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	10/30/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to report immediately, no later than 2 hours, to the administrator and the State Agency (SA), in accordance with established policies and procedures, an allegation of staff to resident abuse for 1 of 1 resident (R204) who was reviewed for allegations of abuse. Findings include: R204's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R204 had moderate cognitive impairment and had diagnoses which included heart failure, Diabetes Mellitus (DM), and anxiety disorder. Identified R 204 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R204's care plan revised 10/11/24, identified R204 was at risk for vulnerability related to mobility limitations and ADL needs. Identified R204 maintained the ability to report maltreatment. Care plan directed staff to observe/suspected abuse, remove resident from aggressor and relocate to safe location.- Report alleged violations in accordance to community protocol/Policy- Staff to observe for any changes in mood/behavior or medical changes and notify appropriate personnel. During an interview on 10/29/24 at 11:24 p.m., R204 stated she was scared of nursing assistant (NA)-C. R204 stated there were two incidents in the last month where she felt NA-C was abusive toward her. R204 stated she was not sure of the exact date however, one evening when NA-C was assisting her with cares, NA-C raised his fist to R204. In addition, a few days later while NA-C and NA-E were transferring R204 with the E-Z stand, NA-C raised his voice to R204 which made R204 very scared. R204 stated NA-E witnessed the incident and told R204 that she did not have to put up with that. R204 stated she spoke with assistant director of nursing (ADON) the next morning and told her about the above incidents with NA-C and that she was afraid of NA-C. R204 stated ADON informed her the facility was short staffed and needed the help however, they would make sure NA-C did not work with her anymore. Review of facility reported incidents to the SA lacked documentation of the SA being notified of the allegation of abuse toward R204. During an interview on 10/29/24 at 11:46 a.m., NA-D stated R204 had told her a few weeks ago, NA-E had been rough with her. NA-D stated she had reported those concerns to the ADON recently. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 11:54 a.m., NA-E stated a few weeks ago while she and NA-C were transferring R204 with the EZ - stand, R204's foot slipped off the foot plate and NA-C yelled you need to listen to us because we are the boss of you at R204. NA-E stated she told the ADON the next day about the incident. NA-E stated the ADON told her thank you and stated NA-C would no longer be allowed to work with R204. During a telephone interview on 10/29/24 at 11:59 a.m., NA-C stated he was aware R204 had told administration that he verbally abused R204. NA-C stated administration had told him a week or two ago, R204 was trying to get him fired therefore, he was no longer allowed to care for R204. NA-C stated he had not been removed from the schedule but he had the next few days off after the allegation of verbal abuse was made toward NA-C During an interview on 10/29/24 at 12:58 p.m., ADON stated she was not aware of any concerns with staff being rough with R204 however, she was aware R204 was afraid of NA-C because he had raised his voice to her. ADON stated she had been made aware of the allegation of abuse towards R204 a few weeks ago. ADON stated even though she felt it was an allegation of abuse she did not feel it needed to be reported to the administrator or the SA because the next day R204 had stated it was ok for NA-C to work with her as long as another staff member was present. During an interview on 10/29/24 at 2:36 p.m., director of nursing (DON) stated she had been aware on 10/7/24, NA-C had been loud with R204. DON indicated she had initiated an investigation and asked NA-C to not work with R204. DON stated she followed up with R204 a few days later and R204 had stated she was ok with NA-C working with her as long as another staff member was present. DON stated she was not aware that R204 had been scared of NA-C. DON stated she did not feel it was an allegation of abuse at the time. DON indicated her expectation was that all allegations of abuse would have been reported to the administrator and the SA per facility policy. During an interview on 10/29/24 at 3:20 p.m., administrator stated she was not aware of the allegation of abuse towards R204. Administrator indicated her expectation was that all allegations of abuse would have been reported to the administrator immediately and to the the SA immediately but no more than two hrs per policy. Review of a facility policy titled Abuse, Neglect, and Exploitation Policy undated, identified possible indicators of abuse include, but were not limited to: Verbal abuse of a resident overheard. Further identified, the facility policy includes: Reporting of all alleged violations to the Administrator or designee, state agency, adult protective services and any other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury. . .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and standards of practice related to medication administration for 1 of 1 residents (R210) observed to receive medication. Findings include: According to the National Institute of Health article titled, Crushing tablets or opening capsules: many uncertainties, some established dangers, last updated September 23, 2014, The clinical consequences for the patient of crushing tablets or opening capsules can be serious: alteration of the drug's absorption can result in sometimes fatal overdose, or conversely underdosing, rendering the treatment ineffective. When it disrupts a drug's sustained-release properties, the active ingredient is no longer released and absorbed gradually, resulting in overdose. When a gastro-resistant layer is destroyed by crushing, underdosing is likely. The active ingredient released may degrade on contact with light, moisture or the food with which it is mixed for administration. In practice, there are many drugs that should never be crushed or opened. Before crushing a tablet or opening a capsule, it is better to consider and research the impact it will have on the drug's effects. R210's quarterly Minimum Data Set (MDS) dated [DATE], identified R210 had severe cognitive impairment and diagnoses of type two diabetes, chronic kidney disease stage four (severe irreversible damage to the kidneys), bipolar disorder (mental health condition that cause extreme mood swings), anxiety, borderline personality disorder, depression, congestive heart failure (progressive heart disease affecting pumping action