DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 29, 2022

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

RE: CCN: 245585
Cycle Start Date: October 6, 2022

Dear Administrator:

On October 21, 2022, we notified you a remedy was imposed. On November 16, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 4, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 5, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 21, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 6, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

November 29, 2022

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

Re: Reinspection Results
Event ID: 99DH12

Dear Administrator:

On November 16, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 6, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 21, 2022

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

RE: CCN: 245585
Cycle Start Date: October 6, 2022

Dear Administrator:

On October 6, 2022, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 6, 2022, the situation of immediate jeopardy to potential health and safety cited at F760 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 5, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 5, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 5, 2022, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 6, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Traverse Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 6, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904

Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 6, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 10/06/2022

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 10/3/22 thru 10/6/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F760 began on 9/30/22, when the facility failed to correctly transcribe diuretic medication orders for R1 which resulted rehospitalization of R1. The administrator, and director of nursing (DON) were notified of the IJ on 10/5/22 at 4:00 p.m. The IJ was removed on 10/6/22 at 4:30 p.m.. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 10/6/22. The following complaints was found to be SUBSTANTIATED: H55854899 (MN87209) with incidental finding at F760 The following complaints was found to be UNSUBSTANTIATED: H55854846 (MN87237), H55855238C (MN87084) and H55855236 (MN87099). 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/07/2022

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure physician ordered Torsemide (diuretic medication that can lower blood potassium levels) was transcribed into the electronic health record causing elevated potassium levels for 1 of 3 residents (R1) reviewed for significant medication errors. The facility's failures resulted in immediate jeopardy (IJ) for R1. The immediate jeopardy began on 9/30/22 when R1 was not administered three doses of Torsemide which resulted in bradycardia (slow heart rate) and hospitalization. The executive director, administrator, director of nursing (DON) and corporate nurse consultant were notified of immediate jeopardy on 10/5/22, at 4:00 p.m. The IJ was removed on 10/6/22 at 4:30 p.m., but noncompliance remained at the lower scope and severity level D scope and severity, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 760	Immediate corrective action: A focused assessment of the identified resident, R1, was completed on 10/5/2022 with no significant clinical findings. Corrective Action as it Applies to Others: A medication review was completed on 10/5/2022 to ensure medication orders have been accurately transcribed for 18 additional residents identified as being at-risk of experiencing a serious adverse event. No further discrepancies were noted. Prevent Recurrence: The policy and procedure for Physician's Orders was reviewed by the Director of Nursing, and Regional Director of Quality and Clinical Services on 10/5/2022 and a policy for the Transcription of Physician's orders was developed and reviewed by the QAPI committee on 10/6/2022. Specifically, the Policy will require a 2nd check verification process to ensure	11/2/22

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F 760	Continued From page 2 Findings include: R1's diagnosis list 10/5/22, included hyperkalemia (high potassium), bradycardia (low heart rate), chronic kidney disease stage 4, non-st elevation myocardial infarction (NSTEMI - heart attack), and congestive heart failure (heart muscle doesn't pump blood causing fluid build up.) R1's significant change minimum data set dated 8/23/22, indicated that R1 was cognitively intact. R1's hospital discharge summary dated 9/29/22, indicated R1 was readmitted to the hospital on 9/20/22, for low heart rate and hyperkalemia. R1's potassium level was 7.0 (normal range is 3.5-5.0). The summary identified upon discharge back to the facility on 9/29/22, R1's potassium level 4.6. The discharge summary included an order to start Torsemide (diuretic medication that can lower potassium levels) 10 mg (milligrams) by mouth daily. R1's medication administration record for September and October 2022 also did not identify the new order for Torsemide on 9/29/22; there was no indication R1 received Torsemide on 9/30/22, 10/1/22, and 10/2/22 thereby missing three doses. R1's progress note dated 10/3/22, at 7:16 a.m. included R1 was complaining of dizziness, nausea and feeling awful, was pale in color and heart rate between 34-44 apically (listening of heart with stethoscope). R1 was sent to hospital by ambulance. R1's emergency department (ED) progress note dated 10/3/22, identified upon admit to ED, R1	F 760	medication orders are transcribed accurately. Licensed staff were educated on the policy on 10/6/2022. Date of Alleged Compliance: 11/2/2022 Ongoing Monitoring: Audits will be conducted to ensure ongoing compliance with the policy for the transcription of physician's orders in accordance with facility policy. Audits will be conducted, 5x weekly for 2 weeks, then 3x weekly for 2 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Completed By: Don/Designee	

