DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 7, 2025

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

RE: CCN: 245638
Cycle Start Date: May 29, 2025

Dear Administrator:

On June 30, 2025, the Minnesota Department of Health 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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2025

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

RE: CCN: 245638
Cycle Start Date: May 29, 2025

Dear Administrator:

On May 29, 2025, 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:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 29, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 29, 2025 (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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

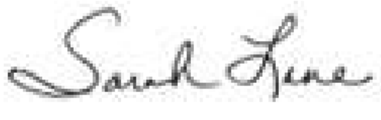
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 12, 2025

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

Re: Event ID: VL4L11

Dear Administrator:

The above facility survey was completed on May 29, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00669N	A. BUILDING: _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/28/25 through 5/29/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00669N	A. BUILDING: _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 H56385528C (MN00113325). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/28/25 and 5/29/25, 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. The following complaint was reviewed: H56385528C (MN00113325) As a result of the investigation, a deficiency was cited at F635. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure hospital physician's discharge orders for a follow-up appointment with urology	F 635	5 1. Deficiency Identification Deficiency Citation: F635	6/20/25

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

Electronically Signed | 06/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 635	Continued From page 1 was scheduled upon admission from hospital and completed for all necessary care for Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/19/25, identified he re-entered facility on 12/15/24, from a critical access hospital. He had severely impaired cognition, no behaviors, impaired mobility, and required substantial/maximum assistance with bathe/shower, all transfers, upper body dressing, roll left and right, sit to lying, lying to sit, and sit to stand. R1 was dependent for toileting and personal hygiene, and unable to ambulate. He had an indwelling urinary catheter and frequently incontinent of bowel. Diagnoses included neurogenic bladder (nerves that control the bladder are damaged leading to loss of bladder control that can result in urinary incontinence, difficulty emptying the bladder or other urinary problems), renal failure diabetes mellitus (DM), anxiety, and depression. He received antiplatelet (prevents blood clots from forming and inhibits the action of platelets) from medication seven out of seven days. R1's progress notes from 12/8/24 through 12/15/24, identified: -12/9/25 at 10:22 p.m. resident is alert and oriented able to make some of his need known. Resident bladder scan 481 ml. Straight catheterized output was 1000 ml with lots of sediment. -12/10/24 at 2:22 p.m. at 11:50 a.m. was with therapy and t-shirt was soaking wet, clammy, neck and back pain. Temperature 98.2, respirations 40, pulse 91, and oxygen saturation	F 635	Regulation/Standard Not Met: The facility failed to ensure that hospital physician's discharge orders for a follow-up appointment with urology were scheduled upon admission from the hospital and completed for all necessary care. 2. Corrective Action for Residents Affected • Immediate Actions Taken: 1. Conducted an immediate review of R1's medical records to verify the oversight in scheduling the urology follow-up. 2. Coordinated with the urology department to secure an expedited appointment for R1. 3. Communicated the appointment details to R1 and their family, ensuring they are informed and prepared. 4. Arranged necessary transportation and support for R1 to attend the appointment. 3. Corrective Action for Other Residents • Identification and Protection Measures: 1. Initiated a facility-wide audit of all residents admitted from the hospital in the past 30 days to identify any other missed follow-up appointments. 2. Scheduled any outstanding appointments and communicated these to the residents and their families. 3. Established a temporary oversight team to ensure all follow-up appointments are tracked and confirmed. 