of the heart muscles), hypertension (high blood pressure), anemia (deficiency of healthy red blood cells in blood to carry oxygen to body's tissues). Indicated R210 required extensive assistance of staff with toileting, dressing and personal hygiene. R210's care plan revised 9/26/24, identified R210 had congestive heart failure and coronary artery disease. Facility staff to give cardiac medications as ordered by the physician, monitor and document side effects and report adverse reactions to the doctor as needed. R210's care plan revised 6/27/24, identified R210 had a mood problem related to disease process Bipolar disorder, depression, anxiety, borderline personality disorder. Facility staff to administer medications as ordered and monitor/document for side effects and effectiveness. R210's admission Care Area Assessment (CAA) date 12/7/23, identified R210 received physician ordered antipsychotic and antidepressant medication to manage bipolar disorder. R210 was at risk for adverse reactions to those medications. The pharmacist reviewed medications monthly and made necessary recommendations to the physician and nursing staff. The doctor would be updated with medication refusals. Would proceed to care plan with goal to have no drug related side effects. R210's Medication Review Report signed 8/20/24, identified the following orders: -Abilify 5 milligrams (mg) one time a day related to bipolar disorder. -Calcitriol capsule 0.25 micrograms (mcg) Give 0.5mcg by mouth one time a day every Mon, Tue, Wed, Thu, Fri related to chronnic kidney disease stage four. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Effexor XR capsule 150mg by mouth one time a day. Take with 75mg and 37.5mg for total of 262.5mg. Do not crush, may open capsules as needed related to bipolar disorder, anxiety. -Ferrous Sulfate 325mg by mouth one time a day related to anemia in chronic kidney disease. Do not crush. -Isosorbide Mononitrate extended release (ER) Give 30mg by mouth one time a day related to congestive heart failure. Do not crush. -Metoprolol Succinate ER Give 50mg by mouth one time a day related to congestive heart failure. Do not crush. -Seroquel 25mg Give 0.5 tablet by mouth one time a day related to bipolar disorder. -Torsemide Give 20mg by mouth one time a day related to congestive heart failure. -Tylenol eight hour arthritis pain extended release Give 650mg by mouth three times a day for pain management. Do not crush. During an observation on 10/28/24 at 12:03 p.m., registered nurse (RN)-C was standing next to the medication cart in the hallway outside of R210's room preparing R210's medications. RN-B was in R210's room, opened the door and asked RN-C what medications were being prepared for R210 as R210 did not feel well and RN-B advised RN-C to crush R210's medications. RN-C proceeded to crush R210's medications, mixed with applesauce and handed the plastic medication cup with crushed medications to RN-B to give to R210. RN-B took the medications and closed R210's door behind her as R210 was currently in enhanced respiratory precautions. During an interview on 10/28/24 at 4:57 p.m., RN-C verified she crushed the medications for R210 and opened capsules to sprinkle the powder into the applesauce earlier that day. RN-C stated R210 usually chews medications. RN-C verified R210's facesheet/banner on the electronic health record (EHR) stated medications to be given whole. RN-C confirmed the doctor had not been notified R210 was chewing medications or receiving medications crushed. RN-C stated it would be important to follow the physician orders of 'do not crush' because of how the medications would be absorbed and that R210 was probably not receiving the correct dose of medication due to medications being crushed. During an interview on 10/28/24 at 5:27 p.m., consultant pharmacist verified medications that are extended release would not be crushed as that would change the efficacy of the medication. The consultant pharmacist confirmed the expectation of nursing staff to update the physician and pharmacist if a resident required medications to be crushed or if a resident was not taking medications as ordered like chewing medications. The consultant pharmacist stated this was important to ensure residents were safe receiving medications as the medication was intended to be taken. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/24 at 5:51 p.m., RN-B confirmed R210's facesheet/banner in the EHR stated medications to be given whole and stated she was unaware R210 was to have medications taken whole. RN-B stated R210 usually chews medications. RN-B confirmed she gave the crushed medications to R210. RN-B confirmed the physician and pharmacist should be notified when a resident was receiving medications crushed instead of whole as that could affect how the medication acts in the resident's body and that neither the physician nor the pharmacist had been updated on R210 receiving medications crushed or chewing medications. During an interview on 10/28/24 at 5:57 p.m., director of nursing (DON) verified R210's facesheet/banner in the EHR stated medications to be given whole. DON stated medications labeled extended release (ER) should not be crushed as the delivering of the medication would be altered and the resident could adversely be affected. DON confirmed the physician and the pharmacist expected to be updated by facility staff if a resident chewed medications or was receiving medications crushed. DON verified that was important so the right medication dose ordered was given and the timeliness of the medication released is received. A facility policy titled Medications Administration Policy, undated, was provided. It was the policy of this facility that medications were administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy further identified do not crush medications with 'do not crush' instructions and administer medications as ordered in accordance with manufacturer specifications.