Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 10, 2026

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

RE: CCN: 245638
Cycle Start Date: September 24, 2026

Dear Administrator:

On October 27, 2026, we notified you a remedy was imposed. On November 11, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 30, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 11, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 27, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 30, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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

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October 27, 2026

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

RE: CCN: 245638
Cycle Start Date: September 24, 2026

Dear Administrator:

On September 24, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 11, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 11, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 11, 2026.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 11, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, TRAVERSE CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Tina Larsen, Regional Operations Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us

Office: (320) 223-7374 Mobile: (320) 423-0619

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 24, 2027, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

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October 27, 2026

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

Re: Event ID: 3C5596-H1

Dear Administrator:

The above facility survey was completed on September 24, 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 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245638	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 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
F0000	INITIAL COMMENTS On 9/22/26 through 9/24/26, 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. The following complaints were reviewed: H56384294C (3207221 and 3207375) with a citation at F684. 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.	F0000		10/30/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure diabetic ulcers were routinely monitored and comprehensively assessed on an	F0684	1. Corrective Action for Resident Affected by Deficient Practice Resident R1 was discharged from the facility on 9/14/26. Prior to survey completion, the facility reviewed the resident's medical record and confirmed the resident had received follow-up medical evaluation, wound debridement, and antibiotic treatment through outside providers following discharge. The facility conducted a comprehensive review of R1's wound management records to identify opportunities for improvement regarding weekly wound assessments and measurements, documentation of wound characteristics, consistent completion and documentation of treatments, timely provider notification for significant changes in wound condition, and coordination and communication with hospice and medical providers.	10/30/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245638	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0684 SS = G	Continued from page 1 ongoing basis to ensure healing and prevent complication; failed to ensure consistent treatments were completed to promote healing of the ulcers; and failed to ensure worsening ulcer characteristics suggestive of infection were promptly communicated to the provider to ensure evaluation for 1 of 3 residents (R1) reviewed. R1 admitted with several diabetic ulcers on their lower extremities, including a left ankle ulcer that developed after admission, which did not have ongoing evaluations (i.e., weekly characteristics) recorded and did not have consistent treatments being done to promote healing. The left ankle ulcer subsequently worsened and developed infection which needed intravenous (IV) medications and debridement. This constituted actual harm for R1. R1's admission Minimum Data Set (MDS), dated 8/18/26, identified R1 was cognitively intact. Overall, R1 was independent with mobility and activities of daily living and was free of behaviors and/or rejection of care. The MDS identified R1 was checked for "Diabetic foot ulcer(s)," and application of dressings to the feet and application of nonsurgical dressings on other parts of the body. R1's Diagnoses List included chronic kidney disease, chronic heart failure, peripheral vascular disease, type 2 diabetes with diabetic polyneuropathy (can cause loss of sensation to legs and feet) and non-pressure chronic ulcer of left heel. R1's Admission Assessment dated 8/12/26, identified a left heel wound that measured 2 centimeters (cm) by (x) 1.5 cm with a depth of 0.25 cm and a wound bed of 70% epithelial tissue (thin, light pink or pearl white new skin often covering healthy granulation tissue) and 30% granulation tissue (pink-red moist tissue that fills an open wound when it starts to heal). The assessment also identified a right lateral ankle wound that measured 3 cm x 3.5 cm with a depth of 0.2 cm with a wound bed of 50% epithelial tissue and 50% granulation tissue. R1's Care Plan dated 8/12/26, identified an actual or potential for complications with impaired skin integrity related to diabetic foot ulcers, skin tears, incontinence, fragile skin, and neuropathy with venous stasis chronic ulcer. Interventions included: incontinence care with incontinent brief changes, observe skin with cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader, weekly skin check, Lotion to dry skin, review skin concerns with	F0684	Continued from page 1 The findings were incorporated into the facility's corrective action and education plan. 2. How Other Residents Having the Potential to be Affected Will Be Identified and Corrected By 10.30.26, the Director of Nursing or designee will complete a facility-wide skin assessment audit of all current residents in the facility including those that have a current wound, ulcer, skin alteration, or surgical incision, that receive wound treatment orders, and that are receiving hospice services with facility-managed wound care. The audit will verify physician/provider orders are current and accurately reflected on the MAR/TAR; wound assessments include measurements, wound-bed description, drainage, odor, surrounding tissue assessment, and signs/symptoms of infection; weekly wound assessments are completed and documented; treatments are completed as ordered and properly documented; any identified changes in wound condition have been communicated to the provider and documented; and appropriate follow-up occurs when provider responses are delayed. Any deficient findings will be immediately corrected, including obtaining new provider orders, completing overdue assessments, revising treatment plans, and updating care plans as indicated. 3. Systemic Changes to Prevent Recurrence The facility has implemented education on the standardized wound assessment process which requires initial comprehensive wound assessment upon identification of any new wound; weekly wound assessments until healed; and documentation of location, measurements (length, width, depth when applicable), tissue type, drainage, odor-If applicable, peri wound condition, pain, and signs/symptoms of infection. Weekly wound measurements will be documented on the designated wound assessment tool and reviewed by the DON or designee. Nursing staff will document completion of all wound treatments on the TAR/MAR according to facility policy. Any treatment not completed will include documentation of the reason and any follow-up action taken. The DON or designee will review new wound treatment orders to ensure interventions are transcribed accurately, frequency is appropriate, and monitoring requirements are included.	10/30/2026