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F 760	Continued From page 3 was found to be bradycardia with a rate of 40 beats per minutes (bpm). R1's normal heart rate was between 72-84 bpm. R1's potassium level was 5.6. This was treated with gentle fluids and intravenous (IV) Lasix (diuretic medication). Repeat potassium at 11:37 a.m. was 5.7. The note indicated R1 was experiencing chest heaviness while in the ED and was subsequently admitted to hospital. R1's hospital discharge note dated 10/4/22 identified R1's Torsemide (Bumex) had not been started by the facility as ordered on 9/29/22 per hospital discharge record of 9/29/22. According to the note, on 10/4/22, R1's potassium level had decreased to 5.0 and was discharged back to the facility. During an interview on 10/6/22, at 3:15 p.m. registered nurse (RN)-A indicated when a resident was re-admitted from the hospital, a nurse would review the orders and enter them into the medical record. RN-A stated the facility did not have a double check system in place to make sure orders were accurate. RN-A indicated she was the nurse that had been responsible to enter the R1's orders when R1 came back to the hospital and missed the Torsemide order on the 9/29/22 discharge summary. During an interview on 10/4/22, at 4:40 p.m. nurse practitioner (NP)-G indicated R1's increased potassium level that resulted in elevated potassium level and hospitalization was the result of R1 not receiving the Torsemide as ordered. During an interview on 10/5/22, at 11:30 a.m. director of nursing (DON) reviewed R1's record	F 760		

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F 760	Continued From page 4 and confirmed the hospital discharge order was not transcribed and was not aware R1 had not received the medication. DON indicated the hospital discharge summary and orders should be double checked for accuracy to make sure nothing was missed, however the facility currently does not have a double check system currently. During interview 10/5/22, at 1:45 p.m. MD-H, medical director, expected all physician orders should be double checked for accuracy. Facility policy Physician's order dated November 2016, included 1. Medications a) All ordered medications are listed, with specified dosage. b) full directions for administration are provided. 3) All orders are dated, and include the resident's name, admission information, and signature of nurse completing the form. The facility policy did not address transcription of orders into the facility electronic health record. The immediate jeopardy was removed on 10/6/22, after it was verified the facility had developed and implemented the following correction measures: -Developed and implemented policy for reviewing new order-transcription with double check system -Educated staff responsible for order entry on the facility's new policy and ensured competency/understanding. -Reviewed physician orders for accuracy for residents who were identified at risk for significant medication errors.	F 760		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		11/4/22

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F 803	Continued From page 5 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the resident's menus and/or the individual resident's food plan met their nutritional needs in accordance with physician orders for 2 of 2 resident (R1, R3) reviewed for therapeutic diets. Findings include During an interview on 10/5/22, at 5:00 p.m. R1 stated she had recently had a heart attack and had been hospitalized. She also had congestive	F 803	Immediate corrective action: The diet order for R1 was clarified and updated. Corrective Action as it Applies to Others: An extension menu was developed to meet the dietary needs of residents with alternate dietary requirements. Prevent Recurrence: The policy for Therapeutic Diets was reviewed and remains current. Dietary and nursing Staff will be	

