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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traverse Care Center	303 Seventh Street South Wheaton, MN 56296

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 43083 Based on observation, interview and document review, the facility failed to follow facility policy and procedure to prevent drug diversion for 1 of 3 residents (R3) reviewed. Findings include: R3's Order Summary Report dated 7/17/24, indicated R3 received a Fentanyl Transdermal Patch every 72 hours for osteoarthritis, Lyrica 100 mg three times daily for pain, and Zolpidem Tartrate 5 mg at bedtime for insomnia. R3's care plan as of 7/17/24, identified R3 had actual complications with pain related to current medical and physical status, pain in legs and all over at times. Further, R3's interventions for pain were medications as ordered, observe for effectiveness, non-pharmacological interventions which included snacks, remove stimuli, music, distraction, walk, 1-1 interactions, massage, art, aroma therapy, and deep breathing. R3's Pain Interview dated 6/24/24, R3 stated he had occasional pain in the last 5 days that had rarely or not at all effected sleep or day-to-day activities. R3 rated his pain a 3 out of 10 on the numeric rating scale for pain intensity. On 7/17/24 at 2:19 p.m., licensed practical nurse (LPN)-A stated there were two locked medication carts and each cart contained its own locked controlled substance box. LPN-A stated any time a controlled substance was going to be administered there needed to be two nurses or a licensed nurse and a trained medical assistant (TMA) present to verify and ensure no mistakes happen. LPN-A stated the process was the same for Fentanyl patches, verification by two nurses that the old patch was removed, new patch applied, and the old one destroyed, which both staff would sign the book acknowledging they were a witness. LPN-A stated R3 was the only resident currently residing in the building who utilized a Fentanyl patch, and stated R3's pain had been managed and there had been no changes. Further, LPN-A stated there had been a recent incident with suspected drug diversion when R3's Fentanyl patch was being changed and there was a patch on R3 that was clear and did not say Fentanyl in green like it was supposed to. Also there were signatures of both LPN-A and LPN-B however LPN-A stated the signature was not in her writing. LPN-A stated TMA-A was suspected of doing something and was walked out of the facility and had not returned. (continued on next page)

