



Protecting, Maintaining and Improving the Health of All Minnesotans

**This letter addresses the complaint completed by the Minnesota Department of Health exited on July 27, 2026. CMS split the FMS survey exited 02/18/26 to a separate cycle.**

Electronically Delivered  
September 10, 2026

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

RE: CCN: 245638  
Cycle Start Date: July 27, 2026

Dear Administrator:

On September 9, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308    Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2026

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

Re: Reinspection Results  
Event ID: 2AA955-H2

Dear Administrator:

On September 9, 2026 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 July 27, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697

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*An equal opportunity employer.*



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

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

RE: CCN:245638

Cycle Start Date: July 27, 2026

Dear Administrator:

On July 27, 2026, a 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.

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" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Nikki Harvey, Regional Supervisor, Federal Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
1400 E. Lyon St.  
Marshall, MN 56258  
Email: [nikki.harvey@state.mn.us](mailto:nikki.harvey@state.mn.us)**

**Office: (320) 223-7318 Mobile: (320) 216-5631**

## 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 October 27, 2026 (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 January 27, 2027 (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)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308    Fax: 651-215-9697

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August 13, 2026

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

Re: State Nursing Home Licensing Orders

Event ID: 2AA955-H1

Dear Administrator:

The above facility survey was completed on July 27, 2026 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 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](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:

**Nikki Harvey, Regional Supervisor, Federal Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
1400 E. Lyon St.  
Marshall, MN 56258  
Email: [nikki.harvey@state.mn.us](mailto:nikki.harvey@state.mn.us)**

**Office: (320) 223-7318 Mobile: (320) 216-5631**

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,



Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308    Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245638 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X3) DATE SURVEY COMPLETED<br><br>07/27/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRAVERSE CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              | (X5)<br>COMPLETION<br>DATE |
| F0000                                                    | INITIAL COMMENTS<br><br>On 7/23/26, 7/24/26, and 7/27/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed H56383425C (3105215, 3105045) with no deficiencies and H56381214C (2979516) with a citation at F880.<br><br>Deficient practice was identified related to incidental findings at F609, F689.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in e POC, 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.<br><br>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. |                                                                  |  | F0000                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              | 08/18/2026                 |
| F0609<br>SS = D                                          | Reporting of Alleged Violations<br><br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§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 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                                                                                                                                                                                                                                                                                                                                                      |                                                                  |  | F0609                                                                                             | Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the facility with the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed because it is required by State and Federal regulations.<br><br>R1 was immediately assessed upon identification of the injury and was transferred to the Emergency Department for evaluation on 7/19/26. The facility completed a comprehensive investigation of the incident, including review of medical records, staff interviews, resident interviews, and evaluation of facility practices. Appropriate monitoring of R1 was implemented and continued in accordance with the resident's plan of care. To identify any other residents who may have been affected, the Director |                                              | 07/27/2026                 |

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 reverse for further 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.

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

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| NAME OF PROVIDER OR SUPPLIER<br><br>TRAVERSE CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              |                            |
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| F0609<br>SS = D                                          | <p>Continued from page 1</p> <p>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.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to report an allegation of an injury of unknown origin to the State Agency (SA) within two hours for 1 of 1 resident (R1) investigated for injury of unknown origin.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 6/10/26, identified severely impaired cognition with no behaviors and rarely socially isolated herself. R1 had impaired lower bilateral extremity range of motion (ROM) and used a walker and wheelchair for mobility. R1 was frequently incontinent of bladder and occasionally incontinent of bowel. R1 required partial/moderate assistance with all transfers and was dependent upon staff for shower/bath and toileting. R1's diagnoses included non-Alzheimer's dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), anxiety, depression, and poor vision. R1's medications included antidepressants and anticoagulants.</p> <p>R1's care plan dated 7/20/26, identified:</p> <p>-At risk for abuse vulnerability related to cognitive deficit, safer awareness, confusion, and impaired vision. Areas of vulnerability include physical, emotional, and mental. Staff were directed to observe suspected abuse, remove resident from aggressor and relocate to safe location, provide annual vulnerable training by staff, report alleged violations in accordance with community</p> |                                                                  |  | F0609                                                                                             | <p>Continued from page 1</p> <p>of Nursing and Charge Nurse conducted resident interviews and skin checks, with no additional abnormal bruising identified. To prevent recurrence, the facility reviewed and reinforced its Abuse Prevention Policy with all leadership staff, provided education to all facility staff regarding mandatory reporting obligations and notification procedures, and established a centralized reporting log maintained by the Administrator or designee. This log tracks the date and time an allegation is identified, the date and time the Administrator is notified, the date and time the State Agency is notified, investigation status, and the date investigation findings are submitted. Additionally, any future allegation of abuse, neglect, exploitation, mistreatment, or injury of unknown origin will be reviewed immediately by the Administrator or designee upon notification to ensure all required reports are submitted within mandated timelines. To ensure continued compliance, the Administrator or designee will conduct audits of all allegations, injuries of unknown origin, abuse investigations, and reportable incidents on a weekly basis for three months. These audits will verify timely notification to the Administrator and Director of Nursing, timely reporting to the State Agency and any other required agencies, completion of investigations, submission of investigation findings within five working days, and appropriate documentation and follow-up actions. Audit results will be reviewed at the facility's QAPI Committee meetings for three months, and additional monitoring or corrective actions will be implemented as indicated. All corrective actions described in this Plan of Correction were completed by 7/27/26. The Administrator and Director of Nursing are responsible for implementation of and ongoing compliance with this Plan of Correction.</p> |                                              | 07/27/2026                 |