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 2 resident (R206) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: R206's quarterly Minimum Data Set (MDS), dated [DATE], identified R206 had diagnoses which included Alzheimer's disease, dementia and anxiety. R206 required assistance of one staff for bed mobility and transfers. R206 required assistance of one staff to roll from left to right. Indicated R206 was at risk for pressure ulcers and currently had an unhealed pressure ulcer on her coccyx. Review of R206's Braden scale (tool used in healthcare to assess a patient's risk of developing pressure ulcers) on 10/23/2024 indicated R206's score was 14 and R206 was at a high risk for developing pressure ulcers. Requested most recent Care Area Assessment (CAA) however was not provided. R206's care plan revised on 10/15/24, identified R206 had the potential for complications with impaired skin integrity related to incontinence and a red area on her coccyx. Indicated R206 was to have skin prep two times a day (BID) and as needed (PRN) to her coccyx. R206 was to have an air mattress overlay. R206 was dependent on staff for all cares. R206's treatment authorization request (TAR) dated 10/30/24, identified R206 was to have a Mepilex (absorbent foam) dressing put on the skin between gluteal folds for an open area: wash with skin wash (soap and water) and put a facility barrier cream with the Mepilex dressing BID and PRN. Review of R7's progress notes dated 8/3/24 to 10/29/24, revealed the following: -10/11/24, reddened area to butt by coccyx with dark area next to it. Intact and not open. Measures 3 x 4 centimeter (cm) red area with a 1.1 x 1 cm dark area. Skin prep being used over area and an air mattress overlay was applied. -10/15/2024, provider also noted and assessed R206's coccyx wound. Provider voiced to continue skin prep and pressure relieving device to bed and chair. -10/25/2024, hospice nurse ordered Mepilex dressing to be put on skin between gluteal fold: wash with skin wash (soap and water) and put a facility barrier cream when completing Mepilex dressing change BID and PRN. -10/27/2024, skin prep to butt crease BID for red area on coccyx area and cover with Mepilex dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/29/2024, R206 has pressure wound on coccyx measuring 1.7 x 1 cm. Slough (a type of necrotic tissue that accumulates on the surface of a wound) in middle of wound. No pain noted. Mepilex dressing put on skin between gluteal folds: wash with skin wash (soap and water) and put a facility barrier cream with Mepilex dressing PRN. During an observation on 10/30/24 at 7:25 a.m., R206's door was closed as R206 was in isolation precautions. R206 was laying in her bed on her back covered with a quilt. R206's eyes were closed and call light was within reach. During continuous observations on 10/30/24 from 8:05 a.m. to 10:40 a.m., revealed the following: -7:25 a.m., R206's door was closed as R206 was in isolation precautions. R206 was laying in her bed on her back covered with a quilt. R206's eyes were closed and call light within reach. -8:05 a.m., R206's day was closed and R206 remained in the same position as above. -8:57 a.m., R206's day was closed and R206 remained in the same position as above. -9:19 a.m., R206's day was closed and R206 remained in the same position as above. -9:45 a.m., R206's day was closed and R206 remained in the same position as above. -10:13 a.m., R206's day was closed and R206 remained in the same position as above. -10:24 a.m., R206's family member entered the room and closed the door. R206 remained in the same position as above. -10:40 a.m., R206's day was closed and R206 remained in the same position as above. Requested registered nurse (RN)-B to enter R206's room to reposition and measure R206's pressure ulcer on coccyx. During an observation and interview on 10/30/24 at 10:45 a.m., RN-B donned personal protective equipment (PPE) and entered R206's room. R206 remained in the same position as above. RN-B changed R206's brief, measured R206's pressure ulcer on coccyx, checked R206's heels for redness and bogginess (tissue texture abnormality characterized principally by a palpable sense of sponginess in the tissue), and repositioned R206. During an observation and interview on 10/30/24 at 11:04 a.m., RN-B doffed PPE and exited R206's room. RN-B confirmed R206 had a pressure ulcer on her coccyx that measured 2 x 1.4 cm. RN-B further confirmed a small amount of serosanguinous (thin, clear or pink fluid from a wound) drainage coming from the center of the wound. RN-B stated there were no open areas on R206's heels. RN-B indicated R206 should have been turned and repositioned every two hours. RN-B stated her expectations were that nursing assistants (NA)'s should be repositioning R206 every two hours as care planned. RN-B confirmed she did not turn or reposition R206 while providing morning cares to other residents on the unit. RN-B stated it was important to turn and reposition residents every two hours to reduce skin breakdown. R206 had not been repositioned for a total of two hours and 35 minutes during this observation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 11:16 a.m., nursing assistant (NA)-A, confirmed she had not been in R206's room since about 6:30 a.m. NA-A stated she had other residents who had been putting their call lights on for assistance and NA-A further stated are we supposed to tell the residents who put their call lights on to wait while we reposition other residents? NA-A indicated she was aware R206 had an pressure ulcer on her coccyx and should have been repositioned every two hours to prevent further breakdown. During an interview on 10/30/24 at 12:21 p.m., NA-F indicated she did not remember what time she was in R206's room and stated she does not always watch the time. NA-F stated it was important for residents to be turned and repositioned every two hours to prevent skin breakdown. NA-F further stated R206 should have been turned and repositioned every two hours. During an interview on 10/30/24 at 1:09 p.m., director of nursing (DON) confirmed R206 had a pressure ulcer on her coccyx. DON confirmed the above findings and was not aware nursing staff had not turned and repositioned R206 for two hours and 35 minutes. DON stated her expectations were nursing staff were to reposition residents no more than every two hours to prevent skin breakdown. DON further stated nursing staff were to answer residents call lights, ask if they can come back to help them, try to find help, and get to the resident that needed to be repositioned. Review of facility policy titled Policy: Pressure Injury Prevention and Management, undated, this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Interventions for Prevention and to Promote Healing, Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for 2 of 3 residents (R53, R206) investigated for fall safety. Findings Include: R53 R53's quarterly Minimum Data Set, dated dated dated [DATE], identified R53 was cognitively intact and had diagnoses which included Alzheimer's disease, rib fractures, and hypertension. Indicated R53 had one fall with major injury. R53's comprehensive Care Area Assessment (CAA) dated 4/5/24, identified R53 required assistance with toileting and bed mobility and nursing provided activities of daily living (ADL), mobility, and transfer assistance as needed. R53's CAA identified functional status would be addressed in care plan to slow or minimize decline. R53's Morse Fall Scale assessment dated [DATE], identified R53 had fallen before, and