E 039	Continued From page 11 engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a second full-scale community based exercise, a facility based exercise, a table top, or a facility drill to test their emergency preparedness program at least twice per year. This had the potential to affect all 39 residents who currently resided in the facility, along with staff who work in the facility. The findings include: On 5/6/21, at 10:15 a.m. the administrator was interviewed regarding the facility's Emergency Preparedness Plan. The administrator confirmed the facility had not participated in any additional	E 039	o How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ The community has scheduled a community disaster plan drill in June 2021 (the specific date pending community organizers). A "Table Top" discussion is scheduled for 9/21/2021, to discuss scenarios to prepare for an emergency. The plan was developed and added to the facility's Emergency Preparedness Plan. o How the facility will identify other residents having the potential to be	

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E 039	Continued From page 12 emergency preparedness exercises since COVID-19 began. A policy for Emergency Preparedness was requested, but not provided.	E 039	affected by the same deficient practice. ¿ No residents were affected. Residents residing in the facility have the potential to be affected. ¿ Emergency Preparedness Plan regarding Exercises, Drills, and Simulations was reviewed. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Plant Operations Director or designee will re-educate staff on Traverse Care Center□s Emergency Preparedness Plan regarding Exercises, Drills, and Simulations. ¿ The facility Plant Operations Director or designee will engage in community Disaster Drill annually, will conduct internal drills, and will conduct "Table Top" discussion to include a scenario of alternative care site and challenge questions and use of volunteers and other professionals to test the revised Emergency Preparedness Plan. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Plant Operations Director or designee will provide updates to all at the Safety and monthly QAPI committee meetings. The Executive Director will monitor for ongoing compliance. o The date that each deficiency will be corrected: July 12, 2021	

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E 041	Continued From page 13	E 041		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.	E 041		7/12/21

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E 041	Continued From page 14 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013.	E 041		

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E 041	Continued From page 15 (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement emergency and standby power system routine testing for weekly generator safety checks. This deficient practice had the potential to affect all 39 residents residing in the facility. Findings include: On 5/6/21, at 10:15 a.m. administrator reviewed the facility Emergency Preparedness program with surveyor. Administrator confirmed a fire safety survey had been completed, there were problems noted with the generator and he was unaware of the details. On 5/5/21, the state fire marshal conducted a facility tour, reviewed emergency generator maintenance documentation, and conducted an interview with the plant operation manager (POM), which revealed the facility failed to conduct weekly testing of the emergency	E 041	o How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ No residents were affected. o How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents residing in the facility have the potential to be affected. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ Plant Operations Director was re-educated on the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110, section 8.4.2. ¿ Plant Operations Director was re-educated on the Generator Testing	

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E 041	Continued From page 16 generator in the last 12 months. The POM confirmed these findings at that time.	E 041	Policy and Procedure. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Executive Director will audit the Plant Operations Generator log monthly for 3 months to assure compliance. Results of the audits will be brought to the Safety and QAPI Committee for further recommendations. o The date that each deficiency will be corrected: July 12, 2021	
F 000	INITIAL COMMENTS On 5/3/21, to 5/6/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5585017C (MN00069966). H5585018C (MN00069474). H5585019C (MN00056787). The following complaint was found to be substantiated with no tags issued. H5585020C (MN00066440). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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F 000	Continued From page 17 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		7/12/21

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F 550	Continued From page 18 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promote dignity while utilizing gait belts for extended periods of time for 3 of 3 residents (R9, R33 and R24) who received assistance with activities of daily living (ADL's). Findings include: R9 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.	F 550	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R9, R33, and R24 will have gait belts removed when not in use to promote care in a dignified manner. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing in the facility who utilize gait belts have the potential to be affected. A review was completed for the lack of removal of the gait belt and no other residents were affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing / designee will re-educate Nursing staff regarding Resident Rights and dignity with the focus on removal of gait belts when not in use.	

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F 550	Continued From page 19 During observations on 5/4/21, at 9:28 a.m. R9 was seated in the main dining room area with other residents eating breakfast independently and had a white gait belt fastened around her waist. R9 got up independently and began to walk independently with her four wheeled walker out of the main dining room area. Nursing assistant (NA)-C came over a few minutes later and began to walk with R9 while she held onto the back of the gait belt into the living room area. NA-C assisted R9 to sit down in the recliner in the living room area and immediately left. R9 continued to have the white gait belt fastened around her waist while she rocked in the recliner. -at 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. During observations on 5/5/21 at 12:43 p.m. R9 was walking to the main dining room with her four wheeled walker and NA-C was holding onto the back of 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	F 550	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ Director of Nursing or designee will complete daily audits for 2 weeks; then weekly audits for 1 month to ensure appropriate gait belt utilization. Audit results and the data collected will be presented to the QAPI Committee monthly by the Direct of Nursing or designee. The QAPI committee will review and make any necessary recommendations regarding audits • The date that each deficiency will be corrected: July 12, 2021	

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left leaving the gait belt fastened around her waist while she waited for lunch.
-at 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 and in the halls at times.

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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.

R24

R24's admission Minimum Data Set (MDS) dated

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6/29/20, identified R24 had severe cognitive impairment, and had diagnoses which included: heart failure, dementia, diabetes mellitus (group of diseases that affect how your body uses blood sugar), and arthritis. R24's quarterly MDS further identified he required limited assist with transfers, and walking in his room and supervision walking in corridor. R24's MDS identified he used no mobility devices.

R24's quarterly MDS dated 3/1/21, identified R24 required supervision with transfers and walking in his room and corridor. R24's MDS identified R24 used a walker for mobility.

R24's care plan dated 5/6/21, identified R24 was at risk for falls, and had an activity of daily living (ADL) self care performance deficit related to dementia and disease process. R24's care plan identified R24 required assistance with transfers on and off the toilet and was independent with transfers. R24's care plan did not include interventions for gait belt use.

On 5/5/21, at 7:44 a.m. R24 was sitting on the edge of his bed, and nursing assistant (NA)-B was in his room to complete morning cares. NA-B assisted R24 to use the bathroom, completed personal hygiene and dressed R24. At 8:27 a.m. NA-B applied a gait belt and assisted R24 to transfer from his chair with the use of his front wheeled walker and assisted him to walk to the dining room. At 8:40 a.m. R24 was seated in a dining room chair next to the table eating his breakfast. There were other residents and staff present in the dining room at this time. R24 continued to have the gait belt around his waist. At 8:41 a.m. NA-B confirmed she had assisted R24 to his chair in the dining room. At 9:12 a.m.

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R24 continued to be seated in the dining room while his gait belt remained around his waist.

On 5/5/21, at 12:38 p.m. R24 was in the dining room, seated in a chair next to a table with two other men at his table and other residents and staff in the room. R24 had a gait belt around his waist.