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F0684 SS = G	Continued from page 2 medical doctor, pressure reduction cushion to wheelchair and pressure reduction mattress to bed. R1's Skin/Wound note dated 8/13/26, identified a diabetic foot ulcer on the left heel described as "open sore 2 x 1.5" and a diabetic foot ulcer on right lateral ankle. The note lacked any additional description of the left heel and lacked any other details related to the ankle wound. R1's Treatment Administration Record (TAR), August 2026, directed application of an "Allevyn" dressing three times a week (Tuesday, Thursday, Saturday) to the right medial ankle, starting on 8/14/26. The TAR identified that on 8/27/26 the viewer was directed to see R1's nursing notes by a coded "9", and that 8/29/26's treatment validation box was blank. Additionally, on 8/15/26, the TAR directed application of Iodine, gauze, and Kerlix to the left plantar foot diabetic ulcer which was to be completed every other day. The TAR identified that on 8/16/26, the viewer was directed to see R1's nursing notes by a coded "9," and the treatment validation box for 8/21/26, 8/23/26, and 8/26/26 were blank. The TAR lacked directives to monitor the areas for improvements or deteriorations, nor did the TAR direct staff to comprehensively assess the wounds routinely. R1's Orders – Administration Notes identified the following: -8/16/26, at 10:03 a.m., R1 was out on pass. -8/27/26 at 3:05 p.m., R1 was out of the facility for an outing and thus the dressing/treatment was unable to be completed. R1's Weekly Skin Check Tool dated 8/17/26, identified "Existing (healing)" skin impairments; however, no detailed information was documented. R1's Long Term Care Evaluation note dated 8/17/26, identified there had been skin changed since the last assessment and indicated the presence of a right lateral ankle wound and a left heel "pressure / injury." The note lacked evidence of wound description(s) or measurements (s) to support these two wounds were comprehensively assessed. R1's Weekly Skin Check Tool dated 8/24/26, indicated two diabetic ulcers were "dressed" after the bath. The assessment identified the right ankle wound was scabbed over and measured 1.5 cm x 0.5	F0684	Continued from page 2 A wound change notification protocol has been implemented requiring immediate notification of the provider and/or hospice nurse when increased drainage is observed; green, yellow, or purulent drainage is present; foul odor is present; redness, warmth, swelling, or pain increases; wound measurements worsen; and/or measurable healing progress is identified. Nursing staff will document date and time of provider notification, clinical information communicated, orders or recommendations received, and follow-up actions taken. If no provider response is received within the expected timeframe and the resident demonstrates signs of infection or deterioration, nursing staff will escalate concerns through the chain of command until medical direction is obtained. Education The DON or designee will educate all nursing staff licensed nurses 10/30/26, by current staff roster, and any newly hired staff and seasonal staff to be educated prior to start of next shift. The education will include the skin assessment policy, wound treatment management policy, comprehensive wound assessment documentation, treatment documentation requirements, provider including hospice notification expectations, and recognition of signs and symptoms of wound infection, including new or worsening. 4. Monitoring to Ensure Ongoing Compliance The DON or designee will conduct an audit that reviews all residents with wounds for a weekly wound assessment, complete wound measurements and descriptions, timely provider/hospice notification for significant wound changes, and treatment completion and documentation. Audits will occur weekly for 8 weeks. Then monthly up until next QAPI meeting and reviewed at QAPI for continuation. DON or designee will complete and review audit findings, with additional follow-up if needed. 5. Completion Date 10.30.26	10/30/2026