was at high risk for falls. R53's care plan revised 10/15/24, identified R53 was at high fall risk with potential for complications with falls. R53's interventions included: make sure walker was clear of recliner footing with getting up from the chair, assist with toileting needs per plan and Dycem non-slip mat under wheelchair cushion to prevent sliding. R53's care plan also identified R53 required assistance with dressing, toilet use, and transfers. Review or R53's progress notes from 9/30/24 to 10/31/24, identified the following: -10/13/24 at 6:15 p.m., nurse progress note- Late Entry- R53 found on floor parallel to bed. Wheelchair cushion under R53. R53 stated left elbow hurt, no other injuries. -10/14/24 at 3:15 p.m., incident/Huddle- 10/13/24 at 6:00 p.m. R53 was sitting in wheelchair parallel to bed waiting for transfer assist. R53 found on floor. R53 stated wheelchair cushion had slipped out and slid onto floor. No injuries noted. -10/14/24 at 3:29 p.m., nurse progress note-Dycem to be placed between wheelchair cushion and chair. -10/15/24 at 9:09 a.m., RN Incident Root Cause Analysis-identified R53 complained that wheelchair cushion slipped from wheelchair, plan of action to prevent this from further happening with Dycem non-slip mat to be placed under cushion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/24 at 11:58 a.m., R53 was in wheelchair, dressed in street clothes and shoes, being transported to dining room. At 12:57 p.m. R53 was in wheelchair in dining room, drinking from a cup with straw. At 1:31 p.m., R53 was in wheelchair in dining room, same location, and Bingo activity was beginning. At 3:20 p.m. R53 continued in wheelchair in dining room playing Bingo. At 3:45 p.m. R53 received stand by assistance from nursing assistant (NA-B) to pivot transfer from wheelchair to bed. During an interview on 10/29/24 at 3:47 p.m. , NA-B indicated was aware R53 had slid of wheelchair recently, however unaware of any other interventions, except indicated the last time had checked R53 was independent with stand by assistance with transfers. During an observation on 10/30/24 at 8:24 a.m., R53 was seated in her wheelchair in the bathroom, completing oral cares with NA-A in the room with her. R53 was dressed in street clothes. During an interview on 10/30/24 at 10:49 a.m., NA-A stated R53 was at risk for falls, and indicated R53 was supposed to call for assistance with transfers. NA-A indicated she assisted R53 by using a gait belt during transfers. During an observation on 10/30/24 at 12:52 a.m., case manager registered nurse (RN)-B was in R53's room, transferring R53 from the toilet with stand by assist to the wheelchair, then assisted R53 to the sink to wash her hands. At 12:58 p.m., RN-B assisted R53 to bed, using stand by assistance while R53 pivot transferred from wheelchair to bed. RN-B then assisted R53 to put legs into bed. NA-A stated R53's care plan had interventions listed, and that was what they followed. During an interview on 10/30/24 at 1:04 p.m., RN-B stated R53 had a recent fall and RN-B confirmed R53 was to have Dycem under her cushion in her wheelchair. At 1:07 p.m., RN-B entered R53's room and verified R53 did not have a Dycem mat under her cushion. RN-B reviewed R53's electronic medical record (EMR) and confirmed R53 fell on [DATE] at 6:37 p.m., and R53's cushion had slid out of her wheelchair. At that time they added Dycem to be placed under her wheelchair cushion. RN-B indicated had thought it was added to R53's treatment administration record (TAR) to be checked to assure it was in place, however reviewed R53's EMR and verified it had not been added, however it was included on R53's care plan. RN-B indicated expectation was for the Dycem to be under cushion in wheelchair so cushion did not slip and indicated she was concerned it had not been in place as that was a fall prevention intervention. 48583 R206 R206's quarterly MDS, dated [DATE], identified R206 had diagnoses which included Alzheimer's disease, dementia and anxiety. R206 required assistance of one staff for bed mobility and transfers. Requested a copy of R206's most recent CAA however was not provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R206's care plan revised on 10/15/24, identified R206 was at risk for falls related to impaired cognition secondary to Alzheimer's disease, dementia, anxiety, depression and history of a pelvic fracture. R206 had an actual fall on 9/18/24. A goal was listed for R206 to remain free of falls with major injuries and several interventions were identified to help R206 meet this goal. These interventions included: - Revised 7/14/24, 30 minute checks. - Initiated 9/24/24, staff to assist with ambulation if R206 gets up on own and starts to walk. - Initiated 10/8/24, assist with toileting needs. - Initiated 4/18/24, call light positioned for easy access. Review of R7's progress notes dated 8/3/24 to 10/29/24, revealed the following: - 8/31/2024 on p.m. shift R206 was putting self on the floor in the living room and with cues was able to get self up off the floor. - 9/4/24 R206 purposely laid on floor. - 9/5/24 R206 transferred self to the floor and scooted around room on floor. - 9/5/24 R206 purposely laid down on the floor and requested someone to help her up. - 9/6/24 R206 got out of her wheelchair and placed self on floor. - 9/8/24 R206 had been self-transferring and also transferring with the assist of one. - 9/10/24 R206 laid herself on the floor in the dining room. R206 was assisted back into her wheelchair. - 9/11/24 R206 put herself on the floor two times and would just lie there. - 9/13/24 R206 put herself on the floor. - 9/14/24 R206 was found out in the front lobby, put herself on the floor two times, and was crawling around on the floor. - 9/17/24 R206 put self on floor two times this shift. Resident was able to get self-back into wheelchair with supervision by staff. - 9/18/24 R206 was walking on her own in the morning saying she felt stiff. R206 continued to walk in the hallway hanging onto hand rail with appropriate foot wear. Nursing staff provided walker and resident said that was better. Staff walked R206 to living room and sat in chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/18/24 R206 had a witnessed fall. R206 was half laying half sitting on the floor next to the receptionist window. R206 was assisted up from the floor with the assistance of two staff and mechanical lift. - 9/19/24 R206 had put self on the floor four times during the shift. - 9/20/24 R206 had put self on the floor and was pushing her wheelchair over. - 9/22/24 R206 scooted to the edge of the chair and crawled down onto the floor. R206 then continued to lay down on the floor. - 9/25/24 R206 was on the floor by the door to her room. R206 got herself