4. Systemic Changes • Policy Updates: 1. Updated the admission policy to include a mandatory verification step for all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 635	Continued From page 2 (SaO2) 94 %, blood pressure 70/40 . . . left with ambulance at 12:30 p.m. -12/10/24 at 2:22 p.m. called hospital for report. Almost septic per nurse, had a urinary tract infection (UTI). -12/15/24 at 11:05 a.m. returned from hospital via ambulance with a foley catheter in place. R1's Hospital Discharge Summary dated 12/15/24 at 8:58 a.m. identified discharge instructions: -Continue Augmentin 875/125 milligrams (mg) two times a day (BID) times 5 days (starter pack sent with, prescription (Rx) to pharmacy). -Continue Flagyl 500 mg three times a day (TID) (starter pack sent with, Rx to pharmacy). -Urine retention/cystitis (inflammation of the bladder usually caused by a UTI). Foley placed and remained in place until follow-up with urology. Change every four weeks. Foley catheter cares. -Follow-up with PCP on Wednesday 12/18/24, 10:00 a.m. with nurse practitioner (NP). R1's hospital follow- up appointment with physician assistant (PA)-A on 12/18/24, identified he had been admitted to hospital with hypotension secondary sepsis secondary to colitis (inflammation of the large intestine (colon), which can lead to inflammation of the large intestine causing diarrhea, abdominal pain and bloody stools), urinary retention, UTI, and rectal stool ball compaction. Foley was in and continued to down drain. This was expectedly a more chronic duration now while we stabilize his bowel regimen and improved constipation. R1's order dated 12/4/24, straight catheterization if amount is greater than 300 ml with bladder scan. Discontinued 12/15/24.	F 635	follow-up appointments as per discharge orders. • Process Changes: 1. Implemented a standardized checklist for nursing staff to complete within 24 hours of a resident's admission, ensuring all follow-up appointments are scheduled. • New Protocols: 1. Developed a digital tracking system integrated with the facility's electronic health records to monitor and confirm all follow-up appointments. 5. Monitoring and Quality Assurance • Monitoring Methods: 1. Conduct bi-weekly audits of new admissions to ensure compliance with the updated scheduling process. 2. Utilize the digital tracking system to generate reports on the status of follow□up appointments. • Quality Assurance Activities: 1. Hold monthly quality assurance meetings to review audit results and address any issues. 6. Responsible Parties • Implementation and Compliance: 1. The Director of Nursing (DON) will oversee the implementation of corrective actions and ensure compliance. 2. The Admissions Coordinator will be responsible for verifying the scheduling and documentation of all follow-up appointments. 7. Timelines • Deadlines: 1. Immediate corrective actions for affected residents: Completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 635	Continued From page 3 R1's order dated 12/5/24, post void bladder scan BID. Discontinued end date 12/15/24. R1's order dated 12/16/24, Foley catheter to remain in until follow-up with urology. Order discontinued on 12/26/24. R1's order revision date 2/26/25, 16 French catheter, 10 milliliter (ml) balloon. Foley Catheter to remain in until follow-up with urology, discontinued/end date 4/23/25. Review of R1's medical records did not identify a follow-up appointment with urology was scheduled and/or completed as ordered on 12/15/24. R1's progress noted from 5/17/25 through 5/19/24, identified: -5/17/25 at 2:15 p.m., no urine noted from Foley catheter since early a.m. irrigation not successful. Catheter changed . . . -5/19/25 at 1:00 p.m., resident taken to the bathroom and had some bleeding at catheter insertion site, tubing noted to be taught. Had urine flow . 5/19/25 at 2:11 p.m., urine output concentrated, dark amber, very cloudy . . . 5/19/25 at 4:20 p.m., No urine output in catheter bag . . . bladder scanned 165 ml . . flushed with 30 ml of normal saline. No urine output . . attempted to deflate balloon, no saline was obtained when attached . . . since no saline was obtained from catheter balloon foley catheter was pulled. Balloon noted to be flat and resident had a large amount of red blood from penis. Bleeding slowed down after two to three minutes . . . daughter requested he be sent to emergency room (ER) . . . Ambulance arrived and taken to local ER. -5/19/25 at 10:22 p.m., ER called to update on	F 635	06/20/2025. 2. Systemic changes and policy updates: Implemented by 06/20/2025. 3. Initial staff training: Completed by 06/27/2025. 8. Training and Education • Staff Training Plans: 1. Conduct comprehensive training sessions for all nursing and administrative staff on the new admission and follow-up appointment protocols. 2. Distribute educational materials to reinforce the importance of adhering to discharge orders. 9. Documentation • Record Maintenance: 1. Maintain comprehensive records of all corrective actions, including appointment schedules, audit results, and training attendance. 2. Ensure documentation is organized and accessible for review by regulatory bodies. 10. Follow-Up Plan • Assessment of Effectiveness: 1. Schedule follow-up audits at 30, 60, and 90 days post-implementation to evaluate the effectiveness of corrective actions. 