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 10/06/2022

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

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F 803	Continued From page 6 heart failure and kidney failure. R1 indicated she was recently hospitalized because her potassium level was high and was supposed to have a low potassium diet. R1 stated that her meals were always the same as the other residents and was not sure if the foods that were on her plate were considered low in potassium. R1 indicated staff did not give her options or replacements. R1's diagnosis list dated 10/5/22 included heart failure, hyperkalemia (high potassium), bradycardia (low heart rate), chronic kidney disease stage 4 (severe), non-stemi myocardial infarction (heart attack), type 2 diabetes. Review of R1's significant change Minimum Data Set (MDS) dated 8/23/22, indicated that R1 was cognitively intact and independent with eating after set-up. R1's hospital discharge summary dated 9/26/22 identified that R1's diet was strict diabetic, non-hemodialysis (HD) renal diet. R1's physician order dated 6/12/22, included diabetic diet, encourage fluids, texture as tolerated, thin/regular liquid consistency. R1's physician orders did not identify the hospital diet order. During an interview on 10/3/22, at 1:15 p.m. Cook (C)-A stated an awareness that R1 required a renal low potassium diet. C-A stated that she went to R1's room on 10/1/22 to talk to her about her renal diet. R1 gave her copies of "Ideas for Kidney Disease" food cards that she had received from the hospital. C-A indicated she went through them with R1 to find her preferences. C-A stated R1's diet was complicated because of her kidney	F 803	reeducated on the policy and extension menus Date of Alleged Compliance: 11/4/2022 Ongoing Monitoring: Audits will be conducted to ensure residents are served food and fluids in accordance with their prescribed diets. Audits will be conducted, 5x weekly for 2 weeks, then 3x weekly for 2 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Monitored By: DON/Designee	

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F 803	Continued From page 7 disease and diabetes. C-A articulated R1 could have sugar free candy, fruit sauces, protein that comes from fish, chicken, and turkey. C-A indicated residents could choose off the substitution list, however the list did not follow specific diet types. Further alternatives to the regular menu for specific diet types were not prepared or served. During an interview on 10/4/22, at 1:20p.m. with registered dietician (RD) stated an awareness of R1's diet needs. RD indicated the certified dietary manager (CDM) or nursing had made her aware of R1's hospital discharge summary from 9/16/22 that identified R1's new diet order. RD stated then she had extensive conversations with the nurse practitioner (NP). RD indicated that she had provided education to R1 and R1's family member of what foods to avoid and were encouraged. RD explained it was important for R1 to follow a low potassium diet because an elevated potassium level could cause serious heart complications. A follow up interview with RD was attempted on 10/6/22 at 12:20 p.m. in order to answer further questions about the dietary extension menu's or the facility's policy/program to provide appropriate prescribed diets. No return call was received. During an interview on 10/4/22, at 4:15 p.m. with dietary manager (CDM) stated that the facility does not have a dietary extension menu that identified the appropriate replacements for physician ordered diets. CDM provided a dietary menu for week of 10/2/22 through 10/8/22, the menu did not include a daily meal menu that would meet the physician ordered diet types (dietary extension). CDM indicated the menus did	F 803		

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F 803	Continued From page 8 not identify appropriate replacements for foods that were potassium rich, high carbohydrates, or sugar. R3 R3's diagnosis list dated 10/3/22 included type 2 diabetes and dysphagia (difficulty swallowing). Review of R3's quarterly MDS dated 8/31/22, indicated that R3 was had moderate cognitive impairment, required supervision with encouragement and/or cueing during meals and had no swallowing problems. R3's physician order dated 7/6/2020 included an order for a CSC diet (low carbohydrate), regular texture, regular liquids. During an observation on 10/3/22, at 12:10 R3 was served vegetable lasagna, lettuce salad and regular chocolate chip cookie. At 1:15 p.m. Cook (C)-A confirmed R3 was served lasagna and cookie; lasagna and cookie would not be consistent with a diabetic or CSC. During an observation on 10/4/22, at 12:30 R3 was served popcorn shrimp, cheesy mashed potatoes, and pound cake. At 1:15 p.m. C-A confirmed R3 was served pound cake and the cake would not be consistent with a diabetic diet or CSC diet. During an interview on 10/3/22, at 1:15 p.m. C-A confirmed residents who required CSC and diabetic diets received the same foods but smaller pieces portions of the foods high in sugar like pie or cake. C-A did not identify how serving smaller portions equated to providing the same amount or nutritional value. Dietary staff would try	F 803		