up into her wheelchair independently. - 9/28/24 R206 put herself on the floor two times this morning. - 9/29/24 R206 was crawling around on the floor crying. - 9/30/24 R206 put self on floor three times and back into her wheelchair while staff were sitting next to her. - 10/8/24 R206 refused to stand and and required the assistance of two to transfer. - 10/16/24 R206 put herself down on the floor several times. - 10/16/24 R206 had put herself on the floor two times. Progress notes lacked documentation if staff were present with R206 when she transferred herself to the floor as indicated in the progress notes above. Review of R206's safety checks (30 minute) dated 7/18/24 to 10/22/24, revealed the following: - 7/18/24 to 7/24/24, 78 checks were not documented. - 7/25/24 to 7/31/24, no logs. - 8/1/24 to 8/7/24, no logs. - 8/8/24 to 8/12/24, no logs. - 8/13/24 to 8/19/24, no checks were missed. - 8/20/24 to 8/26/24, 28 checks were not documented. - 8/27/24 to 9/2/24, 135 checks were not documented. - 9/3/24 to 9/9/24, 46 checks were not documented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/10/24, no logs. - 9/11/24 to 9/17/24, 85 checks were not documented. - 9/18/24 to 9/24/24, no checks were missed. - 9/25/24 to 10/1/24, no logs. - 10/2/24 to 10/8/24, 169 checks were not documented. - 10/9/24 to 10/15/24, 154 checks were not documented. - 10/16/24 to 10/22/24, 154 checks were not documented. During an observation on 10/30/24 at 7:25 a.m., R206's door was closed as R206 was in isolation precautions. R206 was laying in her bed on her back covered with a quilt. R206's eyes were closed and call light within reach. During continuous observations on 10/30/24 from 8:05 a.m. to 10:40 a.m., revealed the following: -7:25 a.m., R206 door was closed as R206 was in isolation precautions. R206 was laying in her bed on her back covered with a quilt. R206's eyes were closed and call light within reach. -8:05 a.m., no staff were observed to check on R206. -8:57 a.m., no staff were observed to check on R206. -9:19 a.m., no staff were observed to check on R206. -9:45 a.m., no staff were observed to check on R206. -10:13 a.m., no staff were observed to check on R206. -10:24 a.m., R206 family member entered the room and closed the door. No staff were observed to check on R206. -10:40 a.m., no staff were observed to check on R206. Requested registered nurse (RN)-B to enter R206's room to check on R206. R206 had not received 30 minute checks per care plan for a total of two hours and 35 minutes during this continuous observation. During an observation and interview on 10/30/24 at 10:45 a.m., RN-B donned personal protective equipment (PPE) and entered R206's room to check on R206. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/30/24 at 11:04 a.m., RN-B doffed PPE and exited R206's room. RN-B confirmed the above findings and indicated R206 had orders for every 30 minute checks. RN-B was not aware nursing staff did not check on R206. RN-B stated her expectations were for nursing staff to check on R206 every 30 minutes as indicated in care plan. RN-B further stated the checks were to be completed to ensure R206 was not attempting or laying on the floor. RN-B confirmed she did not complete any 30 minute checks on R206. During an interview on 10/30/24 at 11:16 a.m., nursing assistant (NA)-A stated she was in R206's room about 6:30 a.m., and had not been in there again. NA-A further stated she was aware R206 had 30 minute checks and NA-A had not completed any checks on R206. During an interview on 10/30/24 at 12:21 p.m., NA-F stated she was aware R206 had 30 minute checks. NA-F further stated she had not completed any checks on R206. During an interview on 10/30/24 at 1:09 p.m., director of nursing (DON) confirmed the above findings and indicated she was not aware staff had not completed 30 minute checks on R206. DON indicated she was aware R206 had a fall intervention to complete 30 minute checks for safety. DON revealed staff stopped doing 30 minute checks when R206 went on hospice on 10/23/24. DON stated the intervention had not been removed from R206's care plan and staff were expected to continue the 30 minute checks until in had been removed. DON further stated her expectations were staff followed the care plan. During a follow-up interview on 10/30/24 at 2:04 p.m., DON indicated was aware R53 had falls, and stated the facility's usual practice was to have interdisciplinary team meetings (IDT) to discuss resident falls, determine root causes and to put interventions in place. DON stated her expectation was that R53's Dycem to be in place to prevent R53's cushion from moving and R53 from sliding out of her wheelchair again. The facility policy Fall Prevention Program Policy, undated, identified each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy identified fall risk would be included if at risk for falls in the resident's care plan, and the interventions would be monitored for effectiveness.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview, and document review, the facility failed to ensure insulin pens were accurately dated when opened for 3 of 5 residents (R54, R152, and R202) who received insulin injections. Further, the facility failed to ensure Tubersol solution (a solution that is injected under the skin to test for tuberculosis) was discarded after 30 days per manufacturer's recommendations. Findings include: R54 R54's quarterly Minimum Data Set (MDS) dated [DATE], indicated R54 had diagnoses which included diabetes mellitus (DM), hypertension (elevated blood pressure) (HTN) and anemia. Indicated R54 required limited to extensive assist with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R54's signed physician orders dated 10/9/24, identified R54 had a physician's order for Glargine insulin 26 units at bedtime. R54's medication administration record (MAR) dated 10/4/24 through 10/30/24, identified R54 had been receiving 26 units of Glargine insulin at bedtime. R152 R152's quarterly MDS dated [DATE], indicated R152 had diagnoses which included DM, HTN, and peripheral vascular disease (a condition where the blood vessels are narrowed and reduce blood flow to the lower limbs). Identified R152 required extensive assist with ADL's which included bed mobility, transfers, and toileting. R152's signed physician orders dated 10/9/24, identified R152 had a physician order for Troujeo insulin 10 units at bedtime. R152'2 MAR dated 10/4/24 through 10/30/24, identified R152 had been receiving 10 units of Troujeo at bedtime. R202 R202's significant change MDS dated [DATE], indicated R202 had diagnoses which included DM, HTN, and muscle weakness. Identified R202 required extensive assist with ADL's which included bed mobility, transfers, and toileting. R202's signed physician orders dated 10/9/24, identified R202 had a physician order for Humalog insulin 12 units every a.m. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R202's MAR dated 10/4/24 through 10/30/24, identified R202 had been receiving 12 units of Humalog insulin every a.m. During an observation and interview on 10/29/24 at 12:55 p.m., while completing medication storage of the medication carts with licensed practical nurse (LPN)-A, the top drawer of the medication cart contained an open insulin Glargine Subcutaneous Solutions 100 units/ml insulin pen for R54 with a fill date of 9/3/24, which was not dated when opened. An insulin pen which contained an open Tresiba Subcutaneous Solution 100 units/ml pen for R152 with a filled date of 8/7/24, which was not dated when opened and an open Humalog Subcutaneous Solution 100 units /ml insulin pen for R202 with a fill date of 9/3/24 which was not dated when opened. Further, the refrigerator in the medication room contained an open multi-dose vial of Tubersol solution which contained an open date of 9/25/24. LPN-A verified the undated insulin pens and Tubersol solution. LPN-A stated R 54, R152, and R202 had current orders for insulin and the facility had been using the undated pens in the medication cart and the Tubersol solution in the medication fridge. LPN-A stated insulin pens and Tubersol solution were good for 30 days and should be discarded after 30 days. LPN-A further stated her expectation was that the insulin pens should have been dated to ensure it was discarded after 30 days and the Tubersol solution should have been discarded after 30 days. During an interview on 10/29/24 at 2:44 p.m., pharmacy consultant (PC) stated the facility should have dated the insulin pens to ensure they were used or discarded within 28 days. PC further stated he believed the Tubersol solution was ok to use until the expiration date because it had a lot of preservatives. PC stated his expectation was that all insulin pens would have been dated once opened . During an interview on 10/29/24 at 3:42 p.m., director of nursing (DON) stated her expectation was that all insulin pens would have been dated to ensure they were not used more than manufacture recommendations. DON further stated her expectation was that Tubersol solution would have been discarded after 30 days per manufacturer's recommendations. During a follow up email on 10/31/24 at 10:28 a.m., PC stated after further review Tubersol solution should have been discarded after 30 days. PC stated he would work with the facility to ensure that happened. Review of manufacturer's specifications for In-use Pen, store the pen you are currently using at room temperature [up to 86 Fahrenheit (F) (30 Celsius (C))] and away from heat and light. Throw away the pen you are using after 28 days, even if it still had insulin left in it. Review of manufacturer's specifications for use, 3 ml single-patient-use insulin glargine in use pen expires 28 days after opening. Review of manufacture's specific use for Tresiba, 3 ml single use insulin pen expires 56 days after opening. Review of manufacturer's specific for use, 3 ml single-patient-use Humalog pen expires 28 days after opening. Review of manufacture's specific use for Tubersol solution multi-dose vial indicated a vial of Tubersol which has been in use for 30 days should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Insulin Pen Policy undated, indicated the facility would use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort. Indicated once opened, clearly labeled insulin pens may be stored at room temperature in a locked medication cart. Further indicated insulin pens should be disposed of after 28 days or according to manufacturer's recommendation. A facility policy titled Policy: Storage of Medication Requiring Refrigeration undated, identified it was the policy of this facility to assure proper and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls. Further identified staff should observe fro proper storage and remove any expired medications from active stock and discard medication according to facility policy. .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 1 of 1 residents (R54) observed for enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) and for 5 of 5 residents (R151, R157, R152, R202, R206) observed for COVID-19 transmission based precautions (TBP). In addition, the facility failed to to provide sanitary catheter care to help prevent the development of infections for 1 of 1 resident (R54) observed who utilized a urinary catheter. Further, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 29 residents who resided in the facility. Findings Include: PPE Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. Review of CDC guidance dated 6/24/24, Infection Control Guidance SARS-COV-2 indicated health care professionals (HCP) who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of CDC guidance dated 5/16/23, How to Use Your N95 Respirator indicated N95 respirators must form a seal to the face to work properly. This was especially important for people at increased risk for severe disease. R54's quarterly Minimum Data Set (MDS) dated [DATE], identified R54 had moderate cognitive impairment, and had diagnoses which included: chronic kidney disease, diabetes mellitus, and anxiety. R54's MDS also identified R54 was always incontinent of urine and did not have a catheter in place. R54's care plan revised 10/23/24, identified R54 had actual complications and deficits with activities of daily living (ADL)s and required assistance with dressing, hygiene, toilet use and transfers. Indicated R54 had use of Foley catheter from 10/22/25 to 10/25/24, then trial of voiding. R54's care plan lacked EBP goals and interventions. R54's Order Recap Report, dated 10/1/24 to 10/31/24, included the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Catheter size is 16 french (F) with 10 milliliters (ml) saline needed for balloon inflation. -Change to foley leg bag on every morning. -Change foley night bag every night, at bedtime. -Foley catheter cares two times a day. During an observation on 10/30/24 at 7:41 a.m., R54 was sitting in recliner, covered with a blanket, dressed in street clothes, while his foley night bag was lying on the floor under the raised foot rest, uncovered and folded, with clear yellow urine visible in the bag. R54's doorway had a sign identifying EBP. At 8:02 a.m., R54 remained in recliner, while leg bag remained folded lying on the floor. During an observation on 10/30/24 at 9:08 a.m., nursing assistant (NA)-A was in R54's bathroom, had a gown on and was applying gloves. NA-A applied leg straps to R54's leg, then picked up R54's leg bag from the floor, clamped the tubing, unattached the foley night bag, used alcohol