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |  |                                                                                                   |                                                                                                                          |                                              |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245638 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                      |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/27/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRAVERSE CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296 |                                                                                                                          |                                              |                            |
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| F0609<br>SS = D                                          | <p>Continued from page 2<br/>protocol/policy, and notifications to immediate supervisor, unit manager (UM), director of nursing (DON), social worker (SW), nursing home (NH) administrator, and complete paperwork per community protocol/policy. Revised: 9/2/22.</p> <p>Emergency Department (ED) note dated 7/19/26 at 9:54 a.m., identified emergency medical services (EMS) was told R1 had chest pain and she denied chest pain during evaluation. R1 was oriented to self and place but not time. R1 had noticeable and large bruises as well as hematoma on her left upper arm. When asked about this, R1 stated someone grabbed her when they came to help her to the bathroom last night. When asked why they grabbed her she stated that she must have been mad at me. R1 was unable to provide any information about this person, however confirmed that it was someone who came and checked on her frequently at that nursing home. Furthermore, R1 said that when she came into the room she got scared because she was such a snot. When asked several different ways, R1 continued to say that the injury on her arm was caused by another person and denied falls. Physical exam: skin – Significant bruising on left upper arm, appeared to be in patter of a hand gripping the skin tightly. Hematoma is present on upper inner left arm. Neurological: disoriented. Motor: weakness left arm unable to keep lifted against gravity. Clinical Impressions: Hematoma: adult physical abuse suspected. Assessment/Plan/Decision Making: hematoma and adult physical abuse suspected. X-rays negative for signs of fracture. Medical Decision Making: Contacted facility and spoke with lead registered nurse (RN)-A today. I did let her know my concerns for physical abuse based on appearance of bruising. She notes that she shared the same concern and had already reported this to administration and director of nursing (DON) at the care center. RN-A stated she will do her best to ensure that the staff that was on last night and taking care of the patient will not oversee her care today or this evening.</p> <p>ED notes by ED registered nurse (RN)-B dated 7/19/26 at 10:01 a.m., identified R1 arrived with significant bruising and swelling to arm. Per R1, she stated someone was helping her to the bathroom last night, had a temper and then told her to just get her arm checked out in the morning. Minnesota Adult Abuse Reporting Center (MAARC) report was filed. Clinical impressions: hematoma and adult physical abuse suspected. Pictures added to chart.</p> <p>Minnesota Adult Abuse Reporting (MAARC) report received on 7/19/26 at 12 :05 p.m., identified R1 was</p> |                                                                     |  | F0609                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| F0609<br>SS = D                                          | <p>Continued from page 3</p> <p>seen in ED on 7/19/26, for bruising on left upper arm. R1 had a large hematoma on the inside of her left upper arm and significant bruising on the back of the upper arm that extended onto the outer side that bruised in a pattern of hand gripping the arm with significant amount of force. Unable to hold up her left arm against gravity. R1 stated someone grabbed her arm last night when helping her to the bathroom but was unable to say who it was and must have made her mad, when she came into the room she got scared because she is such a snot. This statement was concerning as it means that some abuse may have happened before last night.</p> <p>MAARC report received on 7/19/26 at 12:30 p.m., identified R1 arrived at ED with complaints of left arm pain. Nursing home called to state there was some bruising and no injury reported that staff was aware of. R1 stated whoever put her to bed last night was helping her to the bathroom, had a temper, and was mad at her. R1 was oriented to self, place, situation, unable to tell year. Bruising pictured and added to chart. Marks lined up with how a hand would grab R1's arm with finger marks. R1 stated she disliked when this aid helps her because she must hate her job, she had a bad temper.</p> <p>R1's progress noted dated 7/19/26, through 7/24/26, identified:</p> <p>7/19/26 at 10:15 a.m., staff found two areas of purplish bruising on upper left arm, upper one larger with areas of swelling, lower one near elbow also had swelling. R1 complained of pain. Measurements obtained. Per director of nursing instructions R1 was sent via ambulance to local hospital for evaluation.</p> <p>7/19/26 at 10:55 a.m., R1 denied anyone being too rough with her during cares or any other time.</p> <p>7/19/26 at 11:52 a.m., reviewed with staff the current continued use/need for T-bars (upper side railing) while in bed due to recent bruising. Staff, nursing assistants (NA), charge nurse, trained medication administration assistant (TMA) reported yes, she utilized them appropriately and needed for repositioning. Will continue with current plan of care (POC) and monitor.</p> <p>During an observation on 7/23/26 at 11:10 a.m., NA-A assisted R1 out of bed and into a wheelchair. NA-A pushed R1 into the bathroom, transferred her to the toilet and removed her long-sleeved shirt, and completed cares. R1 complained of left arm pain when removed her shirt and stated oh be careful that right arm was sore. R1 had a dark purple solid</p> |                                                                  |  | F0609                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| F0609<br>SS = D                                          | <p>Continued from page 4</p> <p>bruise on the left upper arm from underneath her arm (a straight line) and lateral outer side of the arm down to her wrist area, and a lump/bump located on her left bicep approx. 3 inches in diameter and yellow discoloration that went from the lump to the crease of her arm. NA-A verified the bruise/color, and location. R1 stated to NA-A do you know what person grabbed my arm that lump really hurts and she thought someone may have grabbed her but unable to remember. NA-A stated no he did not and had not worked with/cared for R1 prior to the bruising.</p> <p>Interview on 7/23/26 at 1:20 p.m., trained medication assistant (TMA)-A stated he assisted R1 to the bathroom during the shift worked (7:00 am. to 7:30 p.m.) on 7/18/26 and did not see any bruises. TMA-A stated he worked the same hours on 7/19/26 and completed R1’s morning cares. TMA-A stated on the morning of 7/19/26, he removed R1's long-sleeved pajama top, noted dark solid purple bruising on R1's left arm around her bicep, and mostly the outer back side of her upper left arm. TMA-A stated he did not see finger marks on her arm. R1 had a golf ball sized lump located on her bicep, hard to touch, did not compress and caused slight pain according to R1. R1 was unable to identify what happened and it was reported to the day staff nurse, licensed practical nurse (LPN)-A, immediately.</p> <p>Interview on 7/24/26 at 1:34 p.m., the administrator approached surveyor and appeared upset. The administrator stated she was not informed by RN-A how bad R1's bruise was and the report was not filed with the state agency (SA). The administrator stated she was informed on 7/19/26 at 11:26 a.m., R1 had a bruise. The administrator figured R1 had taken a blood thinner twice a day and possibly hit her arm when going to bathroom, on the bar located on the wall. Staff were informed to use their judgement, send to ED if needed. The administrator was informed RN-A would start an investigation to see what was going on and did not feel the need to report this. The administrator stated that today (7/24/26) she looked at documentation in EPIC medical records system, the hospital reported and noted the facility nurse RN-A working shared with the hospital, concern of physical abuse based on the appearance of bruising. The administrator was not aware of RN-A's concerns. The administrator stated the expectation would have been RN-A should have expressed her concerns about possible abuse and the concern would have been reported right away. RN-A filled out the form/questionnaire for the abuse investigation and did not allude she had concerns</p> |                                                                     |  | F0609                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| F0609<br>SS = D                                          | <p>Continued from page 5</p> <p>about abuse. The administrator talked to RN-A on 7/23/26, RN-A did not express concerns about possible abuse nor had any of the staff express concerns about abuse. RN-A was a mandated reporter and if she had thought there was a possibility of abuse she would have been expected to report her concerns to the SA. The administrator stated she was appalled with this information she was made aware of today, it wasn't anything anyone should have taken lightly, ever. The administrator stated R1's bruise was of unknown origin and if staff, including the DON and assistant administrator, did not know what caused the bruise the administrator would have been expected a report was immediately filed with the SA. The administrator stated that when she spoke to the DON and the assistant administrator, they understood the bruise came from being bumped.</p> <p>Interview on 7/24/26 at 2:30 p.m., RN-A stated on 7/19/26, she was made aware of R1's bruise by LPN-A. At approximately at 9:45 a.m., RN-A assessed R1's left arm, asked R1 if anyone had been rough with her and R1 stated no. RN-A verified she observed R1's upper left arm had two areas of purplish bruising, one upper with large areas of swelling and lower one near the elbow also had swelling, R1 complained of pain, and measurements were taken. The DON and the administrator were notified at approximately 10:00 a.m. They were informed bruising was found and R1 complained of left arm pain. RN-A was not asked what caused the bruising during the call. At approximately 10:10 a.m., EMS arrived and transported R1 to the ED. RN-A stated she had no time to investigate the bruising prior to R1 being sent to the ED. RN-A stated she received a phone call from the ED medical doctor (MD), was asked if she was aware of R1's bruising. RN-A informed the MD she was aware. RN-A stated MD informed her she thought the bruises were associated with abuse, RN-A told MD she understood and MD stated as long as we are on the same page. The MD informed RN-A, the staff ED nurse and herself would file an adult abuse report. RN-A stated she understood what MD words conveyed and responded verbally to MD, she understood. RN-A stated there was potential for R1 to have fallen and/or self-transferred. RN-A stated she could not rule out abuse and was unable to identify what happened. RN-A stated she was not expected to call the police department, but thought if R1 was hurt, she would have. RN-A stated she had shared the ED MD concerns with the DON, the same day R1 was sent to ED. RN-A stated the MD asked about night shift and requested the same staff that worked the prior night not care for R1, she informed</p> |                                                                  |  | F0609                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| F0609<br>SS = D                                          | <p>Continued from page 6</p> <p>the MD that would be possible and she would make it happen. RN-A stated she relayed this information to LPN-A. LPN-A verbally responded she would let the evening nurse, LPN-B, know. RN-A stated she assumed it had been taken care of. RN-A stated she did not know if this was reported and probably should have followed up with the DON or the administrator. RN-A stated she did not report this bruise to the SA and should have immediately since it was unknown how R1 received it.</p> <p>Interview on 7/27/26 at 9:30 a.m., ED nurse (RN)-B stated R1 was initially sent to ED for chest pain, but did not have chest pain when she arrived to the ED. The facility staff called and stated she was sent in for bruises. R1’s left arm had deep purple bruising that appeared fresh with a large hematoma, three lines located on the outside/lateral backside of her left arm. RN-B stated she placed her hand on R1’s left upper arm with her fingers on the three lines located on the lateral side of the upper arm, wrapped her palm of her hand down and around the front of her upper arm. RN-B's thumb lined up with the hematoma located on the bicep. RN-B stated R1 had told her the staff that placed her in bed last night was a snot to her and informed R1 her arm would be fine, and she would have to get it checked out in the a.m. RN-B stated it had to be a hard/firm grab to break blood vessels, "it was a pretty deep purple for sure." RN-B stated she had been told by the MD, she talked to facility RN charge nurse and she thought it was abuse also.</p> <p>Interview on 7/28/26 at 12:45 p.m., NP-A stated if R1 was grabbed tightly, R1 would have bruised easily due to her being on Eliquis. R1 had a poor memory. NP-A was unsure if R1 would have been able to recall how her left arm was bruised. Staff would have been expected to follow the facility protocol/procedures regarding reporting.</p> <p>Interview on 7/27/26 at 11:02 a.m., LPN-B stated on 7/19/26, she assessed R1’s bruise on her left arm along with RN-A. R1’s bruise looked fresh, dark purple, with no yellow areas. The DON was notified by RN-A and sent R1 to the ED. LPN-B stated, "We did not know what caused the bruise. According to facility protocol, we should have reported to State Agency right away."</p> <p>Interview on 7/27/26 at 2:50 p.m., the DON stated she was informed on 7/19/26 at 8:20 a.m., a NA noticed a large bruise and a lump on R1’s left upper arm. There was no mention of what color it was or of suspected abuse. The DON told RN-A to send R1 to the ED for eval. The DON stated if she had</p> |                                                                     |  | F0609                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245638 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                      |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/27/2026 |                            |
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| F0609<br>SS = D                                          | <p>Continued from page 7</p> <p>suspected abuse, it would have been reportable within two hours. The DON stated RN-A informed her on 7/19/26, the ED nurse and the MD planned on filing a report with the state. The DON stated it was not reported because the provider and the nurse from the ED, both reported it. The DON stated she was informed by RN-A the area was a bruise. The DON was not made aware the ED MD had concerns of abuse. RN-A completed the questionnaire provided to each staff and indicated a bruise and nothing more.</p> <p>Facility abuse policy dated 5/16/26, identified it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled using technology i.e. social media. The facility will have written procedures to assist staff in identifying the different types of abuse. Possible indicators of abuse include, but are not limited to resident, staff, or family report of abuse, physical marks such as bruises or patterned appearance such as a handprint, belt, or ring mark on a resident's body, physical injury of a resident, of unknown source, and physical abuse of a resident observed. The facility will have written procedures that include reporting of all alleged violations to the administrator or designee, state agency, adult protection service and any other required agencies (i.e., law enforcement when applicable) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. The administrator or designee will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 days of the incident, as required by the state agencies.</p> |                                                                     |  | F0609                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| F0689<br>SS = D                                          | <p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure a call light was within reach for 1 of 3 residents (R5) who had severe cognitive impairment and was at high risk for falling, leaving the resident unable to summon assistance.</p> <p>Findings include:</p> <p>R5’s quarterly Minimum Data Set (MDS) dated 6/3/26, identified he was admitted to facility on 1/29/26 from an acute hospital setting. R5 had minimal difficulty hearing in some environments, did not wear hearing aids, wore glasses, and had severely impaired cognition. R5 used a walker and wheelchair for mobility. R5 required partial/moderate assistance with toilet transfer, substantial/maximal assistance with toileting hygiene and supervision or touching assistance to walk 10 to 150 feet. R5 was always incontinent of bladder and always continent of bowel. R5’s diagnoses included Alzheimer’s disease and non-Alzheimer’s dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick’s disease; and dementia related to stroke, Parkinson’s or Creutzfeldt-Jakob diseases), anxiety, and depression.</p> <p>R5’s care plan dated 2/5/26, identified:</p> <p>Potential for falls related to history of falling and diagnosis of syncope (fainting or passing out). A “Call Don’t Fall” sign was posted in R5's room. Staff were directed to position call light for easy access, reinforce need to use the call light to request assistance, use assistive devices such as walker, gait belt, and staff when walking, encourage proper footwear, check for unmet needs: pain, toileting, hunger, thirst and temperature, ensure</p> |                                                                  |  | F0689                                                                                             | <p>Upon identifying the deficiency, the call light for Resident R5 was repositioned immediately to ensure accessibility, with staff confirming that R5 could easily reach and use the call light. A facility-wide audit was conducted to identify any other residents with inaccessible call lights, and all identified issues were promptly corrected by repositioning call lights to ensure accessibility for all residents. Weekly audits were implemented for a three-month period to ensure compliance with call light accessibility, alongside data collection on accessibility issues, which is reviewed by the Quality Assurance Committee and quarterly by the QAPI committee to identify trends and areas for improvement. The Director of Nursing is responsible for overseeing the implementation of corrective actions. Immediate actions were completed on 7.27.26 and weekly audits commenced on 7.27.26. All care staff received training on the importance of call light accessibility and updated protocols during mandatory education held on 7.27.26. The QAPI committee will review them quarterly to assess the effectiveness of corrective actions. Adjustments to the plan are made as necessary to ensure ongoing compliance with call light accessibility requirements.</p> |                                              | 07/27/2026                 |