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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 3:07 p.m., during an observation, LPN-B opened narcotic book to page 68, both LPN-B and LPN-A verified the medication, number of tabs of medication that should be on the card and LPN-A punches out a pill into the medication cup. LPN-B and LPN-A again verify the remaining medications on the card, and both sign off in the narcotic book. LPN-A placed the medication card back into the lock box, in the medication cart, and locked both the box and the cart, and LPN-A and LPN-B both walked to R3's room. R3 was utilizing the restroom, so LPN-A and LPN-B remained outside of R3's room until R3 was ready. LPN-A and LPN-B enter R3's room. R3 was sitting in his recliner and appeared comfortable. LPN-A administered the medication to R3, and LPN-B was present. Both LPN-A and LPN-B verify R3's Fentanyl patch was intact and did not appear to be tampered with. On 7/17/24 at 3:20 p.m., LPN-B stated staff were expected to verify, with two nurses, a Fentanyl patch was still intact and not tampered with once a shift. LPN-B also stated, staff were expected to place a Fentanyl patch on a resident, with two nurses, as well as removing an old patch and immediately destroying the old patch. Two nurses would have to witness both events and sign off to confirm. LPN-B stated recently there had been an incident of drug diversion with a suspected TMA. LPN-B stated she went to change R3's Fentanyl patch and had noticed the patch did not say Fentanyl in green writing, and faintly seen two nurses signatures, and the date of three days prior to when the patch should have been last changed, and there was a new Tegaderm strip placed on the old patch that had a new date written and TMA-A's initials in Sharpie marker over the old patch, even when the facility process required the initials of two nurses on the Tegaderm to confirm two staff had verified the patch administration. LPN-B stated she then went to look at the medication destruction log, and noticed a staff had forged LPN-B's signature, and that was when LPN-B knew it was TMA-A, and reported the suspected drug diversion immediately to the director of nursing (DON). On 7/17/24 at 3:37 p.m., clinical services manager (CSM), from a contracted agency company, stated her team had received a phone call from administrator on approximately 6/25/24, reporting TMA-A was supposed to change a resident's Fentanyl patch however, TMA-A did not remove the old patch, took the new patch, and forged the initials of a nurse. CSM stated TMA-A's contract was terminated and the agency obtained a statement from TMA-A, where TMA-A admitted she re-applied the old Fentanyl patch on the resident, but did not mean to, and destroyed the new Fentanyl patch with a nurse. On 7/17/24 at 3:50 p.m., during a phone interview, TMA-A stated she was a contracted employee through a staffing agency and had worked at the facility since February of 2024. When asked if there were any incidents of drug diversion, TMA-A stated, as far as I can tell there was an error, and I think everything was logged correctly, and then TMA-A hung up the phone and would not answer any further calls from the State Agency. Review of TMA-A's written statement dated 6/24/24, indicated TMA-A was working on R3's unit on 6/20/24, and was completing a normal medication pass at dinner time. TMA-A stated R3's order required his Fentanyl patch to be replaced and TMA-A had asked the nurse to verify the drug as it was a controlled narcotic. TMA-A stated immediately after, she took the patch along with R3's pills to R3 who was sitting at the dinner table. TMA-A handed R3 his oral medications and checked R3's shoulder for his old patch. TMA-A stated she removed the old patch, had the old patch in one hand and the new in the other hand, and applied the patch to the shoulder area and went back to the medication cart with a patch and placed it into the medication cup to be destroyed after dinner time. TMA-A confirmed she was busy and distracted and did not destroy the patch immediately, and when noticed she still had the patch, she asked the nurse for the keys to the medication room so we could destroy the patch. The destruction of the patch was witnessed by LPN-C, and they signed the medication destruction log. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/18/24 at 9:47 a.m., administrator stated she was not aware of any recent drug diversion incidents or concerns. On 7/18/24 at 10:19 a.m., DON stated controlled substance procedure included verification from two nurses or a licensed nurse and a TMA, staff would obtain medication administration record for the resident, grab the narcotic book and both staff would need to verify the medication or patch was administered, as well as immediately destroying the old patch, and then both staff would sign off in the record. When asked if there had been any recent concerns regarding drug diversion, DON stated no. When asked about the incident related to R3's Fentanyl patch, DON stated she was out of office when the concern was brought up that TMA-A had replaced R3's Fentanyl patch with something else, and DON was not part of the investigation and was unaware of any further details. DON stated upon returning to the facility, she did not do any additional investigating or implementing interventions to prevent reoccurrence. On 7/18/24 at 10:50 a.m., registered nurse (RN)-A stated she was made aware of the suspected drug diversion because DON was out ill from the facility. RN-A stated LPN-B had reported concerns related to TMA-A not changing R3's Fentanyl patch and forging LPN-B's signature. RN-A stated she emailed her investigation to DON, Admin-A, and Admin-B and RN-A's investigation which concluded the facility's-controlled substance