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F0684 SS = G	Continued from page 3 cm with no drainage, redness or swelling. The tool did not identify a wound to the left heel; however, an 8/24/26 Orders – Administration Note, directed the left heel to have Iodine, gauze, and Kerlix treatment every other day. R1's provider Nursing Home Rounds visit note dated 8/25/26 identified an active problem of diabetic ulcer of left heel associated with type 2 diabetes myelitis, with necrosis of bone which indicated the provider reviewed these problems, and they were up to date. The physical exam section lacked skin concerns in which skin was warm and dry and free from jaundice. The note lacked any additional skin/wound related information. R1's Hospice Physician Order, dated 8/31/26, directed facility nursing was to complete wound care to feet ulcers and hospice was to monitor. R1's Weekly Skin Check Tool dated 9/1/26, identified "Existing (healing)" skin impairments were noted in which "4 skin issues on lower legs addressed today." The "right" heel was measured 1.8 cm x 0.8 cm with yellow/gray base and a new "left lateral lower leg" ulcer measured 1.6 cm x 1.6 cm. The tool identified "bottom of heel: callous-drying out-better than last time seen-used provolone iodine on it." The tool lacked specific information related to the prior right ankle ulcer. The tool indicated hospice was contacted and was ok with using hydrocolloid dressing (a wound dressing that absorbs fluid with a waterproof outer layer that blocks bacteria) to be left in place for 5-7 days. The tool lacked evidence of wound descriptions for the lower leg wound and heel wound, or measurements for the heel, to support the wounds were comprehensively assessed. R1's Weekly Skin Check Tool dated 9/7/26, identified a diabetic ulcer to outer left ankle "wound to [left lower extremity]. Wound care [treatment] in place." The tool lacked measurements or a description of the wound. The tool indicated the bottom of heel was "drying out-better than last time seen;" however, also lacked additional information for the heel wound and/or the possible continuation of the right ankle ulcer. R1's TAR, September 2026, identified the right medial ankle Allevyn directive was discontinued on 9/1/26 in which the 9/1/26 treatment validation box directed the viewer to R1's progress notes by a coded "9," and the left plantar foot Iodine treatment was discontinued on 9/14/26 (day of discharge). Between 9/2/26 and 9/14/26, there were eight days	F0684		10/30/2026

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TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH , WHEATON, Minnesota, 56296