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F 803	Continued From page 9 to substitute higher sugar foods with something with less sugar, however the menus did not reflect the substitutions. During an interview on 10/4/22, at 1:20 p.m. RD indicated that diabetics should be receiving less carbohydrates than what was served for regular diets. RD stated expectation that the ordered diets are followed unless the resident/family refuse, then the refusal should be in writing and in the resident's chart During an interview on 10/4/22, at 4:15 p.m. CDM indicated that diabetic diets should be receiving sugar free foods or fresh fruit and if we serve them pie/cake leave off the topping. CDM stated that it was important to follow the ordered diets for the health of the residents. During an interview on 10/5/22, at 1:45 p.m. medical director (MD)-H indicated an expectation that specific diet orders be followed. During an interview on 10/5/22, at 4:35 p.m. nurse practitioner (NP)-G stated expectation diets are followed per physician order. Review of the facility revised policies of Diet Therapeutic and Dining and Food Service both dated 11/16, stated to verify diet with physician orders that includes the type of diet, consistency and the need for adaptive equipment and the dietary department will maintain a list of therapeutic diets offered by the facility.	F 803		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink	F 805		11/4/22

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F 805	Continued From page 10 Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide textured diets to meet dietary needs for 1 of 3 residents (R4) reviewed for therapeutic diets. Findings include R4's diagnosis list dated 10/4/22, included dysphagia (difficulty or discomfort in swallowing), Parkinson's disease and dementia. R4's significant change Minimum Data Set (MDS) dated 7/14/22, identified R4 had severe cognition impairment, required extensive assistance from one staff member for eating, and had no difficulty with swallowing. R4's physician order dated 7/28/22, included general/standard diet, pureed (a very smooth, crushed or blended texture), nectar thickened liquids (comparable to heavy syrup found in canned fruit). R4's diet card (used by dietary staff to plate and serve meals) identified regular diet, cut up meat. The card also included the hand-written word "Pureed" which was circled. The diet card did not identify R4 required nectar thickened liquid as per the physician order dated 7/28/22. During a lunch meal observation on 10/4/22, at 12:54 p.m. R4 sat in the wheelchair at the dining room table, resting with her eyes closed. R4's	F 805	Immediate corrective action: The dietary card for R3 was updated to reflect the current dietary orders. Corrective Action as it Applies to Others: Dietary cards will be reviewed for other residents to ensure the cards reflect current physicians orders. Prevent Recurrence: The policy for Therapeutic Diets was reviewed and remains current. Dietary and nursing staff will be educated on the policy. Date of Alleged Compliance: 11/4/2022 Ongoing Monitoring: Audits will be conducted to ensure residents are served food and fluids in accordance with their prescribed diets. Audits will be conducted, 5x weekly for 2 weeks, then 3x weekly for 2 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Monitored By: DON/Designee	

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F 805	Continued From page 11 plate was observed to have pureed food textures, however had two cups that contained clear thin liquids. Nursing assistant (NA-C) sat next to R4 attempting to wake R4 up to eat. During an observation and interview on 10/4/22, at 12:58 p.m. director of nursing (DON) and registered nurse (RN)-A were informed R4 received the wrong liquid consistency. DON and RN-A reviewed R4's diet order and confirmed the order was for nectar thickened liquids. DON and RN-A then went to the dining room and looked at R4's liquids. DON and RN-A stated the liquids in the cups were thin liquids and not nectar as they should have been. RN-A then removed the liquids from in front of R4. During a lunch meal observation on 10/5/22, at 1:15 p.m. R4 was sitting at the dining room table. R4 had two cups in front of her; one 4 oz glass and a blue water mug both with varying amounts of clear thin liquid. Dietary assistant (DA)-A was standing near R4's table recording resident meal intakes. During an observation and interview on 10/5/22, at 1:17 p.m. DA-A stated the food and fluids in front of R4 had been R4's. DA-A stated the liquid in the cups were regular/thin fluids. DON was in the dining room conversing with cook (C)-B. DON observed R4's liquids, DON stated the liquids were thin and not nectar consistency. DON and C-B reviewed R4's dietary card. DON indicated the diet card was incorrect. C-B changed the diet card to reflect R4's nectar thickened liquids per R4's physician order. During an interview on 10/4/22, at 12:58 p.m. RN-A and DON stated that the speech therapist	F 805		

