Electronically delivered
August 26, 2021

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

RE: CCN: 245585
Cycle Start Date: August 6, 2021

Dear Administrator:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 November 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 February 6, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/4/21 through 8/6/21, a standard abbreviated survey was conducted at your facility. 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 SUBSTANTIATED: H5585023C (MN75226), with a deficiency cited at F600. The following complaints were found to be UNSUBSTANTIATED: H5585024C (MN75166), H5585025C (MN75160), H5585026C (MN75441), However related deficiencies were cited as a result of the investigation at F657 and F609. 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 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		9/17/21

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

Electronically Signed | 09/04/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 600	Continued From page 1 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 2 residents (R3) reviewed who was called fat by another resident in the facility, which was resolved by the intervention after a physical altercation between R3 and R4 occurred. Findings include: R3's quarterly minimal data set (MDS) dated 6/11/21, indicated R3 has a diagnoses which included dementia, depression and had moderate cognitive impairments. Further review of MDS, indicated R3 did not have behaviors. R3's progress note dated 7/31/21, indicated "Resident noted to refuse breakfast stating she was not hungry. Did refuse supplement when offered. Ate at FSL (fireside lounge) for noon meal with staff feeding eating 50%. Husband came from main dining room with finding resident. As soon as resident saw husband she stopped eating, immediately grabbed her walker and proceeded to ambulate to room. When asked	F 600	Corrective Action R3 and R4 have a new seat assignment during meals. R3 and R4 are referred too psychiatry for behavioral intervention. R3 and R4 family/guardians have been updated and agree with interventions in place. Identification of other residents All residents are at risk for verbal abuse Measure out in place Staff reeducated on reporting verbal abuse immediately Monitoring Mechanisms Dinning area will be monitored for verbal abuse 2 times weekly for 30 days. Then 1 x weekly for 90 days. Results will be reviewed by QAPI Compliance date 09/17/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 600	Continued From page 2	F 600		

if she was still hungry resident stated, "I can't eat anymore he doesn't want me to." Husband could be heard stating "she doesn't need to eat all of that." Resident came to main dining room for evening meal with eating a few bites of sandwiches and 100% of dessert."

R4's quarterly MDS dated 6/11/21, indicated R4 had diagnoses which included dementia, anxiety and had moderate cognitive impairments. Further review of MDS, indicated R4 did not have behaviors.

R4's progress note dated 7/17/21, indicated "resident had increased behaviors at supper time. Resident wanted to go back to room with wife wanting to stay in main dining room little bit longer. Resident would yell, become agitated, and upset. Would redirect with short lived." Further review of progress notes dated 8/1/21, indicated "Resident noted to be upset when staff would move away from wife who was in dining room talking to other residents at a table. Resident believed his wife should go with him back to room. Did call wife fat this shift with wife eating some when moved to the other room."

Review of report number 343200 dated 7/27/21, indicated R4 was witnessed by a staff member hit R3 on the mouth while sitting in the dining room. R4 wanted to return to their room, which R3 declined and used foul language towards R4 which resulted in R4 hitting R3.

On 8/5/21, at 11:37 a.m. nursing assistant (NA)-C indicated since the physical altercation, "we try to get them [R3 and R4] apart when they eat. Sometimes R4 would say things to R3 like you are fat and then R3 will stop eating and R3 don't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 600	Continued From page 3	F 600		

like to eat anymore but since we [staff] are keeping them apart in the dining room R3 will eat."
On 8/5/21, at 12:07 p.m. NA-D indicated R4 was known to have verbal behaviors and witnessed R4 call R3 fat and staff will encourage R3 to eat but R3 states "no he [R4] says I am too fat." Further, NA-D stated when R4 calls R3 fat staff will write R4 a note, due to hearing difficulty in the dining room, and redirect him to not call R3 fat. In addition, NA-D indicated since the physical altercation between R3 and R4 in the dining room, R3 and R4 have been placed at separate tables, which resolved R4 calling R3 fat and R3 will eat her meal.