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F0684 SS = G	Continued from page 4 of treatment opportunities for the Iodine; however, only two days showed staff initials to indicate this was completed (9/4/26 and 9/13/26). Four days remained blank (9/2/26, 9/6/26, 9/9/26, 9/14/26), one day directed the viewer to R1's progress notes by a "9," (9/7/26) and one indicated a code of "1" (absent from home without meds) (9/11/16). The TAR lacked directives to monitor the areas for improvements or deteriorations, nor did the TAR direct staff to comprehensively assess the wounds routinely. R1's Orders – Administration Notes identified the following: -9/1/26 at 3:36 p.m., no Alleyn was available so hydrocolloid was used instead. -9/7/26 at 4:25 p.m., R1 was out on pass. R1's Medication Administration Record (MAR), September 2026, identified that on 9/8/26, staff were directed to start hydrocolloid dressing to the left lateral lower leg, right lateral lower leg [ankle region], and right back of heel. This was to be checked and changed on bath days "every Tue." On 9/12/26, this treatment was discontinued. The MAR lacked directives to monitor the areas for improvements or deteriorations, nor did the MAR direct staff to comprehensively assess the wounds routinely. R1's Skin/Wound note dated 9/12/26, identified the left heel wound measured 1 cm x 2 cm and was described as a firm callus. The note also identified a wound to left lateral ankle with an open area that measured 4 cm x 3 cm with topical green on the top half of wound 0.5 cm wide. A dark semicircle on the lower wound bed measuring 2cm x 0.5 cm, strong odor. Hospice was notified and agreed to apply MediHoney (medical grade wound care product) per standing orders. A progress note was sent to the provider for update. Facility Standing Orders identified the orders were PRN (as needed) only and directed for "Skin Care" and "Wound Care" to follow wound care protocols. The standing orders directed the provider was to be notified of any "…ulcers…that require treatment" and the provider was to be notified of all wounds. The attached Wound Care Protocols identified standing orders for pressure ulcers, which included the hydrocolloid dressing or medical grade honey per manufacturer instructions; however, the protocol directed for "Lower Extremity Ulcers: Wounds	F0684		10/30/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = G	Continued from page 5 Secondary to: …Diabetes," to refer to the "Lower Extremity Ulcers Guidance." This guidance was not attached to the protocols. R1's Weekly Skin Check Tool dated 9/13/26, indicated "Wound are to bilateral heal [sic]. Orders in place and actively being treated." The tool lacked any additional information related to the bilateral heel ulcers and/or the ankle ulcer. R1's MAR, September 2026, identified starting on 9/13/26, staff were directed to apply a hydrocolloid dressing to the left lateral lower leg, right lateral lower leg [ankle region], and right back of heel, and to apply "medi honey on wounds under dressing." This was to be checked and changed on bath days "every Tue;" however, this order was discontinued that same day and another directive for the hydrocolloid/medi honey was entered to start on 9/15/26 with updated directions to "check and change prn (as needed)." This order was ultimately discontinued on 9/14/26 when R1 was discharged and thus this treatment was unable to be completed. R1's hospice Visit Note Report dated 9/14/26, identified a left lateral ankle wound that measured 4 cm x 3 cm with topical green on the top half of the wound with loose yellow slough covering less than 25% of the wound bed. There was a small amount of thin, watery, pale red/pink drainage and a faint odor. The narrative section of the report indicated R1 had a new left lower extremity wound with an order to cleanse with wound cleaner, apply med honey and cover with hydrocolloid dressing to be changed every 3 days and as needed. R1's medical record lacked evidence that R1's diabetic ulcers were routinely monitored (i.e., weekly) and comprehensively evaluated to ensure healing and if any additional intervention was needed for them; also it lacked evidence in the TAR(s) of a consistent, appropriate dressing or treatment being completed on the ulcers to promote healing; and it lacked evidence the provider was contacted and updated about the left lateral lower leg ulcer worsening after 9/12/26 despite the provider not responding to a sent fax for multiple days and the wound having obvious changes in characteristics suggestive of potential infection. An Order Summary Report, dated 9/14/26, identified R1's active orders for Dietary, Other, and Pharmacy. The summary lacked orders related to wound/ulcer management and treatment. R1's Discharge progress note, dated 9/14/26 at	F0684		10/30/2026

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F0684 SS = G	Continued from page 6 2:52 p.m., identified R1 discharged from the facility to an assisted living facility. R1's Nurse Progress Note, dated 9/15/26, at 4:24 p.m., identified progress notes with wound care documentation, as well as order recap sent to hospice managing resident's care at that time per request. R1's ED Provider Note, dated 9/17/26, identified R1 presented to the wound clinic, at the request of his primary care provider, for evaluation of a left ankle ulceration with seropurulent drainage underlying possible superficial abscess, surrounding cellulitis, and significant odor. In addition, he had a chronic left heel ulceration. R1 reported the ulceration was present for several weeks and had worsened over the "past week or so" and now had significant odor and discomfort. The wound required debridement and R1 required IV antibiotics. After the antibiotics R1 was discharged home with a Clinical Impression of "Abscess of skin of left ankle." R1 was directed to continue oral antibiotics, follow up with the provider the next day at 11:00 a.m. and over the weekend "for daily dressing changes and single dose IV antibiotic therapy…" A subsequent provider progress note, dated 9/18/26, identified R1 presented to the clinic and again received a dressing change and IV antibiotics. During an interview on 9/23/2026 at 9:54 a.m., R1 stated that while at the facility he developed a new wound on his left ankle. He stated he had no feeling in his legs due to neuropathy and the wound was in a place he couldn't easily see, so he did not know how bad it was until he was admitted to the assisted living. R1 stated he went to the clinic where they cleaned the wound and gave him antibiotics. He had not wanted to be admitted to the hospital, so the providers worked it out for him to receive the antibiotics and wound care as outpatient. The wound was currently healing well, and his new hospice company provided excellent wound care. During an interview on 9/24/2026 at 10:59 a.m., registered nurse (RN)-B stated wounds should be measured at least weekly but there was no assigned day. RN-B would measure a wound if there were instructions in the MAR or TAR (treatment administration record) to do so. RN-B would not automatically measure a wound on the weekly skin check day. A nurse could utilize standing orders for a new wound dressing, and the provider would be notified. If a resident was on hospice, then the hospice nurse would be notified with the information about the wound as well as the dressing the facility	F0684		10/30/2026