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| F0689<br>SS = D                                          | <p>Continued from page 9<br/>environment was free of clutter, and have commonly<br/>used articles within easy reach.</p> <p>Activities of Daily Living (ADL) deficit related to<br/>history of falls and balance issues and Alzheimer's<br/>disease. Staff were directed to use assist of one with<br/>gait belt and front wheeled walker 10 to 150 feet,<br/>provide supervision with transfers (sit to stand, chair<br/>to bed, and toilet), assist of one for personal<br/>hygiene, and supervision with toilet hygiene.</p> <p>R5's fall risk assessment dated 4/29/26 at 5:32<br/>p.m., indicated R5's fall risks included: history of<br/>falls; used ambulatory aids such as cane or walker;<br/>had impaired gait (difficulty raising from a chair,<br/>keeps head down when walking, watches the<br/>ground, grasps furniture, person or aid when<br/>ambulating, and cannot walk unassisted); and<br/>overestimates or forgets limits of his ability to<br/>ambulate safely. R5's fall risk score was 90 and<br/>determined to be at high risk (low risk 0-24,<br/>moderate risk 25-44, high risk 45 and higher).</p> <p>During an observation on 7/27/26 at 10:30 a.m., R5<br/>lay on top of his bed, television was on, eyes were<br/>closed, fully dressed, socks on his feet and shoes<br/>located on the floor. R5's wheelchair was located<br/>across room by the recliner (out of reach), regular<br/>call light button was draped over the left arm of the<br/>chair and an additional soft vinyl bulb design<br/>(required small amount of pressure to activate) call<br/>light was clipped up on the call light cord located on<br/>the wall across the room, both unreachable to R5<br/>from the bed.</p> <p>During an observation and interview on 7/27/26 at<br/>11:35 a.m., R5 lay awake on his back on the bed<br/>fully dressed, with socks on his feet. R5 stated he<br/>had a fall a few months ago, slid out of bed,<br/>bumped his head, did not have any serious injuries,<br/>and was unsure how it happened. R5 stated he had<br/>not fallen since. R5 stated he wanted to get up and<br/>looked around and commented, "I'm not sure how<br/>to get someone here to help me. I usually use the<br/>call light but I can't to find it right now." R5's call<br/>light was observed hung on the wall, out of R5's<br/>reach. R5 stated, "I could get myself up and into my<br/>wheelchair, but I'm not sure I'm supposed to do it<br/>on my own." R5 sat himself up on the edge of his<br/>bed and was encouraged to wait until staff arrived to<br/>assist him.</p> <p>During an interview and observation on 7/27/26 at<br/>11:41 a.m., nursing assistant (NA)-C knocked R5's<br/>door, entered R5's room and stated she stopped in</p> |                                                                  |  | F0689                                                                                             |                                                                                                                          |                                              | 07/27/2026                 |