On 8/5/21, at 12:29 p.m. licensed practical nurse (LPN)-A indicated R4 has not been physical prior to altercation but LPN-A has witnessed R4 call R3 fat "every couple of days".

On 8/5/21, at 4:03 p.m. RN-B stated since the physical altercation between R3 and R4, "we [staff] have separated them at mealtimes and are trying to separate them a little bit more and decrease R3's anxiety with R4. Its hard to differentiate abuse when they {r3 and R4] are a couple and what is their normal behavior. R3 has called R4 fat they [staff] have been telling me for a week or a week and a half. R4 will refuse to eat other times she will eat."

On 8/6/21 at 9:50 a.m. NA-B stated "R4 is very confused but will have moments of clarity." Further, NA-B indicated she has witnessed R4 call R3 fat and staff would encourage him not to say that but since the physical altercation "it has been a lot better lately with keeping them [R3 and R4] separate."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 600	Continued From page 4 On 8/6/21, at 10:47 a.m. Director of Nursing (DON) indicated R4 "likes to tell R3 what to do and R3 is not always in agreement. I have heard him tell R3 that she is fat at the table and R3 won't eat. I have corrected him and tell him R3 can eat." Further, DON stated "we [staff] are checking with R3, monitoring and keeping them [R3 and R4] separate. We [staff] remind him that it is inappropriate to call R3 fat." Review of facility policy titled Freedom of Abuse, Neglect, and Exploitation revised on May 2020 indicates "it is the policy of this community to take appropriate steps to prevent the occurrence of abuse, neglect, and misappropriation of resident property. Further review of facility policy defines verbal abuse as "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. In addition, the facility policy defines mental abuse as "humiliation, harassment, threats of punishment or deprivation.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 609	Continued From page 5 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report to the state agency (SA) allegations of employee to resident abuse for 1 of 1 residents (R1) who reported physical abuse from an employee. Findings include: R1's face sheet dated 8/6/21, indicated R1's had diagnoses which included Asperger's Syndrome, Schizoaffective Disorder, and attention-deficit hyperactive disorder. Review of report number 343317 dated 8/2/21, indicated "on August 2nd at 12:30 p.m. resident was visiting with the Regional Ombudsman and informed him that a staff member slapped her left backside while changing her linens and chux. Administrator asked when this happened, and	F 609	Corrective Action The facility submitted a vulnerable adult report for R1 on 08/06/2021 Identification of other residents All residents are at risk for verbal abuse Measures put in place All staff re-educated on reporting abuse to the Minnesota Department of Health within 2-hours of reports of physical abuse. Monitoring Mechanisms 10% of residents will be interviewed for reports of abuse weekly x 90 days. Results will be reviewed by QAPI Compliance date 09/17/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 609	Continued From page 6	F 609		

resident said it was over the weekend either Saturday or Sunday."

On 8/6/21, at 8:40 a.m. nursing assistant (NA)-A indicated the incident occurred on 8/1/21, when NA-A and NA-B assisted R1 by changing her linen and pad on reclining chair that R1 was sitting on. NA-A stated she brushed the backside of R1 with the linen and R1 had stated "that is unwanted contact. That is abuse. That is harassment. I am going to have your job." Further, NA-A stated she reported incident to registered nurse (RN)-A.

On 8/6/21, at 9:02 a.m. RN-A indicated she was approached by NA-A on 8/1/21, who stated R1 was requesting to speak with RN-A about the incident. RN-A indicated both herself and RN-B spoke with R1. R1 reported to RN-A and RN-B "she was not mad at the girls [NA-A and NA-B] for that [incident] but she [R1] wanted them [NA-A and NA-B] to come in there [R1's room] and tell her {R1] that they [NA-A and NA-B] were sorry. As the day went on it seemed to continue to escalate and there were more issues. It turned from no big deal to she [NA-A] rubbed her [NA-A] arm on her [R1] then it was she [NA-A] slapped her [R1] and then she [NA-A] clapped in her [R1] face or something. We [RN-A and RN-B] filled out a report and it was sent to both Administrator and Director of Nursing (DON)." Further, RN-A indicated "when we [RN-A and RN-B] first went in there [R1's room], R1 did say something about them [NA-A and NA-B] hitting her [R1]. We [RN-A and RN-B] reported immediately." In addition, RN-A indicated she was unsure if RN-B completed the report due to RN-B's shift ended.