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F0684 SS = G	Continued from page 7 nurse utilized. During an interview on 9/22/2026 at 1:08 p.m., licensed practical nurse (LPN)-A stated a skin check was completed every week on a resident's bath day. The nurse should document all new and previously identified skin alterations. LPN-A would not include wound measurements on the Weekly Skin Check Tool. If a new wound were discovered, the skin assessment tool would be utilized to document location, measurements, and a description of the wound. LPN-A would look at a skin assessment tool or the nursing notes to identify if a wound was new and for information about the size and description of the wound. LPN-A did not recall changing R1's dressing on 9/8/26 but stated she recalled noticing the wound on R1's left outer ankle on 9/12/26 because the hydrocolloid dressing was saturated, the wound was greenish looking "like maybe it was infected" and the wound had a very foul smell. LPN-A notified RN-A who then changed the dressing. During an interview on 9/22/2026 at 3:55 p.m., RN-A stated she was the nurse educator and sometimes worked as the floor nurse. RN-A stated skin checks were completed weekly on the resident's bath day. The nurse completing the skin check would alert RN-A, the nurse manager, or the DON about any new wounds. Part of the skin check was keeping track of the wounds. If a nurse was not comfortable with measuring a wound, they could ask RN-A or the nurse manager for assistance. RN-A stated the Weekly Skin Check Tool would be an ideal place for wound measurements. RN-A further stated she completed R1's Weekly Skin Check Tool on 9/1/26 and clarified the new wound on the left lower leg was on R1's ankle. RN-A used the standing order for hydrocolloid dressing to be changed every 7 days. RN-A then contacted R1's hospice company for the ok to use the hydrocolloid dressing to be changed every 5-7 days. During a follow up interview on 9/23/2026 at 3:44 p.m., RN-A stated she assessed R1's left ankle wound on 9/12/26. The wound had a green color and a strong odor along with other changes to the wound bed as documented in her note. RN-A again reached out to hospice for the ok to apply Medihoney to the wound bed prior to covering with the hydrocolloid dressing. RN-A faxed the wound assessment and the wound dressing order to R1's provider for their information only as RN-A stated she already had a provider order from hospice. RN-A reviewed the facility standing orders for wound care and stated the order for hydrocolloid dressing indicated the dressing should be changed every 5 days. RN-A confirmed	F0684		10/30/2026

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F0684 SS = G	Continued from page 8 the order had been incorrectly entered for every 7 days. During an interview on 9/24/2026 at 10:18 a.m., the RN-C (clinic nurse for R1's facility medical doctor (MD) stated the facility would fax information to the clinic about a new wound. The provider would read the information and send back an order if needed. MD could give orders for a resident on hospice but often deferred the orders to the hospice provider. RN-C reviewed MD's notes for R1 and stated there was a fax from the facility on 9/12/26 that was acknowledged by MD on 9/16/26 after R1 discharged. A return phone call from MD was requested but not provided. During an interview on 9/23/2026 at 12:04 p.m., the hospice RN (HRN) manager stated the facility was completing wound assessments and dressing changes for R1. HRN stated the process for wound dressing orders was a facility would reach out to the hospice nurse with information about the wound and what dressing the facility wanted to use. If the dressing was on the hospice standing orders, the hospice nurse could give the order for the dressing. The hospice nurse could also reach out to the hospice provider for wound dressing orders then call or fax an order to the facility. The hospice nurse would write a note about any new wound or any dressing change order requests. HRN stated there were no notes about a left lateral lower leg wound nor any dressing change requests from the facility prior to 9/14/26, R1's day of discharge from the facility. During an interview on 9/23/2026 at 2:11 p.m., R1's community primary care provider (PA) stated she saw R1's wound on 9/16/26. The wound looked like it had been infected for a while based on the appearance, amount of drainage and the odor, in which an appointment was made for R1 to see the wound care provider the following day. R1's left ankle wound was debrided and R1 received IV antibiotics. The provider wanted to admit R1, but he refused so an outpatient plan was set for R1 to have daily dressing changes and an IV antibiotic at the clinic for 3 days with an oral antibiotic administered in the evenings. PA stated that a hydrocolloid dressing was not appropriate for a wound that had drainage and Medi honey was not appropriate for a wound with drainage and odor. A wound with drainage should have a dressing change at least daily. A provider should have been contacted at the first sign of infection and delaying provider notification increased the risk of worsening cellulitis or wound infection. Signs and symptoms of a wound	F0684		10/30/2026