2. Adjust processes and training as necessary based on audit findings to ensure ongoing compliance. By implementing these corrective actions, the facility aims to address the identified deficiency and prevent future occurrences, ensuring compliance with CMS regulations and standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 635	Continued From page 4 resident status. Was admitted for catheter complications and UTI. Will stay in hospital at least two days. R1's hospital discharge instructions dated 5/22/25 at 7:55 a.m., UTI resolved, catheter care; there is a fissure (also known as penile erosion a tear or split in the skin and/or urethra caused by prolonged pressure or friction from the catheter) that had formed on the right inferior aspect of the glans, this was from the catheter. Had been updated the catheter was not correctly removed, caused trauma during removal on 5/19/25, and resulted in the ER visit. Daily dressing changes and as needed (PRN). Paint with betadine and place gauze over the area. Switch catheter bag to the left leg. Be sure the catheter is not pulling. If issues with catheter, please contact provider, do not change without contacting provider first. Urology referral .... will contact daughter to schedule. Discussed the possibility of need for a supra-public catheter. R1's care plan reviewed on 5/28/25, identified bladder complications and risk for infection related to indwelling urinary catheter due to flaccid neuropathic bladder. Staff were directed to complete catheter cares a.m. and bedtime (HS), switch night bag to leg bag in a.m. and back to night bag at HS and observe for changes in urine color, consistency, frequency, odor, discomfort, distention, fever, or confusion, review changes with MD, and Foley catheter in place until urology addresses. During an interview on 5/29/25 at 8:30 a.m., physician assistant (PA)-A stated she had examined R1 when he arrived at the hospital on 5/19/25. The fissure identified was not new,	F 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 635	Continued From page 5 located on the right bottom side of the glans penis bleeding and the ABD (abdominal) dressing was saturated with red blood. She inserted another urinary catheter without resistance, moved the catheter tubing to the other side and the bleeding slowed down. He did not see urology at the hospital (was not offered locally) or prior to coming to the hospital. The catheter was changed three times in the beginning of the month at the facility due to not working most likely from constipation. When R1 was discharged from hospital she placed a referral to be seen by the urologist for a possible supra-public (a urinary catheter inserted in the bladder through a small incision in the lower abdomen to drain urine) catheter to be placed. During an interview on 5/29/25 at 9:21 a.m., family member (FM)-A stated she was concerned about everything that happened with his catheter prior to going to the hospital. FM-A was unaware if he was seen by a urologist and unsure if he had seen one and may have been a good idea. During an interview on 5/29/25 at 9:45 a.m., registered nurse (RN)-A stated R1 may have been scheduled to see a urologist. Facility staff did not have easy access to when the appointments were scheduled, the type of calendar had just changed. She had not seen anything in his electronic medical record and not all appointments were documented. During an interview on 5/29/25 at 10:15 a.m., FM-B stated R1 needed a urology consult. Unsure if he had seen the urologist after his last hospitalization in December 2024. We relied on the facility to have scheduled the appointments and then let family know so we could have	F 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245638	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 635	Continued From page 6 attended with him. During an interview on 5/29/25 at 12:41 p.m., assistant director of nursing (ADON) stated last time R1 had seen a urologist was 2012. He had not been scheduled for an appointment after the December 2024 hospitalization. We did not follow up with urology and it would have been important to see what was going on with his urine and bladder. His medication may have need to be changed, could have been due to constipation, or bladder muscles not working. During an interview on 5/29/25 at 2:15 p.m., director of nursing (DON) stated R1 has had urinary retention since October 2024 with a trial removal of the indwelling urinary catheter, bladder scans, then had to reinsert it in December 2024. DON indicated R1 was not seen by urology after his readmission to the facility after his hospital stay December 2024, "not sure what happened, we dropped the ball." For this circumstance the facility should have followed up with the family and made sure the appointment was scheduled with urology so that he would had received he best care possible, without complications regarding the catheter and constipation, adding placement of a supra pubic catheter would have possibly made a difference. Unable to interview NP-B and medical doctor (MD), both out of office until 6/3/25. Requested facility order/follow-up policy and was not received.	F 635		