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| F0689<br>SS = D                                          | <p>Continued from page 10</p> <p>to check on him. NA-C stated R5 usually used the call light to get assistance from staff and needed it close by to be able to reach it. NA-C stated staff made rounds and sometimes found him walking by himself and he should not be. NA-C unclipped the call light from the cord that hung from the wall and clipped it to R5's pillowcase. NA-C assisted R5 out of bed as he requested.</p> <p>During an interview on 7/27/26 at 1:55 p.m., NA-C stated R5 occasionally takes himself to the bathroom. Staff frequently remind him to use his call light. R5 liked to walk independently in his room and did not like the call light. Staff were expected to check on him every two hours, were responsible to assure R5 had his call light to prevent falling, and R5 was care planned to have call light. NA-C stated R5 had a “call don’t fall” sign in his room. When staff caught him in his bathroom alone, he joked around and stated he did not see the sign.</p> <p>During an interview on 7/27/26 at 2:50 p.m., the director of nursing (DON) stated R5 was at risk for falls and had one fall since admission. R5 attempted to self-transfer often, staff saw him ambulate independently and he should not. Staff would be expected to provide R5 a call light so that he can call if assistance was needed and would have helped prevent falls.</p> <p>Facility policy Call Lights: Accessibility and Timely Response Policy undated identified a call light should be provided to each resident’s bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to staff members or centralized locations to ensure appropriate response. All staff will be educated on the proper use of the residents’ call system, including how the system works and ensuring resident access to the call light. With each interaction in the resident’s room or bathroom, staff will ensure the call light is within reach of resident and secure, as needed.</p> |                                                                  |  | F0689                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              | 07/27/2026                 |
| F0880<br>SS = D                                          | <p>Infection Prevention &amp; Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | F0880                                                                                             | <p>R1's care was immediately reviewed upon identification of the deficient practice, and staff were re-educated regarding appropriate glove use. R1 was assessed and monitored for signs and symptoms of infection, and no adverse outcomes were identified. For R4, staff were immediately re-educated regarding Enhanced Barrier Precautions (EBP). R4 was assessed and monitored for signs and symptoms of infection in accordance with physician orders and facility protocol, with no adverse outcomes identified. To identify other residents who may have been affected, the DON completed audits</p> |                                              | 07/30/2026                 |