On 5/5/21, at 1:26 p.m. NA-D indicated once a resident was seated in the dining room, her usual process was to place the gait belt onto the walker or bring it back to the resident's room. NA-D stated the gait belt should not be kept on a resident while seated in the dining room, because that was a dignity issue.

On 5/5/21, at 2;12 p.m. NA-B stated she had forgotten to take R24's gait belt off of him once he was seated in the dining room. NA-B indicated the facility had a history of leaving gait belts on residents in the past and stated it was better to remove them for dignity and comfort for the resident. NA-B indicated R24's gait belt should have been removed and hung over his walker.

On 5/6/21, at 11:49 a.m. interim director of nursing (IDON) stated gait belts were to be used for transfers and walking of residents if they were not steady. IDON indicated a resident may need to have their gait belt left on if they were having behaviors or if they became upset by removing it. IDON indicated she would expect this to be in the resident's care plan if the gait belt was to be left on. IDON confirmed 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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 24 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.	F 550		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or	F 574		7/12/21

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F 574	Continued From page 25 federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide information to 5 of 5 residents (R23, R27, R17, R10, R31) who	F 574	How corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 574	Continued From page 26 attended the resident council group meeting regarding the Ombudsman services as advocates for residents residing in the facility. This had the potential to affect all 39 residents residing in the facility. Findings include: During the resident group meeting held on 05/05/21, at 1:37 p.m. state surveyors and R23, R27, R17, R10 and R31 were in attendance. Upon asking, R23, R27, R17, R10 and R31 indicated they were not aware of where to find the telephone number to contact the Ombudsman if needed. During observations on 5/5/21, at 1:30 p.m., the Ombudsman information was found posted on the wall by the Resident's Rights poster located by the main entrance of the building. Review of the resident council minutes from 1/1/2021, to 5/1/21, revealed no information regarding how to contact the Ombudsman was found in the minutes. On 5/6/21, at 11:58 a.m. the activity director (AD) confirmed the above findings and stated she was fairly new in her position. The AD indicated she had not informed the residents of where to find the contact information for the Ombudsmen. On 5/6/21, at 12:06 p.m. the administrator confirmed the above finding and indicated he would expect staff to inform the residents where the Ombudsman contact information was located within the building. Review of the facility policy titled, Resident	F 574	practice. ¿ R23, R27, R17, R10, R31 have received a copy of Ombudsman notification. The Ombudsman posters are prominently displayed in resident areas for easy viewing. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing in the facility have received a copy of ombudsmen notification and notified of the location of this posted information. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ Ombudsman information will continue to be provided in the Admission Packet. ¿ Ombudsman information will be reviewed monthly at Resident Council meetings. ¿ All staff will be educated on Ombudsman information, and where to find Ombudsman posters. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Executive Director will monitor Resident Council Notes on a monthly basis for 3 (three) months to ensure a discussion was held regarding the location of the survey results. 10% of current residents will be randomly audited x 90 days for knowledge of the office of Ombudsman, and where this contact	

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F 574	Continued From page 27 Council/Family Council dated 4/1/2008, indicated the resident has the right to organize and participate in resident groups in the facility.	F 574	information can be located. The QAPI committee will review and make any necessary recommendations regarding audits •The date that each deficiency will be corrected: July 12, 2021	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 577	How corrective action will be	7/12/21

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F 577	Continued From page 28 review the facility failed to ensure 5 of 5 residents (R23, R27, R17, R10, R31), who routinely attended resident council, were made aware of the state agency (SA) survey results. This had the potential to affect all 39 residents who resided in the facility. Findings include: During the resident group meeting held on 05/05/21, at 1:37 p.m. state surveyors R23, R27, R17, R10 and R31 were in attendance. Upon asking, R23, R27, R17, R10 and R31 indicated they did not know where the SA survey results were located within the building. During observations on 5/5/21, at 1:30 p.m., the SA survey results were located by the main entrance of the building in a binder. On 5/6/21, at 11:58 a.m. the activity director (AD) confirmed the above findings and stated she was fairly new in her position. The AD indicated she had not reviewed the SA survey results or identified the location of them at the resident council meetings. On 5/6/21, at 12:06 p.m. the administrator confirmed the above finding and indicated the SA survey results were located in a binder by the front entrance. The administrator indicated he expected staff to inform residents where the SA survey results were located within the building. Review of facility policy titled, Examination of Survey Results dated 5/2020, indicated the three preceding years of surveys, certifications and complaint investigations completed by the state and/or federal surveyors were available for	F 577	accomplished for those residents found to have been affected by the deficient practice. ¿ R23, R27, R17, R10, and R31 were updated on the facility location of survey results. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing at Traverse Care Center could be potentially affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ Facility will give written notice to all residents upon Admission to the facility about the location of the Survey Results. ¿ All current traverse care center resident received written notice on the location of survey results and state inspections. ¿ Facility will discuss the location of the survey book with resident council on a monthly basis. ¿ Facility has added a posting regarding availability of such reports in area prominent and accessible to the public near the front entrance of the facility. ¿ All Traverse Care Center staff will be re-educated on location of survey results. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Executive Director will randomly	

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F 577	Continued From page 29 review. The facility would post notices of the availability of the location of survey results in areas of the facility that are prominent and accessible to the public.	F 577	audit 10% of current residents for knowledge of the location of survey results. Weekly for 1 month; them monthly for 2 months. ¿ Executive Director will monitor Resident Council Minutes on a monthly basis for 3 (three) months to ensure a discussion was held regarding the locate of the survey results. The audit results will be reviewed during the facility QAPI Meetings. The QAPI Committee will provide direction or change when necessary. •The date that each deficiency will be corrected: July 12, 2021	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		7/12/21

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F 625	Continued From page 30 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide bed hold documentation for 2 of 2 residents (R18, R20) reviewed for hospitalization. The facility further failed to review and update their bed hold policy yearly. Findings include: R18 R18's significant change Minimum Data Set (MDS) dated 2/22/21, indicated R18 required extensive assistance with bed mobility, dressing, personal hygiene and total assist with transfers and locomotion. The MDS identified R18 had a fall with fracture and was incontinent. The MDS identified R18 had diagnosis which included a right hip fracture, congestive heart failure and arteriosclerosis. R18's progress note dated 2/12/21, at 9:20 a.m., identified R18 was found on floor in his room and complained of right hip pain. R18 was sent to the local emergency room (ER)for an evaluation and found to have a fractured right hip. R18 was transferred and admitted to regional hospital. The progress note identified the family had been called and lacked documentation a bed hold had	F 625	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R18, R20 and/or their representative will be sent bed hold notices for their hospitalizations. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents who require transfer to the hospital or take a therapeutic leave from the facility have the potential to be affected. An audit was completed and no other resident and/or responsible party was affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing / Business Office Manager will educate licensed nursing staff on the need to provide the bed hold notification for all residents that leave the facility for a hospitalization or take a therapeutic leave from the facility.	