policy was not followed, however could not prove TMA-A took the Fentanyl patch or forged the signature. On 7/18/24 at 11:18 a.m., LPN-B stated on the date the suspected drug diversion was discovered, she called DON and the DON came to the facility and LPN-B showed the DON the suspicious Fentanyl patch she placed in the locked medication cart. LPN-B stated DON did not stay at the facility long as she was ill, and DON stated she was going to contact RN-A. When asked about the day the Fentanyl patch was ordered to be changed by TMA-A, LPN-A stated she was a little a way from her [TMA-A], and it looked like she put it [the Fentanyl patch] on, but I can't say for a fact she did. Further, LPN-B confirmed the facility-controlled substance policy and procedure was not followed because the second nurse (LPN-B) was supposed to be able to verify the controlled substance was administered, and immediately following the removal of the old Fentanyl patch, the patch was expected to be destroyed and verified by two nurses, which was not completed. On 7/18/24 at 11:53 a.m., LPN-C stated she recalls an incident about suspected drug diversion with TMA-A related to a Fentanyl patch. LPN-C stated she remembered the unit being so busy and TMA-A approached LPN-C and requested the medication room keys and TMA-A wanted to destroy a Fentanyl patch. LPN-C stated she gave TMA-A the keys and noted TMA-A had a folded patch in her hand, but could not confirm it was Fentanyl, a date or whose patch it was. LPN-C stated she watched TMA-A through the small window of the medication room door and observed TMA-A drop something into the destroyer. LPN-C confirmed she was unable to verify a Fentanyl patch was destroyed, as she did not go into the medication room with TMA-A, and LPN-C confirmed she did not sign the narcotic book or the destruction of a medication book to verify she observed. Further, LPN-A stated she took the medication room keys back from TMA-A. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 12:32 p.m., Administrator-B stated he was new to the administrator role at the facility and Administrator-A had been the lead administrator. Further, Administrator-B stated RN-A had completed the investigation related to R3's Fentanyl patch and was getting guidance from Administrator-A. Administrator- B stated staff had reported suspected drug diversion regarding TMA-A and the discovery of the suspicious Fentanyl patch and LPN-B's signature did not match in the controlled substance books. On 7/18/24 at 12:47 p.m., Administrator-A stated she honestly did not know about the suspected drug diversion with R3's Fentanyl patch and stated she just became aware on 7/18/24. Administrator-A denied reporting TMA-A to the contacted staffing agency as well. On 7/18/24 at 12:58 p.m., RN-A stated she was notified on 6/24/24, by LPN-B. RN-A stated she observed the Fentanyl patch, and stated there was Tegaderm stuck to the patch. RN-A stated on the patch there was an impression in it that read 6/17/24, and then the Tegaderm that was over the patch had a date of 6/20/24, in Sharpie marker. RN-A stated she could not prove drug diversion had occurred. Review of untitled document, a page from the Controlled Drug Record, dated 6/20/24, revealed destruction of Fentanyl patch for R3 occurred on 6/20/24, with TMA-A's initials in addition to another set of initials that are unidentifiable as either CD or DD, however LPN-B and LPN-C denied signing the page for the Fentanyl Patch destruction. Review of Controlled Substance Administration and Accountability policy dated 3/11/24, indicated the facility would have safeguards in place to prevent loss, diversion, or accidental exposure. Further, policy indicated two licensed staff must witness any disposal or destruction of a controlled substance and document on the drug disposition record. Policy direct staff all controlled drug patches removed from patients are disposed of in such a manner as to prevent diversion, after removing the patch, the used patch was folded in half so that the sticky side sticks to itself and placed in the disposal system so that the controlled substance is non-retrievable, disposal of patches is witnessed and cosigned on the medication administration record in the blanks provided with each controlled drug patch order, and two signatures are required for documentation of controlled drug patch disposal.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43083 Based on interview and document review, the facility failed to report suspected drug diversion to the State Agency (SA), as required, for 1 of 3 residents (R3) reviewed. Findings include: R3's Order Summary Report dated 7/17/24, indicated R3 received a Fentanyl Transdermal Patch every 72 hours for osteoarthritis. Review of the facility's internal investigation of suspected drug diversion: - Licensed practical nurse (LPN)-B notified DON on 6/23/24, R3's Fentanyl patch did not look right when removed. Fentanyl patch under the Tegaderm had 6/17/24 date in black pen and Tegaderm had the date of 6/20/24 in Sharpie marker. - Registered Nurse (RN)-A sent email to director of nursing (DON), administrator-A, and administrator-B on 6/24/24, which included R3's Fentanyl Investigation On 7/17/24 at 2:19 p.m., LPN-A stated there were two medication carts and each cart contained its own controlled substance box which required a key to unlock. LPN-A stated any time a controlled substance was going to be administered there needed to be two nurses or a licensed nurse and a trained medical assistant (TMA) present to verify and ensure no mistakes happen. LPN-A stated the process was the same for Fentanyl patches, verification by two nurses that the old patch was removed, new applied, and the old one destroyed, which the staff would sign the book acknowledging they were a witness. LPN-A stated R3 was the only resident currently residing in the building who utilizes a Fentanyl patch, and stated R3's pain had been managed and there had been no changes. Further, LPN-A stated there had been a recent incident with suspected drug diversion when R3's Fentanyl patch was being changed there was a patch on R3 that was clear and did not say Fentanyl in green like it was supposed to, there were signatures of both LPN-A and LPN-B however LPN-A stated the signature was not in her writing. LPN-A stated TMA-A was suspected of doing something and was walked out of the facility and had not returned. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 3:20 p.m., LPN-B stated staff were expected to verify, with two nurses, a Fentanyl patch was still intact and not tampered with once a shift. LPN-B also stated, staff were expected to place a Fentanyl patch on a resident, with two nurses, as well as removing an old patch and immediately destroying the old patch. Two nurses would have to witness both events and sign off to confirm. LPN-B stated recently there had been an incident of drug diversion with a suspected TMA. LPN-B stated she went to change R3's Fentanyl patch and had noticed the patch did not say Fentanyl in green writing, and faintly see two nurses signatures and the date of three days prior to when the patch should have been last changed, and there was a new Tegaderm strip placed on the old patch that had a new date written and TMA-A's initials in Sharpie marker over the old patch, even when the facility process required the initials of two nurses on the Tegaderm to confirm two staff had verified the patch administration. LPN-B stated she then went to look at the medication destruction log and noticed a staff had forged LPN-B's signature and that was when LPN-B knew it was TMA-A and reported the suspected drug diversion immediately to the director of nursing (DON). On 7/17/24 at 3:37 p.m., clinical services manager (CSM), from a contracted agency company, stated her team had received a phone call from administrator- A on approximately 6/25/24, reporting TMA-A was supposed to change a resident's Fentanyl patch however, TMA-A did not remove the old patch, took the new patch, and forged the initials of a nurse. CSM stated TMA-A's contract was terminated and the agency obtained a statement from TMA-A, where TMA-A admitted she re-applied the old Fentanyl patch on the resident, but did not mean to, and destroyed the new Fentanyl patch with a nurse. On 7/18/24 at 9:47 a.m., administrator-A stated she was not aware of any recent drug diversion incidents or concerns. On 7/18/24 at 10:50 a.m., registered nurse (RN)-A stated she was made aware of the suspected drug diversion because DON was out ill from the facility. RN-A stated LPN-B had reported concerns related to TMA-A did not change R3's Fentanyl patch and forged LPN-B's signature. RN-A stated she emailed her investigation to DON, Admin-A, and Admin-B and RN-A's investigation concluded the facility's-controlled substance policy was not followed, however could not prove TMA-A took the Fentanyl patch or forged the signature. On 7/18/24 at 12:32 p.m., Administrator-B stated he was new to the administrator role at the facility and administrator-A had been the lead administrator. Further, administrator-B stated RN-A had completed the investigation related to R3's Fentanyl patch and was working and getting guidance from administrator-A. Administrator-B stated staff had reported suspected drug diversion regarding TMA-A and the discovery of the suspicious Fentanyl patch and LPN-B's signature did not match in the controlled substance books. On 7/18/24 at 12:47 p.m., administrator-A stated she was not aware of the suspected drug diversion until 7/18/24. Administrator-A stated she assumed the facility did not report to the SA because their investigation revealed there was not a diversion. Further, administrator-A stated staff were expected to report to the SA if the facility policy was not followed and there was harm that occurred, and specifically related to drug diversion staff were expected to report immediately once they discover there had been a diversion. Administrator-A stated the facility had a couple hours to investigate before legally having to report to the SA, so in this incident administrator-A would have investigated first. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 12:58 p.m., RN-A stated she was notified on 6/24/24, by LPN-B. RN-A stated she observed the Fentanyl patch, and stated there was Tegaderm stuck to the patch. RN-A stated on the patch there was an impression in it that read 6/17/24 and then the Tegaderm that was over the patch had a date of 6/20/24, in Sharpie marker. RN-A stated she could not prove drug diversion had occurred, and that was the reason for not reporting the suspected drug diversion to the SA. Review of Controlled Substance Administration and Accountability policy dated 3/11/24, indicated the facility would have safeguards in place to prevent loss, diversion, or accidental exposure. Further, policy directed staff any discrepancies which cannot be resolved must be reported immediately as follows: notify the DON, complete an incident report detailing the discrepancy, steps taken to resolve it, and all the names of all licenses staff working when the discrepancy was noted. Further, the DON must also report any loss of controlled substances where theft was suspected to the appropriate authorities such as local law enforcement, drug enforcement agency, state board of nursing, state board of pharmacy, and possibly the state board for nursing home administrators. However, the policy lacked staff direction on when suspected drug diversion should be reported to the SA.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