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| F0880<br>SS = D                                          | <p>Continued from page 11</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the</p> |                                                                  |  | F0880                                                                                             | <p>Continued from page 11</p> <p>of all residents requiring Enhanced Barrier Precautions. Any issues identified during the audit process were corrected immediately. To prevent recurrence, the facility implemented systemic corrective actions including re-education for all clinical staff regarding hand hygiene expectations, proper glove use and removal, required hand hygiene after glove removal, prevention of cross-contamination during resident care activities, proper cleaning and handling of urinary drainage equipment, and Enhanced Barrier Precaution requirements. Standards for urinary catheter care were reviewed and reinforced, including preventing contact between drainage spouts and collection containers or other contaminated surfaces, cleaning drainage ports according to policy, and utilizing proper collection and disposal techniques to minimize contamination risk. Enhanced monitoring of hand hygiene compliance was implemented through direct observation audits, immediate coaching when noncompliance is identified, and reinforcement during shift meetings and staff huddles. Additionally, the DON/Infection Preventionist, Care Coordinator, and ADON will conduct routine infection control rounds to monitor compliance with hand hygiene, PPE utilization, Enhanced Barrier Precautions, urinary catheter care practices, and standard infection prevention measures. To ensure continued compliance, the DON/Infection Preventionist and RN Education Coordinator will conduct weekly hand hygiene, Enhanced Barrier Precaution, and urinary catheter care observation audits for three months. These audits will verify proper hand hygiene before and after resident contact, hand hygiene following glove removal, appropriate glove and gown use, compliance with Enhanced Barrier Precaution requirements, proper urinary catheter drainage bag emptying techniques, and prevention of contamination during catheter care. Any concerns identified will be immediately addressed through counseling, re-education, and corrective action as appropriate. Audit findings and corrective actions will be reviewed by the QAPI Committee for a minimum of three months, with additional monitoring implemented if trends or concerns are identified. All corrective actions outlined in this Plan of Correction were completed by 7/30/26. The Administrator and Director of Nursing are responsible for implementation, monitoring, and ongoing compliance with this Plan of Correction.</p> |                                              | 07/30/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>TRAVERSE CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296 |                                                                                                                          |                                              |                            |
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| F0880<br>SS = D                                          | <p>Continued from page 12<br/>corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to ensure proper hand hygiene was used after removal of gloves for 1 of 3 residents (R1) during toileting and personal cares. Additionally, the facility failed to ensure appropriate personal protective equipment (PPE) recommendations were followed during a high contact care activity and failed to ensure proper was followed when emptying a urine collection bag for 1 of 1 resident (R4) who required enhanced barrier precautions (EBP).</p> <p>R1</p> <p>R1's quarterly Minimum Data Set (MDS) dated 6/10/26, identified severely impaired cognition with no behaviors. R1 had lower bilateral extremity range of motion (ROM) impairment and used a walker and wheelchair for mobility. R1 was frequently incontinent of bladder and occasionally incontinent of bowel. R1 required partial/moderate assistance with all transfers and was dependent upon staff for shower/bath and toileting. R1's diagnoses included non-Alzheimer's dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), anxiety, depression, and poor vision.</p> <p>R1's care plan dated 7/20/26, identified:</p> <p>Activities of daily living (ADLS) deficit related to current medical and physical status including depression and anxiety. Staff were directed to provide partial/moderate assistance with transfers, substantial/maximal assistance with personal hygiene, lower body dressing, extensive assistance with toileting, cleaning after elimination to ensure she was clean after each elimination,</p> |                                                                  |  | F0880                                                                                             |                                                                                                                          |                                              | 07/30/2026                 |