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F 625	Continued From page 31 been discussed. Additional note at 3:56 p.m., identified the daughter called back to the facility for an update and the note lacked documentation a bed hold had been discussed.. R20 R20's quarterly MDS dated 2/24/21, identified R20 had severe cognitive impairment and had diagnoses which included Traumatic Brain Injury (TBI), heart failure and a seizure disorder. The MDS indicated R20 required extensive assist with bed mobility and dressing tasks and total assist with transfers, eating, toileting, personal hygiene and bathing. R20's progress note dated 4/27/21, identified R20 had been seen at the local ER to be suctioned and was admitted to the hospital. The note indicated the family had been notified of the admission. The note lacked documentation a bed hold had been discussed. During an interview on 5/6/21, at 3:44 p.m., the administrator confirmed the facility had not given a bed hold notice to either R18 or R20 or their representatives. His expectation was anytime a resident was discharged with a return anticipated staff would provide information about a bed hold. Review of November 2016, Bed Hold and Re-Admission policy identified at time of transfer to a hospital a written notice of the bed hold would be provided to the resident and/or resident representative. A copy of the notice would be placed in the resident's medical record.	F 625	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Director of Nurses or designee will complete audits on residents who have been hospitalized or take a therapeutic leave from the facility on a weekly basis for 4 weeks.; then monthly for 2 months ¿ Audit results will be reviewed during the facility QAPI Meetings and will dictate the continuation or completion of this monitoring process base on the results " The date that each deficiency will be corrected: July 12, 2021	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		7/12/21

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F 677	Continued From page 32 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide shaving assistance for 2 of 3 residents (R9 and R33) and oral care assistance for 1 of 3 residents (R9) who were dependent on staff with activities of daily living (ADL's). Findings include: R9 R9's annual Minimum Data Set (MDS) dated 2/5/21, identified R1 had severe cognitive impairment and had diagnoses which included Alzheimer's disease, dementia, anxiety. R9's MDS further identified she required extensive assistance of one staff for dressing, personal hygiene and limited staff assistance with transfers, eating, toileting. The MDS indicated R9 required supervision with bed mobility. R9's care plan dated 4/10/21, indicated R9 had an ADL self care deficit related to Alzheimer's and required staff assistance with shaving chin hairs if noted. R9's care plan identified R9 required staff assistance with combing hair, nail care, changing soiled clothes and encouraging/cueing her to brush her teeth. R9's Dental/Oral Data Collection Tool dated 2/2/21, indicated R9 had her own teeth and indicated R9 was able to brush her own teeth	F 677	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R9 received oral hygiene at the time of survey and as directed by their care plan. R9 and R33 were shaved at the time of survey and have been shaved as directed by their care plans. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing in the facility who are dependent on staff for grooming / hygiene including oral care and shaving have the potential to be affected. An audit was completed, and those who required care received those cares during the time of survey. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing will provide education to nursing assistants regarding the importance of offering oral hygiene and shaving as directed by the resident□s care plan. How the facility will monitor its corrective actions to ensure that the deficient	

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F 677	Continued From page 33 after staff assistance with set up and cueing.. During observations on 5/3/21, at 3:12 p.m. R9 was seated out in a recliner in the living room area rocking back and forth in the recliner with her eyes closed. R9 was noted to have several long white facial hairs on her lower chin area that were approximately 1/2 inch or longer. During observations on 5/4/21, 9:30 a.m. R9 was seated the dining room area eating breakfast independently and was noted to have several long white facial hairs on her lower chin area that were approximately 1/2 inch or longer. - at 2:51 p.m. R9 was seated out in the living room area looking out the window and R9's facial hair remained on her lower chin area. - at 3:01 p.m. R9 was seated out in the living room area visiting with her family and R9's facial hair remained on her lower chin area. - at 3:12 p.m. R9 facial hair remained while she continued to visit with her family. At no time did staff offer or provide assistance to R9 to remove the long white facial hairs present on her chin. During observations on 5/5/21 at 10:05 a.m. R9 was laying in bed, when nursing assistant (NA)- C and NA-E entered her room and asked her if she was ready to get up for breakfast. NA-E assisted R9 to the bathroom and provided morning cares which included washing R9's face, hands, upper body, applying a clean incontinent brief and dressing R9 while she sat on the toilet. - at 10:26 NA-C had collected the dirty linen and garbage and immediately left R9's room. NA-E assisted R9 to stand up from the toilet using her walker and gait belt, provided peri cares, pulled up her brief and her pants. NA-E proceeded to walk R9 out of her room and down to the dining	F 677	practice is being corrected and will not recur. ¿ The Director of Nursing or designee will Audit those dependent on staff for shaving and/or oral care daily for 2 weeks; then weekly for 2 months. Audit results will be reviewed at QAPI for recommendations and need to continue audits. " The date that each deficiency will be corrected: July 12, 2021	

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F 677	Continued From page 34	F 677		

room area holding on to the back of the gait belt with walker. NA-E had R9 sit down at the dining room table next to the nurses station and removed her gait belt from her waist. NA-E proceeded to get R9's breakfasts for her and R9 began to eat her breakfast independently. R9 had natural teeth present on the top and bottom of her mouth and continued to have several long white facial hairs on her lower chin area that were approximately 1/2 inch or longer. At no time did NA-C or NA-E offer or provide assistance to R9 to remove the long white facial hairs present on her chin or offer to provide oral cares.
- at 10:46 a.m. R9 continued to be seated at the dining room table eating her breakfast independently when trained medication aid (TMA)-C approached R9 and sat down at the table visiting with her while providing her a supplement to drink. R9 finished her supplement drink and TMA-C immediately got up from the table and left while R9 continued to eat breakfast. R9's facial hair remained and TMA-C did not offer or provide assistance to R9 to remove the long white facial hairs on her chin or to provide oral cares.

On 5/4/21, at 3:41 p.m. family member (FM)-A indicated staff assisted R9 with cares and personal hygiene. FM-A indicated R9 would hate it if she knew she had long hairs on her face and stated "I wish they would take care of it."

On 5/6/21, at 10:10 a.m. NA-E confirmed R9 needed assistance with personal hygiene and grooming and shaving. NA-E indicated the bath aid was the one who usually shaved the residents. NA-E confirmed neither she or NA-C offered to shave R9's chin hairs or offered to provide oral cares. NA-E stated they should have

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F 677	Continued From page 35	F 677		

offered it to her.