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F 805	Continued From page 12 gave orders to dietary about food and fluid consistencies. Both indicated that it was important to follow diet orders for R4 to prevent aspiration pneumonia (inhalation of fluid/food into the lungs causing infection). During an interview on 10/4/22, at 1:20 p.m. registered dietician (RD) indicated that dietary is made aware of diet orders from either the computer, nurse manager or the white board in the kitchen. RD's expectation was to follow the diets unless the resident/family refuse, the refusal would need to be in writing and in the resident ' s chart. During an interview on 10/4/22, at 4:15 p.m. certified dietary manager (CDM) indicated the dietary department received diet orders from the computer or nursing gives the department a dietary slip. CDM further indicated that either she or a cook would update the dietary card. During an interview on 10/4/22, at 4:15 p.m. with CDM stated that it was important to follow the ordered diets for the health of the residents. During an interview on 10/4/22, at 1:20 p.m. RD stated expectation that the ordered diets are followed unless the resident/family refuse, then the refusal should be in writing and in the resident's chart. Review of the facility revised policies of Diet Therapeutic and Dining and Food Service both dated November 2016, directed to verify diet with physician orders that includes the type of diet, consistency and the need for adaptive equipment and the dietary department will maintain a list of therapeutic diets offered by the facility	F 805		

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Electronically delivered
October 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 99DH11

Dear Administrator:

The above facility was surveyed on October 3, 2022 through October 6, 2022 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	00669	A. BUILDING: _____ B. WING _____	C 10/06/2022

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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 10/3/22 thru 10/6/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/07/22

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H55854899 (MN87209) with a licensing order issued at 965 and 1545 and The following complaint was found to be unsubstantiated: H55854846 (MN87237), H55855238C (MN87084) and H55855236 (MN87099). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status 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 ensure the resident's menus and/or the individual resident's food plan met their nutritional needs in accordance with physician orders for 2 of 2 resident (R1, R3) reviewed for therapeutic diets. Findings include During an interview on 10/5/22, at 5:00 p.m. R1 stated she had recently had a heart attack and had been hospitalized. She also had congestive	2 965	Corrected	11/4/22

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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) COMPLETE DATE
2 965	Continued From page 3 heart failure and kidney failure. R1 indicated she was recently hospitalized because her potassium level was high and was supposed to have a low potassium diet. R1 stated that her meals were always the same as the other residents and was not sure if the foods that were on her plate were considered low in potassium. R1 indicated staff did not give her options or replacements. R1's diagnosis list dated 10/5/22 included heart failure, hyperkalemia (high potassium), bradycardia (low heart rate), chronic kidney disease stage 4 (severe), non-stemi myocardial infarction (heart attack), type 2 diabetes. Review of R1's significant change Minimum Data Set (MDS) dated 8/23/22, indicated that R1 was cognitively intact and independent with eating after set-up. R1's hospital discharge summary dated 9/26/22 identified that R1's diet was strict diabetic, non-hemodialysis (HD) renal diet. R1's physician order dated 6/12/22, included diabetic diet, encourage fluids, texture as tolerated, thin/regular liquid consistency. R1's physician orders did not identify the hospital diet order. During an interview on 10/3/22, at 1:15 p.m. Cook (C)-A stated an awareness that R1 required a renal low potassium diet. C-A stated that she went to R1's room on 10/1/22 to talk to her about her renal diet. R1 gave her copies of "Ideas for Kidney Disease" food cards that she had received from the hospital. C-A indicated she went through them with R1 to find her preferences. C-A stated R1's diet was complicated because of her kidney disease and diabetes. C-A articulated R1 could	2 965		