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| F0880<br>SS = D                                          | <p>Continued from page 13</p> <p>During an observation on 7/23/26 at 11:10 a.m., nursing assistant (NA)-A assisted R1 to the bathroom. NA-A placed a clean glove on his right hand only. R1 pulled herself up to stand using the bar located on the wall, NA-A pulled down her pants and brief. R1 lowered herself onto the toilet. NA-A removed the transfer belt, brief, pants from R1, placed clean pants and a brief up to R1's thighs. NA-A removed R1's long sleeved shirt, washed her upper body and dried with a towel, placed a clean long-sleeved sweater on, and applied gait belt. R1 voided into the toilet. R1 stood up and NA-A completed R1's personal hygiene his right hand, then pulled up the brief and R1's pants. NA-A held onto R1's waist band while she pivoted and lowered herself into the wheelchair. NA-A grabbed R1's hairbrush and brushed R1's hair with the dirty glove still on his right hand, picked up her glasses, placed them on her face with both hands, then bagged the dirty garbage, placed R1's dirty clothes in a pile, removed the glove from his right hand, and did not complete hand hygiene. NA-A pushed R1 out of the bathroom in the wheelchair, walked over to R1's bedside and made the bed. At 11:35 a.m., NA-A pushed R1, in her wheelchair out of her room, down the hallway, and into the lounge area. NA-A walked back to R1's room gathered R1's dirty clothing, a clear bag of garbage, exited the room, walked down the hallway, opened the soiled utility room door and dropped off clothing and garbage. NA-A immediately came back out to hallway and sanitized hands from a wall mounted sanitizer located across the hall.</p> <p>During interview on 7/23/26 at 2:18 p.m., NA-A stated he placed a clean glove on right only, the glove made his left hand slippery, it was hard to hold onto R1, and pull up her pants. NA-A stated he completed R1's cares, washed her upper body then after she was done on the toilet, wiped her front peri area and bottom with right hand. NA-A stated he left the glove on his right-hand, pulled up R1's clean brief and pants, and assisted her to the wheelchair. NA-A stated he kept the dirty right-hand glove on, combed R1's hair and was unsure when he removed the glove but should have removed it once R1 was safely back into the wheelchair. NA-A bagged the garbage and grabbed the dirty laundry once he returned to R1's room. NA-A stated it would have been important to wash his hands after he removed his gloves, before he touched the resident again, and before leaving R1's room to prevent the spread of germs/bacteria to help prevent infection.</p> <p>R4</p> |                                                                     |  | F0880                                                                                             |                                                                                                                          |                                              | 07/30/2026                 |

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| F0880<br>SS = D                                          | <p>Continued from page 14</p> <p>R4’s 5-day MDS (conducted between days one to eight after resident readmission to facility) dated 5/5/26, identified R4 had moderately impaired cognition, impaired bilateral lower extremities and required partial/moderate assistance for toilet transfers, was dependent for toileting hygiene, and used a manual wheelchair for mobility. R4 had an indwelling urinary catheter due to a neurogenic bladder (condition where nerve damage disrupts communication between the brain, spinal cord, and bladder. This leads to urinary control problems). R4 had a history of urinary tract infections (UTI), multidrug-resistant organism (MDRO) (a microbe that has developed the ability to withstand/resistant the effects of multiple antimicrobial drugs, such as antibiotics), and history of septicemia (a serious infection that starts somewhere in your body and spreads throughout the blood stream), and diabetes mellitus (DM). R4 was taking antibiotics, diuretics (pulls fluids to remove excess water and salt from the body), and insulin (7 days a week).</p> <p>Physician orders:</p> <p>Date ordered: 8/7/25, change 16 French Coude (a specialized urinary tube featuring a curved or bent tip used to navigate urethral blockages, strictures, or an enlarged prostate) one time a day every one month starting on 6th for one day related to flaccid neuropathic bladder.</p> <p>Provider office visit dated 4/20/26 at 2:00 p.m., identified Assessment/Plan: Urinary tract infection (UTI) due to urinary indwelling Foley catheter, sepsis due Escherichia coli, unspecified whether acute organ dysfunction present, and bacteremia due to Escherichia coli. Plan: finish antibiotic course, labs to follow, and strict catheter cares as he had urosepsis two times with the catheter being mode of transportation.</p> <p>R4’s care plan dated 4/22/26, identified:</p> <p>Risk for infection due to indwelling catheter. Staff were directed to educate R4 on infection control practices, encourage fluids, enhanced barrier precautions (EBP), evaluate urine characteristics, and manage indwelling catheter to minimize risk for infection.</p> <p>Complications with bladder related to diagnoses of flaccid neuropathic bladder and bladder retention. Staff were directed to follow EBP for indwelling catheter and observe for changes in color, consistency, frequency, order, discomfort, distention, fever, or confusion and review changes with medical</p> |                                                                  |  | F0880                                                                                             |                                                                                                                          |                                              | 07/30/2026                 |