R33

R33's quarterly MDS dated 3/12/21, identified R33 had severe cognitive impairment and had diagnoses which included dementia, depression and renal insufficiency. R33's MDS further identified she required extensive assistance of one staff for personal hygiene and 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 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 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

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F 677	Continued From page 36 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 and shaving. NA-E indicated the bath aid should have been completing the cares on her bath day and staff should have been offering to shave her daily. On 5/6/21, at 1:59 p.m. the director of nursing (DON) confirmed the above findings and indicated she would expect staff to shave the residents daily. The DON stated she expected staff to provide or offer dental care and follow the residents care plans. Review of facility policy titled, Shaving revised on 3/1/2014, indicated residents will be provided care and services daily which included shaving as per resident needs and/or care plan. Review of facility policy titled, Oral Hygiene dated 4/1/2008, indicated residents who are unable to perform daily oral hygiene will receive assistance.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		7/12/21

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F 684	Continued From page 37 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, implement interventions, and monitor, for 1 of 1 residents (R27) who had obtained a skin tear. Findings include: R27's admission Minimum Data Set (MDS) dated 3/13/21, identified R27 had diagnoses which included Alzheimer's disease, chronic obstructive pulmonary disease (COPD) (a group of progressive lung disorders characterized by increasing breathlessness) and other fracture. R27's MDS further identified R27 had no skin tears, and no special treatment for skin. R27's MDS indicated R27 required extensive assistance with bed mobility, transfers, dressing, personal hygiene, and toilet use. R27's MDS failed to identify R27's cognitive level. R27's care plan dated 5/6/21, lacked interventions for R27's activities of daily living (ADL) and lacked any interventions to provide any treatment or any monitoring of the skin tear. On 5/3/21, at 2:26 p.m. during interview and observation R27 had two Steri-strips on her right	F 684	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ The skin tear on R27 was assessed, documented, orders obtained, and treated at the time of survey. The MD and family were notified. A skin tool was implemented on R27 to monitor the healing process. R27□s care plan was updated to reflect changes in care. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents residing in the facility have the potential to be affected. A comprehensive skin assessment is completed for all current Traverse Care Center residents, with changes or alteration in skin reported per facility policy. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Director of Nursing will re-educate nursing staff on the wound	

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F 684	Continued From page 38 outer elbow on top of the other criss-crossed closely together. The top Steri-strip had a few brown spots on the center. R27 indicated she had struck her elbow on a door frame and was unable to remember when it occurred. R27 had a cloth elbow protector on her left elbow. On 5/5/21, at 10:31 a.m. R27 was seated in a chair in her room. R27's Steri-strips remained on her right elbow. R27 continued to have brown spots in the center and approximately one inch around the area was slightly pink/red in color. R27 indicated the area was sore. R27 continued to have an elbow protector on her left arm. On 5/5/21, at 2:08 p.m. NA-B indicated she was aware R27 had a skin tear and was not sure how it happened. NA-B stated she had heard about it in report from registered nurse (RN)-B. NA-B indicated she had not noticed the skin tear yesterday and did not believe R27 had the skin tear yesterday. On 5/6/21, at 12:17 p.m. licensed practical nurse (LPN)-A stated she was not aware R27 had a skin tear. LPN-A indicated if R27 had a skin tear, it should have been documented in R27's progress notes and reported. LPN-A stated the facility's usual practice was to complete a skin check weekly during a bath. On 5/6/21, at 2:44 p.m. interim director of nursing (IDON) confirmed she was not aware that R27 had a skin tear. IDON indicated the usual facility process for skin tears was to clean the area, dry it, make sure edges were ok, apply Steri-strips, and Telfa (non-stick dressing) if the skin tear was still bleeding. IDON stated the skin tear should have been assessed weekly. IDON stated all	F 684	care process per facility policy and procedure and reporting requirements for alterations to skin integrity. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Director of Nursing or designee will conduct 2 resident wound care audits 2 times per week for 4 weeks. Then monthly for 2 additional months Results will be reviewed in QAPI for further recommendations. " The date that each deficiency will be corrected: July 12, 2021	

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residents should have their skin assessed weekly on their bath day. At 2:46 p.m. IDON asked R27 if she could assess her skin tear and she agreed. IDON slowly pulled back the Steri-strips on one side and confirmed the area had some light tan discharge, the wound bed was still pink and moist and was not closing up. The area under the Steri-strips center was dime sized with tan slough noted over wound and the area surrounding approximately one inch diameter was pink/red in color. IDON informed R27 she would clean the area, apply a non-stick Telfa dressing and wrap the area depending on if the wound was weeping. IDON confirmed the area around the skin tear was pink/red in color. IDON confirmed the wound had not been monitored and looked like it had deteriorated. IDON indicated she would have expected R27's skin tear to be monitored and her skin assessed properly on her bath day.

R27's SNF Weekly Skin Check Tool dated 5/2/21, identified no skin issues noted.

Review of R27's Medication Review Report (orders) signed 4/19/21, lacked any orders to monitor skin tear.

Review of R27's progress notes from 3/13/21, to 5/6/21, identified the following:

-3/6/21, at 10:28 p.m. nurse progress note- skin integrity: normal color, cool extremities bilaterally and very dry, turgor normal.

-3/31/21, at 10:28 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/1/21, at 3:55 a.m. comprehensive nursing note-no new or worsening skin concerns.

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-4/1/21, at 3:35 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/2/21, at 10:22 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/3/21, at 7:14 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/4/21, at 9:35 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/5/21, at 1:34 a.m. comprehensive nursing note-no new or worsening skin concerns.

-4/5/21, at 4:22 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/6/21, at 2:25 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/8/21, at 11:00 a.m. comprehensive nursing note-no new or worsening skin concerns

-4/9/21, at 2:44 p.m. comprehensive nursing note-new or worsening skin conditions; yes, red on bilateral lower skins, provider faxed, on antibiotic for urinary tract infection (UTI). Red under very lateral area under breasts-Nystatin cream and intra dry fabric.

-4/10/21, at 6:57 a.m. comprehensive nursing note-no new or worsening skin concerns.

-4/10/21, at 1:50 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/11/21, at 10:33 a.m. comprehensive nursing

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note-no new or worsening skin concerns.

-4/12/21, at 1:46 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/12/21, at 3:20 p.m. nurse progress note- R27 had whirlpool bath with no change in skin condition noted.

-4/13/21, at 4:34 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/14/21, at 3:43 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/15/21, at 12:58 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/16/21, at 3:57 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/19/21, at 9:12 a.m. comprehensive nursing note-no new or worsening skin concerns.

-4/20/21, at 11:49 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/21/21, at 5:19 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/22/21, at 12:10 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/23/21, at 4:11 p.m. comprehensive nursing note-no new or worsening skin concerns.

-4/23/21, at 10:01 p.m. comprehensive nursing note-no new or worsening skin concerns.