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2 965	Continued From page 4 have sugar free candy, fruit sauces, protein that comes from fish, chicken, and turkey. C-A indicated residents could choose off the substitution list, however the list did not follow specific diet types. Further alternatives to the regular menu for specific diet types were not prepared or served. During an interview on 10/4/22, at 1:20p.m. with registered dietician (RD) stated an awareness of R1's diet needs. RD indicated the certified dietary manager (CDM) or nursing had made her aware of R1's hospital discharge summary from 9/16/22 that identified R1's new diet order. RD stated then she had extensive conversations with the nurse practitioner (NP). RD indicated that she had provided education to R1 and R1's family member of what foods to avoid and were encouraged. RD explained it was important for R1 to follow a low potassium diet because an elevated potassium level could cause serious heart complications. A follow up interview with RD was attempted on 10/6/22 at 12:20 p.m. in order to answer further questions about the dietary extension menu's or the facility's policy/program to provide appropriate prescribed diets. No return call was received. During an interview on 10/4/22, at 4:15 p.m. with dietary manager (CDM) stated that the facility does not have a dietary extension menu that identified the appropriate replacements for physician ordered diets. CDM provided a dietary menu for week of 10/2/22 through 10/8/22, the menu did not include a daily meal menu that would meet the physician ordered diet types (dietary extension). CDM indicated the menus did not identify appropriate replacements for foods that were potassium rich, high carbohydrates, or	2 965		

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2 965	Continued From page 5 sugar. R3 R3's diagnosis list dated 10/3/22 included type 2 diabetes and dysphagia (difficulty swallowing). Review of R3's quarterly MDS dated 8/31/22, indicated that R3 was had moderate cognitive impairment, required supervision with encouragement and/or cueing during meals and had no swallowing problems. R3's physician order dated 7/6/2020 included an order for a CSC diet (low carbohydrate), regular texture, regular liquids. During an observation on 10/3/22, at 12:10 R3 was served vegetable lasagna, lettuce salad and regular chocolate chip cookie. At 1:15 p.m. Cook (C)-A confirmed R3 was served lasagna and cookie; lasagna and cookie would not be consistent with a diabetic or CSC. During an observation on 10/4/22, at 12:30 R3 was served popcorn shrimp, cheesy mashed potatoes, and pound cake. At 1:15 p.m. C-A confirmed R3 was served pound cake and the cake would not be consistent with a diabetic diet or CSC diet. During an interview on 10/3/22, at 1:15 p.m. C-A confirmed residents who required CSC and diabetic diets received the same foods but smaller pieces portions of the foods high in sugar like pie or cake. C-A did not identify how serving smaller portions equated to providing the same amount or nutritional value. Dietary staff would try to substitute higher sugar foods with something with less sugar, however the menus did not reflect the substitutions.	2 965		

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2 965	Continued From page 6 During an interview on 10/4/22, at 1:20 p.m. RD indicated that diabetics should be receiving less carbohydrates than what was served for regular diets. RD stated expectation that the ordered diets are followed unless the resident/family refuse, then the refusal should be in writing and in the resident's chart During an interview on 10/4/22, at 4:15 p.m. CDM indicated that diabetic diets should be receiving sugar free foods or fresh fruit and if we serve them pie/cake leave off the topping. CDM stated that it was important to follow the ordered diets for the health of the residents. During an interview on 10/5/22, at 1:45 p.m. medical director (MD)-H indicated an expectation that specific diet orders be followed. During an interview on 10/5/22, at 4:35 p.m. nurse practitioner (NP)-G stated expectation diets are followed per physician order. Review of the facility revised policies of Diet Therapeutic and Dining and Food Service both dated 11/16, stated to verify diet with physician orders that includes the type of diet, consistency and the need for adaptive equipment and the dietary department will maintain a list of therapeutic diets offered by the facility. Based on observation, interview, and document review the facility failed to provide textured diets to meet dietary needs for 1 of 3 residents (R4) reviewed for therapeutic diets. Findings include R4's diagnosis list dated 10/4/22, included	2 965		