On 8/6/21, at 9:50 a.m. NA-B indicated on 8/1/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 609	Continued From page 7	F 609		

in the morning "R1 was angry and nothing was right. We [NA-A and NA-B] were changing the pad on the chair and R1 was standing close to the chair, so when the pad was removed it brushed her thigh. R1 then said you are not supposed to touch me why would you touch my ass." Further, NA-B stated NA-A did not make any physical contact with R1, but R1 continued to become upset and stated "NA-A slapped her [R1] ass and she [R1] was calling authorities."

On 8/6/21, at 10:27 a.m. RN-B indicated the incident was reported to her by NA-A and NA-B. RN-B spoke with R1 and R1 reported NA-A "hit" her bottom and R1 wanted NA-A to apologize to her. In addition, RN-B stated "I wrote it all down. I initially did not report because R1 said it was an accident. I reported it the next day to Administrator. I told the Administrator after he got a report from some one else, so then I spoke to him about it." Further, RN-B stated "I know I am supposed to report abuse right away. It is important because they [residents] are vulnerable adults and they [residents] need to be taken care of so the abuse doesn't happen again, but when R1 reported it was an accident is why I did not report it right away."

On 8/6/21, at 10:47 a.m. DON indicated she was made aware of the incident on 8/2/21, in the morning. Further, DON indicated both DON and Administrator spoke with R1 following report of incident. R1 had reported R1 was not sure if it was an accident or not. R1 had reported it to RN-A and RN-B after the incident occurred. R1 reported "it felt like an open hand against her back side when they {NA-A and NA-B] were changing the linens. I may be wrong, but I felt like it was a slap." In addition, DON indicated staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 609	Continued From page 8 were expected to report abuse immediately when abuse is first suspected to either DON or Administrator. On 8/6/21, at 12:13 p.m. Administrator indicated he was made aware of the incident on 8/2/21. Further, Administrator indicated R1 had reported "staff member slapped her backside and following that we immediately had a conversation with R1 and she was unsure if it was purposeful or an accident. We [staff] have to report abuse within two hours, but that two hours has since passed when it was brought to mine and DON attention on Monday." In addition, Administrator indicated staff were expected to report abuse right when it happens, right when R1 said "hit" it should have been reported to myself or DON." Review of facility policy titled Freedom from Abuse, Neglect, and Exploitation revised May 2020, indicated "it is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries or unknown source, and misappropriation of resident property ("alleged violations") are reported immediately to the administrator of the community. If the events that caused the allegation involve abuse or serious bodily injury, it must be reported to the State agency immediately but no later than two hours after forming the suspicion per State and Federal regulation."	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 657	Continued From page 9 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to create a comprehensive care plan after the completion of comprehensive assessment for 1 of 4 (R1) residents reviewed care planning. Findings include: R1's admission Minimal Data Set (MDS) dated 7/26/21, indicated R1 has diagnoses which included dementia, anxiety and schizophrenia. Further review of MDS, indicated R1 is cognitively intact and displayed no behaviors.	F 657	Corrective Action R1 care plan was updated to reflect skin status, behaviors, and behavioral interventions. Identification of other residents All residents will be reviewed skin alterations and behaviors. Measures put in place Residents with skin alterations and behaviors will be reviewed for accurate reflection of current status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 657	Continued From page 10 R1's base line care plan dated 7/21/21, indicated R1 did not have any wounds, and R1 had Asperger's syndrome with gruff outburst, "does what wants" and interventions included "work with her". R1's behavior monitoring from 7/24/21 through 8/5/21, indicated R1 was noted to yell/scream on 6 of the 11 days, push on 1 or the 11 days, use of abusive language on 5 of the 11 days, threatening behavior 3 of the 11 days and rejection of care on 1 of the 11 days. On 8/6/21, at 10:27 a.m. registered nurse (RN)-B indicated R1 had a sore on lower left leg that opened about a week and a half ago. RN-B indicated there is an order for ace wraps to legs, if R1 allows but R1 will often refuse. On 8/5/21, at 10:59 a.m. nursing assistant (NA)-E indicated R1's behaviors included yelling and the use of foul and degrading language towards staff while assisting with cares. Further, NA-E indicated when R1 begins to display behaviors NA-E will just listen to R1 and "I will just let her say what she needs to say." On 8/5/21, at 1:25 p.m. NA-F indicated R1 is assist of two staff members with all cares related to R1's behaviors of being "very violtile and very difficult". Further, NA-F indicated R1 is "verbally aggressive and abusive" towards staff and R1 will make accusations regarding staff. In addition, NA-F indicated interventions for R1's behaviors included re-approach and "get to the root of the problem." On 8/5/21, at 2:00 p.m. NA-G indicated R1's	F 657	Monitoring Mechanisms 10% of care plans will be reviewed for accuracy x 90 days. Results will be reviewed by QAPI. Compliance date 09/17/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 657	Continued From page 11	F 657		