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F 684	Continued From page 42 -4/24/21, at 11:35 p.m. comprehensive nursing note-no new or worsening skin concerns. -4/26/21, at 3:03 p.m. comprehensive nursing note-no new or worsening skin concerns. R27's progress notes lacked identification of when R27 received a skin tear, any treatment provided and any monitoring of the site after skin tear was obtained. The facility policy titled Treatment Record (General) dated 4/1/2008, indicated all treatments provided to the resident must be ordered by the physician and documented. The policy /procedures included instructions to record the following: reasons for refusal of treatments and progress or decline of condition for which as needed (PRN) treatments were given.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		7/12/21

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F 692	Continued From page 43 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete ongoing nutritional assessment, address risk factors for impaired nutritional status and implement approaches to maintain acceptable nutrition parameters for 2 of 4 resident (R18, R22), who had a significant weight loss of 10.8% and 13.1%, reviewed for nutrition. Findings include: R18 R18's significant change Minimum Data Set (MDS) dated 2/22/21, identified R18 had diagnoses which included right hip fracture, dementia with behavioral disturbance, major depression and heart failure. The MDS indicated R18 required extensive assistance with bed mobility, dressing, personal hygiene, and eating. The MDS identified R18 required total assistance for transfers and locomotion. R18's MDS identified R18's weight at 162 and indicated no weight loss. The MDS indicated R18 coughed or choked during meals or when swallowing medications. R18's care plan undated, identified R18 required assistance of one staff with bed mobility, transfers, toileting, bathing, dressing and personal hygiene. The care plan indicated R18 exhibited adequate intake related to usual good	F 692	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ R18, and R22 were reviewed for scheduled monitoring of weekly weights; appropriate nutritional supplements, nutritional interventions, and resident preferences to address significant weight loss. ¿ Registered dietitian has completed a dietary risk assessment on R18, R22 for further recommendations to modified plan of care. How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents residing in the facility have the potential to be affected. The Director of Nursing and Registered Dietician will review current residents for significant weight loss, and care plans updated with appropriate interventions. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ IDT-team members will review resident weights and meal intake weekly to identify variances, and ensure adequate interventions are in place; RD	

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F 692	Continued From page 44 appetite as evidenced by stable body wight, healthy range and good oral intake at most meals. The care plan instructed staff to monitor labs, monitor meal intakes, monitor weights, offer routine house snacks between meals, provide diet as ordered, use a clothing protector,and serve meals in the main dining room as recommended by therapy. R18's Comprehensive Care Area Assessment (CAA) dated 2//22/21, indicated R18 had a mechanically altered diet and a therapeutic diet. The CAA identified R18 had a potential problem for nutrition. The CAA indicated R18 had a swallowing problem and had an inability to perform activities of daily living (ADL's) without assistance. R18's Dietary Profile Tool dated 1/11/21, identified R18 was on a regular diet with mechanical soft texture and regular liquids. The assessment tool lacked documentation R18 had weight loss or any interventions to prevent weight loss or to maintain a stable weight. R18's Order Summary Report dated 5/1/21, identified R18's diet as a diabetic diet with ground meat texture and regular liquids. The report lacked documentation of any type of supplement being offered for R18's weight loss. Review of R18's monthly weights from 10/29/20, to 4/29/21, identified the following: 10/29/20, weight was 170.5 pounds 11/27/20, weight was 172.5 pounds 12/31/20, weight was 171.0 pounds 1/14/21, weight was 160.0 pounds 2/17/21, weight was 161.7 pounds	F 692	will be notified of all residents identified as high risk for significant weight loss weekly. ¿ The Director of Nursing or designee will educate all nursing and culinary staff on the procedures for Nutrition Risk and Weight Loss How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ¿ The Director of Nursing and/or Registered Dietician or designee will audit of residents experiencing weight loss. Resident□s who experience a 5% weight loss will be audited for appropriate interventions weekly for 4 weeks; then monthly for 2 months. Audit results will be reviewed in QAPI for further recommendations. " The date that each deficiency will be corrected: July 12, 2021	

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F 692	Continued From page 45 3/25/21, weight was 156.0 pounds 4/29/21, weight was 152.0 pounds Review of R18's registered dietician (RD) assessment notes from 2/25/21, to 5/5/21, identified the following: On 2/25/21, late entry at 1:17 p.m. identified R18 had a significant change assessment with R18's current weight at 161.7 (on 2/17/21) with no significant weight loss, yet a small and recent weight loss was noted. The plan identified that R18's weight continued to be relatively stable with no significant loss. The note indicated no changes were needed at the time, yet would continue to monitor for need for modifications in dietary interventions. On 5/5/21, at 1:43 p.m. identified R18 showed a recent weight loss. The note identified R18's current weight was 152.0 (on 4/29/21), which showed a 2.5% weight loss from one month prior, a 5% weight loss from three months prior (160.0 on 1/14/21) and 10.8% weight loss from six months prior (170.0 on 10/29/20). The note identified R18 currently was presenting with a clinically significant weight loss for the last 6 months. RD identified recent history and conditions with R18's weight loss and recommended a nutritional supplement to be offered to help support his decreased intake. RD recommended four ounces of Glucerna three times a day given during medication times. During observation and interview on 5/5/21, at 10:14 a.m., nursing assistant(NA)-B identified it was not uncommon for R18 to sleep in late and to not get up until 11:00 a.m. R18 was observed to still be in bed at this time when NA-B asked R18	F 692		

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if he was ready to get up for the day.

During observation on 5/5/21, at 10:58 a.m., R18 was assisted out to the day room area after morning cares. NA-C offered him a drink but nothing to eat.

During interview on 5/5/21, at 1:00 p.m., culinary director (CD)-A identified she reviewed the weights on point click care (PCC) each morning or at least weekly indicating the weights were in red if there was a change for quick identification. CD-A stated if there was a weight change she would talk to the nurse manager to see what interventions could be placed which would include a supplement. During record review, CD-A confirmed the last dietician notes documented in R18's electronic health record (EHR) were from 5/21/19. CD-A confirmed R18 was encouraged to eat but was not currently on any type of supplement or meal modification to increase his weight. CD-A confirmed R18 did have a weight loss and indicated there were no dietary interventions implemented.

During interview on 5/5/21, at 1:58 p.m., registered dietician (RD) identified she had just finished the assessment for the significant change from back in February 2021 for R18 which should of been completed in February 2021. RD stated she had just been given an updated MDS schedule when she was there on 5/4/21. RD confirmed she had not been notified of any weight loss for R18 even though she had been to the facility on 5/4/21. RD stated she expected someone to be monitoring the weights, to notify her of weight loss and to notify nursing to start a temporary supplement until she was able to assess the resident. RD indicated she was only

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contracted two days a month to complete her assessments.

During interview on 5/5/21, at 2:25 p.m., registered nurse (RN) B identified R18's meal intake was a hit or miss if he would eat. RN-B stated direct care staff obtained resident's weights and the licensed nurse entered the weights into PCC. RN-B stated the licensed nurse was expected to compare the weight with the prior weight and determine if a weight loss had occurred. RN-B indicated if a weight loss was identified, the nurse was expected to notify the nurse manager who usually contacted the provider. RN-B confirmed R18 had lost weight and was not on any type of supplement.