to wipe the tip and tubing of the leg bag and attached the leg bag. NA-A went back to the bathroom and emptied the foley night bag, while measuring the amount in a urinal. NA-A removed gown, and returned to R54, applied R54's leg bag with the straps, adjusted R54's pants legs, removed gloves then sanitized hands. NA-A applied R54's shoes. NA-A informed surveyor I should have kept my gown on. NA-A applied a gait belt to R54 and transferred R54 to wheelchair. NA-A removed R54's gait belt, assisted R54 to position self in wheelchair and transported R54 to tub room to get weighed. During an interview on 10/30/24 at 10:55 a.m., NA-A identified R54's catheter was on the floor, and it should have been up off the floor attached to something since the floor could be dirty. NA-A stated she should not have removed her gown before finishing with R54's catheter leg bag and assisting him to transfer to his wheelchair. NA-A indicated R54 was on EBP, and when she had removed the gown, she should have applied a new gown before finishing with R54's cares. During an interview on 10/30/24 at 1:32 p.m., clinical manager registered nurse (RN)-B stated catheter bags should not be lying on the floor for infection prevention and to prevent tripping. RN-B indicated R54 was on EBP, and a gown and gloves should have been worn when carrying for R54's catheter. RN-B stated would not expect EBP to be followed to only transfer a resident, or make their bed, because the catheter was enclosed, and staff would not come in contact with body fluids. RN-B indicated once staff were done completing the catheter cares, they could remove their gown. 45844 PPE: Review of R151's, R157's , R152's Rapid Covid -19 results revealed the following: R151's Rapid Covid -19 test dated 10/28/24, indicated R151 was positive for Covid-19. Review of R157's Rapid Covid-19 test dated 10/25/24, indicated R157 was positive for Covid-19. Review of R152's Rapid Covid test on 10/25/24, indicated R152 was negative for Covid-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 10/18/24 at 12:00 p.m., R151 and R157's door contained a sign that said Enhanced Respiratory Precautions Keep door closed if able: need to put on a gown, N95 or respirator, eye protection, one pair of gloves before entering room. During an observation on 10/28/24 at 12:05 p.m., Infection Preventionist (IP) -assistant director of nursing (ADON) sanitized hands, donned an N95 over her surgical mask, donned a gown, gloves, and eyewear and entered R 151's room with a lunch tray. During an observation on 10/28/24 at 12:25 IP-ADON sanitized hands and donned an N95 over her surgical mask, donned a gown, gloves, and eyewear and entered R157's room with a lunch tray. IP-ADON stood in R157's room within two ft. of R157 for ten minutes before doffing all PPE and returning to the hallway, sanitized hands and applied a clean surgical mask. During a continuous observation on 10/28/24 at 1:08 p.m., R 151 wheeled out of her room into the hallway past registered nurse (RN)-A, NA-A, one unidentified staff member and a family member until she reached the commons area near the front entrance of the facility. At 1:14 p.m., nursing assistant (NA)-A wheeled R151 back to her room. NA-A entered R151's room wearing an N95, no gown, gloves, or eyewear. NA-A returned to the hallway wearing the same N95 and entered R152's room and talked with R152 while shutting off the call light. NA-A then proceeded down the hall into the employee bathroom. At no time during the above observation did NA-A sanitize her hands. During an interview on 10/28/24 at 1:55 p.m., NA-A stated R151 was positive for Covid-19 and was in the hallway without a mask. NA-A further stated she had wheeled R152 back to her room and pushed her into her room and stood within two feet of R151 while encouraging her to eat her lunch. NA-indicated she should have removed her N95 and sanitized her hands after leaving 151's room and prior to entering R152's room since R152 was negative for Covid to prevent the spread of infections. During an interview on 10/28/24 at 2:03 p.m., registered nurse (RN)-A verified R151 was positive for Covid-19 and R151 had to be in the hallway she should have been wearing a mask. RN-A stated she had not noticed R151 wheel by her in the hallway. RN-A stated her expectation was that R151 would have been wearing a mask in the hallway. 49620 PPE: Review of the facility resident matrix dated 10/28/24, identified R202 and R206 had an active covid infection. During an observation on 10/28/24 at 12:17 p.m., R202 and R206's door contained a sign that said Enhanced Respiratory Precautions Keep door closed if able: need to put on a gown, N95 or respirator, eye protection, one pair of gloves before entering. Hospice staff exited R206's room wearing a gown, gloves and an N95 mask wearing a surgical mask on over the N95 mask. The hospice staff removed the gown, gloves and surgical mask and threw them away. The hospice staff left the N95 mask on and proceeded down the hallway past other staff members and stopped in the hallway outside of R206's room. Hospice staff opened the plastic bin outside of R206's room, put on gloves, gown, goggles and a surgical mask over the N95 mask and entered R206's room. (continued on next page)

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	245638	A. Building B. Wing	10/30/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 10/28/24 at 12:20 p.m., activity staff walked down the hallway wearing a surgical mask, opened the plastic bin outside of R202's room, put on a gown, gloves and goggles and entered R202's room. Activity staff was not wearing a N95 mask. During continued observation activity staff exited R202's room at 12:36 p.m., removed gown, gloves and goggles and threw them away and sanitized hands. Activity staff continued to have the same surgical mask on and entered R204's room and visited with R204. Activity staff exited R204's room, walked down the hallway with the surgical mask on visiting residents and staff in the hall before returning to the activity office. During an observation on 10/28/24 at 12:35 p.m., hospice staff exited R206's room, removed the gown, gloves, goggles and surgical mask and threw them away. Hospice staff continued to wear the N95 mask and walked to the nurses station, sat down and started typing on the computer. During an observation on 10/28/24 at 2:27 p.m., nursing assistant (NA)-G was standing outside of R206's room wearing a surgical mask, put on a gown, gloves, goggles and a N95 mask over the surgical mask and entered R206's room. During continued observation NA-G exited R206's room wearing the same surgical mask and sanitized hands. NA-G had removed the gown, gloves, goggles and N95 mask in R206's room prior to exiting. During an interview