behaviors included "screaming and she has belittled everyone that has worked her." Further, NA-G indicated two staff are required to assist R1 related to "behaviors and the charge nurse said for safety reasons just in case you have someone who has your back. R1 will say one thing then she will say another."

On 8/5/21, at 4:03 p.m. registered nurse (RN)-B stated R1 "is a challenge mostly because of the diagnosis of Asperger's and bipolar. She [R1] will get loud and verbally abusive. We [staff] go in by twos." In addition, RN-B indicated R1 would make accusations about staff. Further, RN-B indicated interventions used for R1's behaviors include "when she [R1] has behaviors, management is notified, and we used to stand there and list to her now they [staff] say do your stuff get in and get out." RN-B indicated nursing assistants chart behaviors and each resident has a behavior monitoring tab. When asked who updated each resident care plan RN-B stated "we [staff] are supposed to put behaviors in the care plans and the interventions should go in there also. I have done some care plan, but my understanding is the MDS purse puts it [care plan] together and I don't know where they go from there. I know Director of Nursing (DON) is going to be working on them along with all the other things."

R1's baseline care plan dated 7/21/21 indicated:
-Skin Risk: no wounds
-Behavior/Mood/Safety: Asperger syndrome gruff outburst behaviors: does what wants
Interventions: work with her
Isolation Precautions yes COVID requirements
-Bowel/Bladder continent/incontinent of bowel and bladder
-Cognition: alert and oriented to person place and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/06/2021

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) COMPLETION DATE
F 657	Continued From page 12 time -Nutritional 2000 cc fluid restrictions low NA+ healthy hear 1500 calorie wt reduction diet order..food allergies onions cannot eat cantaloupe/honeydew..special like depends on day currently..food dislikes cannot eat salty food onions "poorly made food" R1's records lacked evidence of a comprehensive Careplan despite her admission date of 7/19/21. On 8/6/21, at 10:47 a.m. DON indicated R1 had one site on her leg that R1 had picked open and staff are monitoring and applying wraps when R1 allows. Further, DON stated "care plans here are a night mare. I think the old DON took the responsibility. I have been doing my best to review and get them updated but I am aware and working on them." DON confirmed that R1 had a base line care plan but does not have a comprehensive care plan and stated "they [staff] have not been accountable for it [care plans] so they [staff] are still not doing it [care plan]" Requested a copy of facility policy related to developing care plan, but facility failed to provide a copy.	F 657		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2021

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

Re: Event ID: UGET11

Dear Administrator:

The above facility survey was completed on August 6, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Minnesota Department of Health

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 08/06/2021

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 8/4/21 through 8/6/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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

Electronically Signed | 09/04/21

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 08/06/2021

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	Continued From page 1 SUBSTANTIATED: H5585023C (MN75226) The following complaint was found to be UNSUBSTANTIATED: H5585024C (MN75166); H5585025C (MN75160); H5585026C (MN75441) The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		