During interview on 5/5/21, at 2:57 p.m., R18's primary medical doctor (MD)-A identified he had been aware of R18's weight loss by verbal communication and had been at the facility to see R18 recently. MD-A indicated R18 had a recent hip fracture with surgery, had recent COVID-19, and the psychiatrist had recently made some medication changes. MD-A stated he had made changes to the recent psychoactive medication dose related to lethargy and consulted with the psychiatrist for further monitoring last month. MD-A indicated he was not surprised about the weight loss yet agreed the facility should have identified the weight loss and acted on it by notifying the dietician for an evaluation or nursing to obtain an order for a supplement. MD-A confirmed a supplement would have been an appropriate intervention for R18.

During interview on 5/6/21, at 11:10 a.m., CD-A confirmed R18's weight loss was not addressed with the dietician when she was in the building on

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5/4/21, as she did not have time since she was cooking. She confirmed she does not give the dietician any types of notes or list of residents with identified concerns for weight loss.

R22

R22's quarterly Minimum Data Set (MDS) dated 2/26/21, identified R22 had significant cognitive impairment and diagnoses which included: heart failure, diabetes mellitus (group of diseases that affect how your body uses blood sugar) and anxiety. R22's MDS indicated R22 required extensive assistance with bed mobility, transfers, dressing and personal hygiene. The MDS indicated R22 required supervision/oversight, encouragement or cueing to eat with set up help only. R22's MDS identified R22's weight was 126 and she had a weight loss of 5% or more in last month or a loss of 10% or more in the last 6 months. The MDS indicated R22 was not on a physician-prescribed weight-loss regimen.

R22's Care Area Assessment (CAA) dated 10/29/20, identified R22 had a potential problem for nutrition. R22's weight was 137. R22's CAA identified R22's nutrition needs would be care planned to maintain her current level of functioning.

R22's care plan dated 5/6/21, identified R22 was at nutritional risk and had a history of complaining about meals. Updated care plan identified involuntary weight loss related to diminished appetite and general decline secondary to COVID-19 infection. The care plan indicated R22's COVID diagnoses on 2/1/21, poor appetite with frequent refusal to eat and significant weight

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loss of 13% for three months, dated 5/5/21. Interventions included: Offer 2 hard boiled eggs daily for extra protein, offer a trial of supplements, offering a nutritional supplement twice a day (BID) due to weight loss and poor intake, and refer to registered dietician for evaluation and/or recommendation as needed (PRN). R22's care plan included interventions to assist R22 with dressing, toilet use, bed mobility when she requested and PRN assistance with transfers if she requested. R22's interventions identified R22 was independent with eating with occasional set up first before eating.

Review of R22's Monthly Weight Report reviewed from 10/1/20, to 5/1/21, identified the following;

-October 2020-weight 135.5
-November 2020-weight 134.5
-December 2020-weight 137
-January 2021-weight 136
-February 2021-weight 126
-March 2021-weight 122
-April 2021-weight 119

On 5/3/21, at 4:58 p.m. R22 was in the dining room seated in her wheelchair. At 5:17 p.m. R22 was at her table with her meal in front of her and R22 drank a few sips of chocolate milk through a straw. At 5:30 p.m. R22 was encouraged to eat by a staff member, offered fruit and shown her ice cream. R22 consumed only a few bites of ice cream and drank a few sips of ice water and chocolate milk and R22 left the table. R22 had not been provided a hard boiled egg or supplements during this meal.

On 5/5/21, at 9:02 a.m. R22 was lying in her bed, eyes open, head of bed slightly elevated. Staff

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delivered a breakfast tray to R22 and informed her she would get someone to assist her up. At 9:05 a.m. Interim director of nursing (IDON) entered R22's room and placed head phones on R22 with a pocket talker attached (hearing assistive device). IDON asked if she could assist R22 into her wheelchair and R22 refused. IDON raised R22's head of bed up and placed her bedside table in front of her. IDON removed the meal cover and informed R22 of her breakfast which consisted of french toast, sausage, toast and fruit. IDON offered to cut up her meal which R22 declined. R22 began eating the watermelon and IDON offered to remove her head phones. R22 stated yes as she did not like them. At 10:01 a.m. R22 remained in bed and was not eating at the time while her breakfast meal remained in front of her. At 10:24 a.m. social service designee (SSD) entered R22's room and asked her to try to eat. SSD used a paper by R18's bedside with different messages on it to communicate to her and left the room. R22 ate a few bites of fruit and no other foods during the meal. R22 had not been provided or offered a hard boiled egg or supplements during the meal.

On 5/5/21, at 12:39 p.m. R22 was seated in her wheelchair at a table in the dining room and had just been served her lunch meal. R22 stated she could not eat all of that. R22 was served a bacon, lettuce and tomato (BLT) sandwich, macaroni and cheese, and a cup of sliced cucumbers. R22 received a glass of ice water and chocolate milk. R22 had not been provided a hard boiled egg or supplements during the meal. At 1:06 p.m. R22 had left the dining room, had consumed 3/4 of her BLT sandwich and had not eaten anything else.

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On 5/5/21, at 12:50 p.m. during a phone interview, family member (FM)-B indicated she was aware of R22's weight loss and indicated R22 had quit eating when she had COVID infection. FM-B stated R22 sometimes ate and sometimes she did not. FM-B indicated staff had been giving R22 supplements however they had not for awhile. FM-B stated she was aware R22 was getting a regular diet and had not seen any modifications made to her diet. FM-B indicated a month ago she had caught a couple of times when R22 had not received a tray for meals and she had reported that to the administrator. FM-B stated she attempted to feed R22 at noon meal and indicated R22 did well when she placed the food onto the silverware for her. FM-B indicated she was aware R22 weighed 119 pounds and had lost 15-16 pounds since she had COVID. FM-B indicated she had not spoken to the registered dietician (RD)-A and was not aware of any changes they had made to R22's diet.

On 5/5/21, at 1:29 p.m. nursing assistant (NA)-D stated R22 had not been eating very well and her family was coming in to help her eat. NA-D indicated they usually encouraged her to eat and only occasionally assisted R22 to eat. NA-D indicated the last time she had assisted R22 with eating was a few weeks ago. NA-D indicated R22 at times had received supplements from the nurses.

On 5/5/21, at 1:42 p.m. registered nurse (RN)-B stated it was very hard to get R22 to eat sometimes and when her family was here R22 ate better. RN-B indicated she thought R22 used to receive supplements, and indicated she thought it was on R22's orders to receive them. RN-B checked on R22's electronic medical

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record and confirmed R22 did not have orders for supplements. RN-B indicated she had not worked with R22 for awhile.

On 5/5/21, at 2:20 p.m. NA-B indicated R22 refused meals often since she had COVID infection. NA-B stated R22 had not eaten her breakfast meal and indicated that was not unusual for her. NA-B indicated she thought the nurses gave R22 supplements with her medications and she had not noticed if this had been done for the last couple of days.