43083

Based on interview and document review, the facility failed to implement appropriate interventions to prevent additional diversion after an incident of suspected drug diversion occurred for 1 of 3 residents (R3) reviewed.

Findings include:

R3's Order Summary Report dated 7/17/24, indicated R3 received a Fentanyl Transdermal Patch every 72 hours for osteoarthritis, Lyrica 100 mg three times daily for pain, and Zolpidem Tartrate 5 mg at bedtime for insomnia.

Review of the facility's internal investigation of suspected drug diversion:

- Licensed practical nurse (LPN)-B notified DON on 6/23/24, R3's Fentanyl patch did not look right when removed. Fentanyl patch under the Tegaderm had 6/17/24 date in black pen and Tegaderm had the date of 6/20/24 in Sharpie marker.

- Registered Nurse (RN)-A sent email to director of nursing (DON), administrator-A, and administrator-B on 6/24/24, which included R3's Fentanyl Investigation

On 7/17/24 at 2:19 p.m., LPN-A stated there were two medication carts and each cart contained its own controlled substance box which required a key to unlock. LPN-A stated any time a controlled substance was going to be administered there needed to be two nurses or a licensed nurse and a trained medical assistant (TMA) present to verify and ensure no mistakes happen. LPN-A stated the process was the same for Fentanyl patches, verification by two nurses that the old patch was removed, new applied, and the old one destroyed, which the staff would sign the book acknowledging they were a witness. LPN-A stated R3 was the only resident currently residing in the building who utilizes a Fentanyl patch, and stated R3's pain had been managed and there had been no changes. Further, LPN-A stated there had been a recent incident with suspected drug diversion when R3's Fentanyl patch was being changed there was a patch on R3 that was clear and did not say Fentanyl in green like it was supposed to, there were signatures of both LPN-A and LPN-B however LPN-A stated the signature was not in her writing. LPN-A stated TMA-A was suspected of doing something and was walked out of the facility and had not returned.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 3:20 p.m., LPN-B stated staff were expected to verify, with two nurses, a Fentanyl patch was still intact and not tampered with once a shift. LPN-B also stated, staff were expected to place a Fentanyl patch on a resident, with two nurses, as well as removing an old patch and immediately destroying the old patch. Two nurses would have to witness both events and sign off to confirm. LPN-B stated recently there had been an incident of drug diversion with a suspected TMA. LPN-B stated she went to change R3's Fentanyl patch and had noticed the patch did not say Fentanyl in green writing, and faintly see two nurses signatures and the date of three days prior to when the patch should have been last changed, and there was a new Tegaderm strip placed on the old patch that had a new date written and TMA-A's initials in Sharpie marker over the old patch, even when the facility process required the initials of two nurses on the Tegaderm to confirm two staff had verified the patch administration. LPN-B stated she then went to look at the medication destruction log and noticed a staff had forged LPN-B's signature and that was when LPN-B knew it was TMA-A and reported the suspected drug diversion immediately to the director of nursing (DON). Review of Nurse Meeting minutes dated 7/8/24, lacked evidence of staff education or retraining related to the facility's controlled substance procedure. On 7/18/24 at 10:19 a.m., DON stated controlled substance procedure included verification from two nurses or a licensed nurse and a trained medication assistant (TMA), staff would obtain medication administration record for the resident, grab the narcotic book and both staff would need to verify the medication or patch was administered as well as immediately destroying the old patch and then both staff would sign off in the record. When asked if there had been any recent concerns regarding drug diversion, DON stated no. When asked about the incident related to R3's Fentanyl patch, DON stated she was out of office when the concern was brought up that TMA-A had replaced R3's Fentanyl patch with something else and DON was not part of the investigation and was unaware of any further details. DON stated upon returning to the facility, she did not do any additional investigating or implementing interventions to prevent reoccurrence. On 7/18/24 at 10:50 a.m., registered nurse (RN)-A stated she was made aware of the suspected drug diversion on 6/24/24, by licensed practical nurse (LPN)-B who reported TMA-A did not change R3's Fentanyl patch and forged the nurse's signature. RN-A stated she called the DON due to the DON being out of the facility ill. RN-A stated she completed the investigation for the suspected drug diversion and the investigation revealed the facility policy related to controlled substances was not followed, however there was no evidence the patch was tampered with. When asked if she saw the patch in question, RN-A confirmed she say the patch and stated on the patch there was an impression in it that read 6/17/24, and then the Tegaderm that was over the patch had a date of 6/20/24, in Sharpie marker. RN-A stated she could not prove drug diversion had occurred. In addition, RN-A stated she was unaware if the facility completed staff education related to controlled substance procedure following the incident and could not provide evidence of this being discussed at the nursing meeting last week.