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2 965	Continued From page 7 dysphagia (difficulty or discomfort in swallowing), Parkinson's disease and dementia. R4's significant change Minimum Data Set (MDS) dated 7/14/22, identified R4 had severe cognition impairment, required extensive assistance from one staff member for eating, and had no difficulty with swallowing. R4's physician order dated 7/28/22, included general/standard diet, pureed (a very smooth, crushed or blended texture), nectar thickened liquids (comparable to heavy syrup found in canned fruit). R4's diet card (used by dietary staff to plate and serve meals) identified regular diet, cut up meat. The card also included the hand-written word "Pureed" which was circled. The diet card did not identify R4 required nectar thickened liquid as per the physician order dated 7/28/22. During a lunch meal observation on 10/4/22, at 12:54 p.m. R4 sat in the wheelchair at the dining room table, resting with her eyes closed. R4's plate was observed to have pureed food textures, however had two cups that contained clear thin liquids. Nursing assistant (NA-C) sat next to R4 attempting to wake R4 up to eat. During an observation and interview on 10/4/22, at 12:58 p.m. director of nursing (DON) and registered nurse (RN)-A were informed R4 received the wrong liquid consistency. DON and RN-A reviewed R4's diet order and confirmed the order was for nectar thickened liquids. DON and RN-A then went to the dining room and looked at R4's liquids. DON and RN-A stated the liquids in the cups were thin liquids and not nectar as they should have been. RN-A then removed the liquids	2 965		

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2 965	Continued From page 8 from in front of R4. During a lunch meal observation on 10/5/22, at 1:15 p.m. R4 was sitting at the dining room table. R4 had two cups in front of her; one 4 oz glass and a blue water mug both with varying amounts of clear thin liquid. Dietary assistant (DA)-A was standing near R4's table recording resident meal intakes. During an observation and interview on 10/5/22, at 1:17 p.m. DA-A stated the food and fluids in front of R4 had been R4's. DA-A stated the liquid in the cups were regular/thin fluids. DON was in the dining room conversing with cook (C)-B. DON observed R4's liquids, DON stated the liquids were thin and not nectar consistency. DON and C-B reviewed R4's dietary card. DON indicated the diet card was incorrect. C-B changed the diet card to reflect R4's nectar thickened liquids per R4's physician order. During an interview on 10/4/22, at 12:58 p.m. RN-A and DON stated that the speech therapist gave orders to dietary about food and fluid consistencies. Both indicated that it was important to follow diet orders for R4 to prevent aspiration pneumonia (inhalation of fluid/food into the lungs causing infection). During an interview on 10/4/22, at 1:20 p.m. registered dietician (RD) indicated that dietary is made aware of diet orders from either the computer, nurse manager or the white board in the kitchen. RD's expectation was to follow the diets unless the resident/family refuse, the refusal would need to be in writing and in the resident ' s chart. During an interview on 10/4/22, at 4:15 p.m.	2 965		

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2 965	Continued From page 9 certified dietary manager (CDM) indicated the dietary department received diet orders from the computer or nursing gives the department a dietary slip. CDM further indicated that either she or a cook would update the dietary card. During an interview on 10/4/22, at 4:15 p.m. with CDM stated that it was important to follow the ordered diets for the health of the residents. During an interview on 10/4/22, at 1:20 p.m. RD stated expectation that the ordered diets are followed unless the resident/family refuse, then the refusal should be in writing and in the resident's chart. Review of the facility revised policies of Diet Therapeutic and Dining and Food Service both dated November 2016, directed to verify diet with physician orders that includes the type of diet, consistency and the need for adaptive equipment and the dietary department will maintain a list of therapeutic diets offered by the facility SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should review the facility policy on provision of therapeutic diets. The RD and certified dietary manager (CDM) could create dietary extension menus to meet the specific prescribed diets to meet residents nutritional needs. The facility also should develop a system to ensure dietary staff are providing the correct consistency of diets and re-educate their staff. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as	2 965		

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2 965	Continued From page 10 identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		11/2/22

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21545	Continued From page 11 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure physician ordered Torsemide (diuretic medication that can lower blood potassium levels) was transcribed into the electronic health record causing elevated potassium levels for 1 of 3 residents (R1) reviewed for significant medication errors. The facility's failures resulted in immediate jeopardy (IJ) for R1. The immediate jeopardy began on 9/30/22 when R1 was not administered three doses of Torsemide which resulted in bradycardia (slow heart rate) and hospitalization. The executive director, administrator, director of nursing (DON) and corporate nurse consultant were notified of immediate jeopardy on 10/5/22, at 4:00 p.m. The IJ was removed on 10/6/22 at 4:30 p.m., but noncompliance remained at the lower scope and severity level D scope and severity, which indicated no actual harm with potential for more than minimal harm that is not immediate	21545	Corrected	