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F0684 SS = G	Continued from page 9 infection included foul odor, thick drainage, green or yellow coloring in the wound bed, and increased temperature. A dressing alone would not treat a wound infection; antibiotics and possible debridement were needed. The infection may have been caught earlier or been prevented with more frequent assessment and dressing changes. During an interview on 9/22/2026 at 4:34 p.m., and follow up interview on 9/23/2026 2:38 p.m., the director of nursing (DON) stated on a resident's bath day the floor nurse should document new and existing skin concerns on the Weekly Skin Check Tool. The floor nurse should measure all wounds and document on the Weekly Skin Check Tool. When a new wound was discovered, a comprehensive assessment of the wound including a description of the wound bed and surrounding skin, drainage, odor, and measurements should be completed and documented on the Skin Assessment Tool. If a new skin concern needed a dressing, the nurse should look at the standing orders for the appropriate dressing and notify the provider or hospice. A resident admitted to hospice would receive all orders from the hospice provider. DON reviewed R1's EMR and stated the new left lower leg wound documented on 9/1/26 included measurements but did not include a description of the wound bed and surrounding skin nor any drainage and/or odor. The next assessment of the wound was completed on 9/12/26. The DON stated there was a dressing change completed on 9/7/26 and a skin assessment completed on 9/8/26 but there was no documentation of an assessment of the wound. A comprehensive assessment and ongoing monitoring of a wound was important so any deterioration could be noticed early and the provider notified for new orders. Education for staff began on 9/22/26 about where to document skin concerns. DON clarified the charge nurse listed on the education referred to the nurse working on the floor. The facility did not have an assigned wound nurse, so the floor nurse was responsible for weekly assessment of wounds. DON could not explain what "add a progress note under the order when completing the dressing change" meant. DON stated a progress note should be completed on days when a full assessment was completed but was not required with every dressing change. DON also stated wound assessment including measurements were to be documented in the weekly skin check but the education instructed the skin assessment tool to be used weekly until healed. DON stated going forward the assessment and measurements would be documented on the Weekly Skin Check Tool and the education would be changed to reflect this expectation.	F0684		10/30/2026

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F0684 SS = G	Continued from page 10 The Skin Assessment policy, reviewed 9/2026, instructed documentation of a skin assessment to include observations, type of wound, description of the wound to include measurements, color, type of tissue in the wound bed, drainage odor, pain, if the resident refused the assessment and other information as indicated or appropriate. The Wound Treatment Management policy, reviewed 8/2026, instructed the effectiveness of treatments would be monitored through ongoing assessment of the wound. Consideration for needed modifications included lack of progression towards healing and changes in characteristics of the wound. The Inservice Sheet dated 9/22/26, instructed Weekly Skin Check Tool was to be completed weekly or after each bath by the charge nurse. The Skin Assessment Tool was to be completed weekly for wounds or skin issues until healed. Charge nurses need to document wound treatments under the TAR and will add a progress note under the order when completing the dressing change.	F0684		10/30/2026

Minnesota Department of Health

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20000	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 9/22/26 through 9/24/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure. The following complaints were reviewed: H56384294C (3207221 and 3207375). NO licensing orders were issued.	20000		10/30/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 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.	20000		10/30/2026