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| F0880<br>SS = D                                          | <p>Continued from page 15<br/>doctor.</p> <p>During an observation on 7/23/26 at 10:03 a.m., a cart was located outside R4's room with PPE supplies. On the top of the cart was an EBP orange colored sign with two red stop signs on the top left and right hand sides of the sign with the following information: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person.</p> <p>During an observation on 7/23/26 at 3:27 p.m., trained medication assistant (TMA)-A brought R4 into his room, did not wash their hands and did not apply PPE before entering. TMA-A washed his hands, applied gloves, and grabbed the urine collection container. TMA-A exposed R4's urine collection leg bag and end of drainage tube, wiped off the end of the tube with an alcohol swab, opened the tube, then laid it inside the container. The drainage tube was touching the inside of the collection container. TMA-A opened the drainage tube and emptied the urine into the collection container. TMA-A closed drainage tube and wiped the end with an alcohol swab. TMA-A emptied the contents of the collection container into the toilet, rinsed container with tap water from the facet, and dumped it in the toilet. TMA-A placed the collection container upside down onto a towel on the bottom shelf in bathroom and removed gloves. TMA-A did not sanitize/wash hands. TMA-A pushed R4, in his wheelchair out of the room, stopped in front the PPE cart located in the hallway outside R4's room, and sanitized his hands. TMA-A did not apply a protection gown during this observation.</p> <p>Interview on 7/23/26 at 3:52 p.m., TMA-A verified R4 was on EBP due to his indwelling catheter. TMA-A stated staff were expected to wear PPE when R4's indwelling catheter was emptied and forgot to wear a gown but he should have, and usually did. TMA-A stated PPE was important to wear and was used to prevent infection being transferred to the resident(s) and staff.</p> <p>Interview on 7/24/26 at 2:44 p.m., TMA-B stated a resident is placed on EBP when they have an</p> |                                                                  |  | F0880                                                                                             |                                                                                                                          |                                              | 07/30/2026                 |

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| F0880<br>SS = D                                          | <p>Continued from page 16</p> <p>indwelling catheter to help prevent the spread of infection. Staff were expected to wear a gown and gloves when they worked with a urinary catheter to help with infection control. The gown and gloves were used to helped prevent splashes of urine from getting on a staff's hands and clothing. TMA-B stated gloves and good hand washing before and after emptying the urine collection bag helped avoid the transfer of germs from one person to another.</p> <p>Interview on 7/27/26 at 11:02 a.m., licensed practical nurse (LPN)-B stated staff would be expected to wear the proper PPE, including a gown and gloves when working with R4's urinary catheter. R4 has had a history of urinary tract infections (UTI), "We want to avoid the transfer of germs to prevent infection." LPN-B stated the tip of the catheter, where the urine was drained from the collection bag, should not touch the inside of collection container to avoid bacteria from getting on it, contamination, and can possibly cause an infection such as UTI.</p> <p>Interview on 7/27/36 at 1:55 p.m., NA-C stated R4's indwelling urinary catheter needed to be emptied frequently. Staff were expected to wear PPE (gown and gloves) when indwelling catheter cares and emptying were completed to avoid splashes of urine on their clothes and prevent the spread of infection. NA-C stated staff were expected to wipe off the end of the catheter bag tubing with an alcohol swab and avoid the catheter from touching the inside of the collection container to avoid infection.</p> <p>Interview on 7/27/26 at 2:50 p.m., the director of nursing (DON) stated R4 had an indwelling urinary catheter with a history UTIs and was placed on EBP due to facility policy and guidelines from center of disease and control (CDC). Staff would be expected to wear PPE while working with R4's catheter to avoid contamination, transmission/spread of the multidrug-resistant organism (MDRO) to other residents and staff. DON stated it would be concerning if the end of the urinary catheter drain tube was placed into the collection container without being held onto and could have caused contamination, infection, and increased R4's risk for a UTI. Staff were expected to use good hand hygiene once they completed peri cares, removed gloves, and sanitize/wash hands to prevent infections.</p> <p>Facility policy Enhanced Barrier Precautions (EBP) dated 2024, identified the EBP along with contact precautions will be implemented during high-contact resident care activities when caring for residents that have increased risk of acquiring a multidrug-resistant organism (MDRO) such as a</p> |                                                                     |  | F0880                                                                                             |                                                                                                                          |                                              | 07/30/2026                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245638 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                      |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/27/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRAVERSE CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296 |                                                                                                                          |                                              |                            |
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| F0880<br>SS = D                                          | <p>Continued from page 17</p> <p>resident with wounds, indwelling medical devices or residents with “infection or colonization with an MDRO.” Definition of EBP was identified as to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP is intended for nursing homes to prevent the spread of novel or targeted MDROs when residents have an infection or colonization with a MDRO or if the resident has a wound or indwelling medical device, regardless of MDRO infection or colonization. When a resident contracts an MDRO, treatment is often limited. The purpose of EBP was to prevent opportunities for transfer of MDROs to employees’ hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or bodily fluids. Clear signage would be expected to be posted outside the resident’s door/wall of their room and an isolation cart with PPE equipment immediately outside the resident room. PPE equipment was required for all staff providing high-contact resident care activities to include device care or use: central line, urinary catheter, feeding tube, and tracheostomy/ventilator.</p> <p>Facility policy Infection Prevention and Control Manual – Standard Precautions/Gloves dated 2024, identified it was the policy of this facility to don (put on) clean non-sterile gloves in accordance with Standard and transmission-based precautions (TBP) (i.e., when anticipating touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin or when a resident was in TBP). Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Perform hand hygiene after the removal of gloves, it is always possible that gloves have tiny leaks.</p> |                                                                     |  | F0880                                                                                             |                                                                                                                          |                                              | 07/30/2026                 |

Minnesota Department of Health

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| 20000                                                    | <div>Initial Comments</div> <div>*****ATTENTION*****</div> <div>NH LICENSING CORRECTION ORDER</div> <div>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.</div> <div>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.</div> <div>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.</div> <div>INITIAL COMMENTS:</div> <div>On 7/23/26, 7/24/26, and 7/27/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</div> <div>The following complaints were reviewed:<br/>H56383425C (3105215, 3105045), H56381214C (2979516) with a licensing order issued at 0830.</div> |                                                    |  | 20000                                                                                             |                                                                                                                          |                                              | 09/02/2026                 |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 20000                                                    | Continued from page 1<br><br>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.<br><br>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 The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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. | 20000                                              |                                                                                                                          | 09/02/2026                                   |  |
| 20830                                                    | Adequate and Proper Nursing Care; General<br><br>CFR(s): MN Rule 4658.0520 Subp. 1<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 20830                                              | corrected.                                                                                                               | 08/18/2026                                   |  |