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21545	Continued From page 12 jeopardy. Findings include: R1's diagnosis list 10/5/22, included hyperkalemia (high potassium), bradycardia (low heart rate), chronic kidney disease stage 4, non-st elevation myocardial infarction (NSTEMI - heart attack), and congestive heart failure (heart muscle doesn't pump blood causing fluid build up.) R1's significant change minimum data set dated 8/23/22, indicated that R1 was cognitively intact. R1's hospital discharge summary dated 9/29/22, indicated R1 was readmitted to the hospital on 9/20/22, for low heart rate and hyperkalemia. R1's potassium level was 7.0 (normal range is 3.5-5.0). The summary identified upon discharge back to the facility on 9/29/22, R1's potassium level 4.6. The discharge summary included an order to start Torsemide (diuretic medication that can lower potassium levels) 10 mg (milligrams) by mouth daily. R1's medication administration record for September and October 2022 also did not identify the new order for Torsemide on 9/29/22; there was no indication R1 received Torsemide on 9/30/22, 10/1/22, and 10/2/22 thereby missing three doses. R1's progress note dated 10/3/22, at 7:16 a.m. included R1 was complaining of dizziness, nausea and feeling awful, was pale in color and heart rate between 34-44 apically (listening of heart with stethoscope). R1 was sent to hospital by ambulance. R1's emergency department (ED) progress note	21545		

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21545	Continued From page 13 dated 10/3/22, identified upon admit to ED, R1 was found to be bradycardia with a rate of 40 beats per minutes (bpm). R1's normal heart rate was between 72-84 bpm. R1's potassium level was 5.6. This was treated with gentle fluids and intravenous (IV) Lasix (diuretic medication). Repeat potassium at 11:37 a.m. was 5.7. The note indicated R1 was experiencing chest heaviness while in the ED and was subsequently admitted to hospital. R1's hospital discharge note dated 10/4/22 identified R1's Torsemide (Bumex) had not been started by the facility as ordered on 9/29/22 per hospital discharge record of 9/29/22. According to the note, on 10/4/22, R1's potassium level had decreased to 5.0 and was discharged back to the facility. During an interview on 10/6/22, at 3:15 p.m. registered nurse (RN)-A indicated when a resident was re-admitted from the hospital, a nurse would review the orders and enter them into the medical record. RN-A stated the facility did not have a double check system in place to make sure orders were accurate. RN-A indicated she was the nurse that had been responsible to enter the R1's orders when R1 came back to the hospital and missed the Torsemide order on the 9/29/22 discharge summary. During an interview on 10/4/22, at 4:40 p.m. nurse practitioner (NP)-G indicated R1's increased potassium level that resulted in elevated potassium level and hospitalization was the result of R1 not receiving the Torsemide as ordered. During an interview on 10/5/22, at 11:30 a.m. director of nursing (DON) reviewed R1's record	21545		

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21545	Continued From page 14 and confirmed the hospital discharge order was not transcribed and was not aware R1 had not received the medication. DON indicated the hospital discharge summary and orders should be double checked for accuracy to make sure nothing was missed, however the facility currently does not have a double check system currently. During interview 10/5/22, at 1:45 p.m. MD-H, medical director, expected all physician orders should be double checked for accuracy. Facility policy Physician's order dated November 2016, included 1. Medications a) All ordered medications are listed, with specified dosage. b) full directions for administration are provided. 3) All orders are dated, and include the resident's name, admission information, and signature of nurse completing the form. The facility policy did not address transcription of orders into the facility electronic health record. The immediate jeopardy was removed on 10/6/22, after it was verified the facility had developed and implemented the following correction measures: -Developed and implemented policy for reviewing new order-transcription with double check system -Educated staff responsible for order entry on the facility's new policy and ensured competency/understanding. -Reviewed physician orders for accuracy for residents who were identified at risk for significant medication errors. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for	21545		

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21545	Continued From page 15 medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		