On 5/5/21, at 2:24 p.m. trained medication aide (TMA)-C stated she was not aware R22 had a supplement order and indicated it was difficult to get her to eat food and drink liquids. TMA-C indicated R22 did not have an appetite anymore and stated she was not aware of any changes with her diet or orders related to her weight loss. TMA-C indicated a few times they tried to get R22 to drink a chocolate supplement drink and she would spit it out. TMA-C indicated they did not have orders to give supplements and did not believe R22 ever had any orders for them. TMA-C stated at times she would try to give supplements or attempt to give R22 a magic cup.

On 5/5/21, at 2:38 p.m. R22 stated she has never ate very much and denied losing any weight. R22 confirmed FM-B came in and assisted her with eating lunch.

On 5/5/21, at 2:55 p.m. during phone interview nurse practitioner (NP)-A identified R22's weight loss was related to her dementia and behaviors. NP-A indicated she would expect the facility staff to encourage R22 to eat, help her eat, and provide nutritional supplements and increase

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protein. NP-A confirmed she would expect those recommendations were to be made by the facility dietician.

On 5/5/21, at 3:30 p.m. during phone interview, RD-A confirmed the last time she completed a comprehensive dietary assessment for R22 was 12/19/20, for her annual assessment. RD-A indicated the first time she had been in the facility since COVID-19 began was 5/4/21, and additionally only one or two times since March 2020. RD-A indicated she was relying on communications from staff for any concerns. RD-A indicated she would receive e-mails from the previous director of nursing (DON) and culinary director (CD)-A, which included new admissions and the MDS schedule for assessments. RD-A indicated in the past she would be notified by DON or CD-A regarding residents with weight loss. RD-A stated she would expect staff to notify her of any weight loss as soon as they identified it. RD-A indicated she was not aware how often the facility reviewed weights. RD-A pulled up R22's electronic medical record and confirmed R22 had a significant weight loss. RD-A identified R22's weight of 119 was much lower than her previous weights. RD-A confirmed R22's weight loss started in February. RD-A stated now that she was aware of R22's weight loss, she would review R22's record remotely and contact CD-A to initiate interventions today.

On 5/5/21, at 3:21 p.m. CD-A indicated her usual process for contacting RD-A was by e-mail. CD-A indicated she had sent e-mails notifying RD-A regarding things such as new residents, changing diet textures and thought she may have notified RD-A about supplements for one resident. CD-A indicated she thought the administrator e-mailed

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the MDS schedule for assessments to RD-A. CD-A confirmed she reviewed residents' weights weekly and indicated they were flagged by the system for weight loss. CD-A stated she would notify RD-A if she had concerns with residents or if the nurses brought concerns to her attention. 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

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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 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 5/6/21, identified the following:

-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 encourage R22 to take medication and drink, not effective. R22 went to hospital, returned with

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order for Zofran (medication to prevent nausea and vomiting).

-2/17/21, R22 ate one bite of egg for breakfast, and refused lunch and snacks sent in by family, except one bite of cookie. R22 took meds crushed in supplement and drank one supplement at breakfast and at noon. R22 continues to have loss of taste and smell.

-2/20/21, spoke with family related to R22 hesitancy to eat and drink at this time. Family stated to continue supplements. R22 drank supplement better after informed facility spoke with family. R22 drank two full glasses of supplement.

-2/21/21, R22 has not been eating or drinking. Staff fed R22 with poor appetite noted and to drink supplements with encouragement.

-2/23/21, R22 is not eating or drinking well. R22 needs much encouragement and at times needs to be fed as allows.

-2/25/21, R22 continues to have loss of taste and smell.

-2/26/21, R22 drank supplement and chocolate milk, ate popcorn the day before with family, but did not eat today.

-2/28/21, R22's family here for noon meal, eating an apple and banana. R22 continues to have loss of taste and smell.

-3/5/21, R22 ate small bites apple and banana. Staff frequently offered food and drink, R22 refused more.

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-3/7/21, R22 ate apple and small malt for family.

-3/10/21, R22 continues to have loss of taste and smell.

-3/12/21, R22 refused breakfast but ate part of magic cup. R22 ate noodles and drank malt for lunch with family. R22 had chicken soup, magic 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 continues to have loss of taste and smell.

-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.

-4/15/21, R22 resistive to eat this morning, did drink chocolate milk and 1/2 of egg. Family here brought in food this afternoon, good appetite. R22 continues to have loss of taste and smell, intake

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fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor.

-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 with ice cream and sometimes with small candy bar, will continue to monitor.

-4/28/21, R22's intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor.

-4/29/21, R22 did not like chocolate milk tonight, took bites of pudding till finished, fed brownie ate two bites of chili, minimal fluid intake. R22's intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor.

-5/4/21, R22's intake fluctuates, eats well occasionally and refused to eat at others. Family comes often to encourage R22 to eat, sometimes successful with ice cream and sometimes with small candy bar, will continue to monitor.

-5/5/21, Dietary Progress note-included: R22 significant weight loss in the last 3 months, current weight 119, 2.5% weight loss 1 month ago, 13.1% weight loss from 90 days ago, and 13.1% weight loss from 6 months ago. R22

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F 692	Continued From page 59	F 692		

diagnosed with COVID-19 2/1/21, likely reason for notable weight loss. R22 now eating in main dining room per family request, and R22 can be supervised/encouraged and assisted as needed. R22 continues to have very little appetite and supplements have been offered at times, not been accepting of supplements like she was on the COVID unit, when drank 5-6 supplements a day. RD-A communicated with dietary manager today and RD-A will recommend supplements to be trialed twice a day and will monitor. RD-A will begin monitoring resident monthly and as needed to assess for any further weight loss, to determine scheduled supplements or further dietary inventions.

-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

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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 was to continue present regimen.

Review of R22's progress notes for nursing home visit dated 4/15/21, identified R22 was seen by NP-B, and identified no current complaints or concerns. R22's progress note plan was to continue present regimen.