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| 20830                                                    | <p>Continued from page 2</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure a call light was within reach for 1 of 3 residents (R5) who had severe cognitive impairment and was at high risk for falling, leaving the resident unable to summon assistance.</p> <p>Findings include:</p> <p>R5's quarterly Minimum Data Set (MDS) dated 6/3/26, identified he was admitted to facility on 1/29/26 from an acute hospital setting. R5 had minimal difficulty hearing in some environments, did not wear hearing aids, wore glasses, and had severely impaired cognition. R5 used a walker and wheelchair for mobility. R5 required partial/moderate assistance with toilet transfer, substantial/maximal assistance with toileting hygiene and supervision or touching assistance to walk 10 to 150 feet. R5 was always incontinent of bladder and always continent of bowel. R5's diagnoses included Alzheimer's disease and non-Alzheimer's dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), anxiety, and depression.</p> <p>R5's care plan dated 2/5/26, identified:</p> <p>Potential for falls related to history of falling and diagnosis of syncope (fainting or passing out). A "Call Don't Fall" sign was posted in R5's room. Staff were directed to position call light for easy access, reinforce need to use the call light to request assistance, use assistive devices such as walker, gait belt, and staff when walking, encourage proper footwear, check for unmet needs: pain, toileting, hunger, thirst and temperature, ensure environment was free of clutter, and have commonly used articles within easy reach.</p> <p>Activities of Daily Living (ADL) deficit related to history of falls and balance issues and Alzheimer's disease. Staff were directed to use assist of one with gait belt and front wheeled walker 10 to 150 feet, provide supervision with transfers (sit to stand, chair to bed, and toilet), assist of one for personal hygiene, and supervision with toilet hygiene.</p> <p>R5's fall risk assessment dated 4/29/26 at 5:32 p.m., indicated R5's fall risks included: history of</p> |                                                    |  | 20830                                                                                             |                                                                                                                          |                                              | 08/18/2026                 |

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| 20830                                                    | <p>Continued from page 3</p> <p>falls; used ambulatory aids such as cane or walker; had impaired gait (difficulty raising from a chair, keeps head down when walking, watches the ground, grasps furniture, person or aid when ambulating, and cannot walk unassisted); and overestimates or forgets limits of his ability to ambulate safely. R5’s fall risk score was 90 and determined to be at high risk (low risk 0-24, moderate risk 25-44, high risk 45 and higher).</p> <p>During an observation on 7/27/26 at 10:30 a.m., R5 lay on top of his bed, television was on, eyes were closed, fully dressed, socks on his feet and shoes located on the floor. R5’s wheelchair was located across room by the recliner (out of reach), regular call light button was draped over the left arm of the chair and an additional soft vinyl bulb design (required small amount of pressure to activate) call light was clipped up on the call light cord located on the wall across the room, both unreachable to R5 from the bed.</p> <p>During an observation and interview on 7/27/26 at 11:35 a.m., R5 lay awake on his back on the bed fully dressed, with socks on his feet. R5 stated he had a fall a few months ago, slid out of bed, bumped his head, did not have any serious injuries, and was unsure how it happened. R5 stated he had not fallen since. R5 stated he wanted to get up and looked around and commented, "I'm not sure how to get someone here to help me. I usually use the call light but I can't to find it right now." R5's call light was observed hung on the wall, out of R5's reach. R5 stated, "I could get myself up and into my wheelchair, but I'm not sure I'm supposed to do it on my own." R5 sat himself up on the edge of his bed and was encouraged to wait until staff arrived to assist him.</p> <p>During an interview and observation on 7/27/26 at 11:41 a.m., nursing assistant (NA)-C knocked R5's door, entered R5’s room and stated she stopped in to check on him. NA-C stated R5 usually used the call light to get assistance from staff and needed it close by to be able to reach it. NA-C stated staff made rounds and sometimes found him walking by himself and he should not be. NA-C unclipped the call light from the cord that hung from the wall and clipped it to R5's pillowcase. NA-C assisted R5 out of bed as he requested.</p> <p>During an interview on 7/27/26 at 1:55 p.m., NA-C stated R5 occasionally takes himself to the bathroom. Staff frequently remind him to use his call light. R5 liked to walk independently in his room and</p> |                                                    |  | 20830                                                                                             |                                                                                                                          |                                              | 08/18/2026                 |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                          |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/27/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRAVERSE CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                    |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296 |                                                                                                                          |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                    |  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                              | (X5)<br>COMPLETION<br>DATE |
| 20830                                                    | <p>Continued from page 4</p> <p>did not like the call light. Staff were expected to check on him every two hours, were responsible to assure R5 had his call light to prevent falling, and R5 was care planned to have call light. NA-C stated R5 had a “call don’t fall” sign in his room. When staff caught him in his bathroom alone, he joked around and stated he did not see the sign.</p> <p>During an interview on 7/27/26 at 2:50 p.m., the director of nursing (DON) stated R5 was at risk for falls and had one fall since admission. R5 attempted to self-transfer often, staff saw him ambulate independently and he should not. Staff would be expected to provide R5 a call light so that he can call if assistance was needed and would have helped prevent falls.</p> <p>Facility policy Call Lights: Accessibility and Timely Response Policy undated identified a call light should be provided to each resident’s bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to staff members or centralized locations to ensure appropriate response. All staff will be educated on the proper use of the residents’ call system, including how the system works and ensuring resident access to the call light. With each interaction in the resident’s room or bathroom, staff will ensure the call light is within reach of resident and secure, as needed.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for call lights. Nursing staff could be educated as necessary to the importance of call light accessibility for all residents. The DON or designee could audit any/all residents with call light concerns that have interventions in place. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> |                                                    |  | 20830                                                                                             |                                                                                                                          |                                              | 08/18/2026                 |