on 10/28/24 at 1:45 p.m., hospice staff stated she used the personal protective equipment (PPE) provided at each facility she entered. Hospice staff verified a fit test for the N95 was completed at this facility but was wearing her own N95 mask as there were not any available in the bins outside of the resident rooms that fit. Hospice staff observed to be wearing surgical mask over N95 mask during interview. Hospice staff stated she was wearing a surgical mask over the N95 mask to protect the residents as she had a cold. Hospice staff stated she was unaware of who to ask at the facility for supplies when the facility did not have them available and stated she was unaware she should not be wearing the same N95 mask from covid positive resident rooms to other rooms and staff areas within the building. During an interview on 10/28/24 at 2:37 p.m., NA-G stated she had not been fit tested for a N95 mask and did not receive training from the facility on how to wear a N95 mask. NA-G stated R202 and R206 were positive for covid and required staff to wear the proper PPE listed on the sign on R202 and R206's door. 48583 SURVEILLANCE Review of the facility's infection control logs within the Peerlytics system (a web-based software for infection management and antibiotic stewardship) included current tracking of residents who were receiving antibiotics, COVID positive, and residents with a fever. Facility infection control mapping within Peerlytics identified residents room numbers and residents with current infections. Facility infection control mapping revealed the following: - R154 had a current urinary tract infection (UTI). - R210 was COVID positive. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- R52 was COVID positive. - R202 was COVID positive. - R151 was COVID positive. - R60 was COVID positive. - R159 was COVID positive. - R206 was COVID positive. - R157 was COVID positive. The provided infection control logs lacked any completed process surveillance or comprehensive analysis to demonstrate if any other infections had potentially spread in the facility. There was no recorded assessment of the five identified residents (R52, R151, R206, R154, and R58) who were on enhanced barrier precautions (EBP). Additionally, there was no recorded assessment of one resident (R54) having an active UTI and one resident (R208) having a wound infection (WI). The logs lacked ongoing surveillance and trending of all infections which included food-borne illness, and other illnesses caused by other viruses or infections. Review of Census Traverse Care Center (TCC) dated 10/26/24, listed residents currently in COVID UNIT - droplet precautions / isolation (R157, R210, R60, R202, R159, R206, R151, and R52), residents currently on antibiotic therapy (R156, R154 and R52), residents currently on prophylactic antibiotics (R156 and R59) and residents currently on EBP (R58, R151, R52, R154 and R206). During an interview on 10/30/24 at 1:51 p.m., infection preventionist/assistant director of nursing (IP) confirmed the expectation that catheter bags should not be on floors for infection prevention reasons, as bacteria may be on the floor and come in to contact with the resident's catheter bag. IP indicated the expectation was for staff to wear gown and gloves during working with devices, such as catheters or completing wound cares. IP was unaware of any other CDC guidance for EBP, and would need to check the EBP sign. IP and surveyor went to R54's door, reviewed the sign, ADON confirmed staff should have worn PPE according the sign. IP verified staff should also wear the gown and gloves when completing close contact cares which included transfers. During a follow-up interview on 10/28/24 at 2:11 p.m., IP stated she applied an N95 over her surgical mask prior to entering Covid-19 positive rooms for added protection. IP stated she should not have placed an N95 over a surgical mask because there would not have been a good seal. IP indicated her expectation was that all staff including herself would follow facility policy regarding PPE use. During a follow-up interview on 10/28/24 at 6:15 p.m., IP stated the expectation of staff would be to wear a gown, gloves, eyewear and a N95 mask prior to entering a covid positive room. IP confirmed staff should not wear a surgical mask over or under a N95 mask as the seal could be separated and may spread infection. IP stated the facility was not currently providing audits to ensure PPE was being utilized appropriately. IP verified not all facility staff had been provided training on use or fit tested for a N95 mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 10/30/24 at 2:25 p.m., IP and registered nurse consultant (RNC) confirmed the above findings and indicated the facility was using Peerlytics. IP indicated the facility began using the program in February/March 2024, and it was a work in progress. IP revealed only infections meeting antibiotic criteria and COVID positive cases were being tracked in the Peerlytics system. IP stated EBP and any additional resident infections were not being tracked in the system. IP and RNC indicated tracking and trending was done within the facility however only for the infections that were uploaded into the Peerlytics system. IP stated she should be going into the Peerlytics system every one to two weeks but does not always get in there right away. During an interview on 10/30/24 at 2:01 p.m., director of nursing (DON) confirmed the expectation was for catheter bags to be off the floor for infection prevention and control reasons DON also confirmed expectation that staff don PPE according to CDC guidance for EBP, which included high contact cares. During an interview on 10/29/24 at 3:42 p.m., DON stated her expectation was that all staff would have worn PPE correctly in Covid -19 rooms and performed hand hygiene before and entering all resident rooms. DON stated staff should be removing all PPE after leaving a Covid-19 room and before entering another resident's room who was not positive for Covid -19. DON indicated it was important to follow CDC guidelines when working with Covid-19 residents to prevent the spread of infections. The facility policy titled Enhanced Barrier Precautions, undated, identified the facility would obtain an order for EBP for residents with any of the following which included residents with indwelling devices including urinary catheters, even if the resident was not known to be infected or colonized with a MDRO. The policy identified gowns and gloves would be worn when performing high-contact care activities, which included: dressing, bathing, transferring, and devise care or use including urinary catheters. The infection preventionist would incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.