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

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F 692	Continued From page 61 weight loss issues.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 755	o How corrective action will be	7/12/21

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F 755	Continued From page 62 facility failed to obtain and administer ordered medication for 1 of 1 residents (R190) who were reviewed for medication administration. Findings include: R190 admission record (face sheet) dated 5/6/21, identified admission to the facility on 5/3/21. Diagnosis included heart failure, hypertension, anxiety disorder, obesity, depression, gastroesophageal reflux and sleep apnea. R190's hospital discharge notes identified she had been admitted to the hospital following a fall in February sustaining a left knee dislocation which ruptured her popliteal artery. R190 under went surgery 2/3/21, and had a synthetic popliteal graft. R190 had an external fixator placed. R190 then transferred to a rehab facility and developed complications and was readmitted to the hospital with sepsis. Ultimately, R190 had increasing leg pain and her wounds had to be reopened for drainage and R190 required skin grafting. R190's admission orders identified original order date of 5/3/21, Fodaparinux Sodium (Arixtra) 2.5 milligrams /0.5 milliliters (mg/ml) inject 2.5 mg (0.5 ml subcutaneous daily for prevention of blood clots. Review of R190's progress notes from 5/3/21, to 5/5/21, identified the following: 5/3/21 4:47 p.m., R190 was admitted to the facility. 5/4/21 7:13 a.m., medication review completed and a clarification was requested for duration of Fodaparinux.	F 755	accomplished for those residents found to have been affected by the deficient practice. ¿ R190 received the medication as ordered without any further concerns on 05/04/2021. o How the facility will identify other residents having the potential to be affected by the same deficient practice. ¿ Residents currently residing at the facility have the potential to be affected. The Director of Nursing and designated licensed nurse audited the medication availability. No other issues were identified. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ Director of Nursing will re-educate all Licensed Nursing Staff on the policy and procedures of pharmacy services, and steps to take when medications are unavailable. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ Director of Nursing or designee will audit medication omissions weekly x 30 days, then bi-weekly x 60 days; results will be brought to QAIP for further recommendation. • The date that each deficiency will be corrected: July 12, 2021	

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F 755	Continued From page 63 The progress notes lacked documentation Fodaparinux was not available to be administered. During an interview on 5/5/21, at 11:02 a.m., R190 stated she had been admitted to the facility on 5/3/2. R190 indicated the facility did not receive her medications until 10:30 p.m. that evening. R190 identified that not all of her medications had been delivered the day she admitted to the facility and she did not get her blood thinner until the evening of 5/4/21, the day after she was admitted. During an interview on 5/5/21, at 12:42 p.m., registered nurse (RN)-B who confirmed that the pharmacy Omni Care who delivered medications for Medicare A and managed care residents did not deliver medication until 9:00 p.m., or 10:00 p.m., normally. RN-B stated medications that come from the Wheaton pharmacy were delivered earlier in the day. RN-B confirmed that R190 received medication from Omni Care and most likely those did not get delivered until after 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 interview on 5/6/21, at 9:18	F 755		

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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 755		
F 812 SS=F	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		7/12/21

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F 812	Continued From page 65 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This 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 plastic shelf was covered in red spillage which ran down to the open bottom area where a white towel was laying and a 1/3 full bottle of water lay. The refrigerator contained 3 bags of whipped cream opened and undated, one package of liquid eggs undated, a plastic carton of milk undated and ranch salad dressing undated.	F 812	o How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ¿ Unlabeled food was discarded, refrigerators and the dishwasher cover were cleaned and sanitized. ¿ Refrigerated food items were properly labeled, dated, and sealed to prevent contamination, ¿ Dishwasher temperatures were maintained according to manufacturer's 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. ¿ Residents currently residing at Traverse Care Center have the potential to be impacted. o What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿ The Administrator with the Culinary Director or designee(s) will review the policies and procedures regarding kitchen sanitation, temperature logs, and deep cleaning. ¿ The Culinary Director or designee (s)	

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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 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 degrees that morning. CD-A stated the	F 812	will provide training to all dietary staff on these policies and procedures. o How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ¿ The Culinary Director or designee(s) will audit cleaning of the kitchen equipment, food is labeled or discarded properly, and temperature logs for completeness and within range 3 times per week for 1 month, then 1 time per week for 2 months. The audit results will be reviewed during the facility QAPI Meetings and the QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process base on the compliance noted from the audits. " The date that each deficiency will be corrected: July 12, 2021	

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dishwasher was serviced by a company last Thursday or Friday. CD-A indicated she would have plant operations manager (POA)-A check it this morning. CD-A confirmed that above the dishwasher where the pipes and temperature gauge were located there were heavy amounts of a brown fluffy substance hanging on the the pipes. CD-A confirmed the brown fluffy substance was also located all over the inside of the metal cover overhanging where the clean dishes would come out and CD-A indicated could cause particles to fall on the clean dishes. CD-A stated she would call the company that cleaned the kitchen vents and have them come to clean above the dishwasher.

The CMA Owners Manual, Model CMA-180VL/180VL Tall Installation And Operation Manual, CMA Dishmachines, undated, identified specifications for cycle temperatures included: wash 155-160 Fahrenheit (F) and Rinse 180-195 F.

Review of The Traverse Care Center Dishwasher Record Log Dishroom, which contained dates, and wash-150 F, Rinse 180 F, with spaces to record wash and rinse temperatures for breakfast, lunch and dinner. The facility logs were reviewed from 3/1/21, to 5/6/21, which identified the following:

-March 2021, log identified the following wash cycle temperature entries: 1-140 F, no 155 F entries, and all other entries were from 150-154 F. Rinse cycle entries were recorded at 180-200 F.
-April 2021, log identified the following wash cycle temperature entries: 12-155 F entries, 1-156 entry, and all other entries 150-154 F. Rinse

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cycle entries were recorded at 181-200 F.
-May 2021, log identified no entries made for 5/1/21 or 5/2/21. The log identified the following wash cycle temperature entries: 7-155 F, and 3 150 F. Rinse cycle entries were recorded at 189-200 F.

On 5/6/21, at 9:58 a.m. during a follow up interview, CD-A provided the dishwasher manufacture guide to surveyor and confirmed they followed the manufactures instructions for use of the dishwasher. CD-A indicated her expectation was for staff to minimally do weekly cleaning and wipe up any spills as soon as they were made. CD-A confirmed the cheese slices were used for sandwiches some supper nights and were also on the alternative menu. CD-A indicated she expected cheese would have been dated and kept sealed in the bags. CD-A confirmed if the refrigerators were not kept clean and foods not stored properly, there was a risk of cross contamination. CD-A indicated when the packages were left open and there were multiple spills in the refrigerator, the potential for infection control concerns were increased.

On 5/6/21, at 3:17 p.m. POA-A indicated he had checked, cleaned, and flushed the kitchen tank heater for the dishwasher and the dishwasher temperatures were now running at 155 for washing. POA-A stated he called the company who cleaned the kitchen vents and they would be coming to clean above the dishwasher next week. POA-A confirmed the company informed him they had never cleaned above the dishwasher and POA-A confirmed it was very dirty. POA-A indicated the dishwasher was last serviced on 4/30/21.

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F 812	Continued From page 69 Review of the requested cleaning logs provided by the facility were not filled out or dated. The forms included the following: -the form titled Cleaning Schedule, included items to be cleaned daily with blank areas to fill in or initial. The form was blank and did not include instructions for cleaning the refrigerators. -the from titled Weekly Cleaning List, instructed staff to wipe out dairy fridge-aide on Thursday. The form was blank. -the form Monthly Cleaning List, identified all jobs need to be done by 20th of each month. The form had hand written "master" over the month and included all vents. The form was blank. A facility policy for food storage and cleaning of kitchen equipment was requested, but not provided.	F 812		