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	01/14/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure that nebulizer medications were administered safely for 3 of 3 residents (R14, R1, R2) who were observed to self-administer a nebulizer and had not been approved to self-administer medications.Based on observation, interview, and document review, the facility failed to ensure that nebulizer medications were administered safely for 3 of 3 residents (R14, R1, R24) who were observed to self-administer a nebulizer and had not been approved to self-administer medications. Findings include: R24's annual Minimum Data Set (MDS) identified that R24 was moderately cognitively impaired. R24 had a diagnosis that included diabetes, anxiety, and depression. R24 required assistance with dressing, toileting, and transfers. R24's Care plan revised on 12/16/24, identified R24 had an altered respiratory status and difficulty breathing. Care plan identified staff were to administer medication and treatments as ordered. Additionally care plan identified R24 as not being able to self-administer medications related to dementia and cognitive impairment. R24's signed physician order dated 12/16/25, identified R24 of receiving budesonide inhalation suspension (reducing inflammation in the airway) 0.5 milligrams (mg) /2 milliliters (ml) 1 vial inhale orally one time a day for bronchitis, and Ipratropium-Albuterol inhalation solution (treat chronic obstructive pulmonary disease) 0.5-2.5mg/3ml 1 application inhale orally three times a day for bronchitis and give prior to budesonide treatment. R24's self-administration of medication assessment dated [DATE] identified R24 of not being capable of administering inhalants or inhalers and the resident was not approved for self-administration of medications. R24's electronic medical administration record (EMAR) dated January 2025, identified R24 received budesonide inhalation suspension 0.5mg/2ml on 1/12/25 at hour of sleep (HS). R24 received Ipratropium-albuterol inhalation solution 0.5-2.5mg/2ml three times on 1/12/25. During an observation on 1/12/26 at 7:45 p.m., R24 was sitting in his room with a nebulizer mask on and a nebulizer machine running. No staff in R24's room, nebulizer treatment appeared to be finished. At 7:47 p.m., trained medical assistant (TMA)-A went to the medication cart and took out budesonide inhalation suspension 0.5mg/2ml and verified medication with the EMAR. TMA went into R24 room and turned off the nebulizer machine and administered budesonide inhalation suspension 0.5mg/2ml to the nebulizer mask, turned on the nebulizer and then left the room. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's R1's quarterly MDS dated [DATE], identified R1 had severely impaired cognition and had a diagnosis of schizophrenia (mental disorder with hallucinations or delusions), and Alzheimer's disease (neurodegenerative disorder that affects memory). R1 was dependent on staff for dressing, hygiene, and toileting. R1's care plan revised on 2/21/24, identified R1 as not being able to self-administer medications related to dementia and cognitive impairment. Nursing staff to administer all medications per the physician's orders and monitor for side effects of medications. R1's self-administration of medication assessment dated [DATE], identified R1 as not being able to cognitively participate in self-administration of medications. R1's signed physician orders dated 12/2/25, identified R1had orders for Ipratropium-albuterol inhalation solution 0.5-2.5mg/2ml two times a day. R1's orders lacked an order for self-administration of medication. R1's EMAR January 2026 identified R1 received for Ipratropium-albuterol inhalation solution 0.5-2.5mg/2ml two times. During an interview on 1/12/25 at 7:56 p.m., TMA indicated that R24 could have the nebulizer treatment without staff present. During an interview on 1/13/26 at 4:10 p.m., RN-A indicated his normal practice was to place a nebulizer treatment on a resident and return in ten minutes to remove the nebulizer treatment. RN-A indicated that if a resident had a self-administration of medications, it would be in the orders. RN-A verified there were no self-administration orders for R1 and R14. RN-A was unaware if a self-medication assessment was done for R1 or R14. During an interview on 1/13/26 at 4:18 p.m., the administrator indicated a resident could self-administrator medications after a self-administration of medications assessment was completed and a resident was deemed capable of self-administrating medications. If a resident is not able to self-administrate medications, staff should keep the resident in their line of sight when administrating medications. The administrator indication a self-administration assessment is important to ensure a can properly administer the medication. R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact and had diagnoses which included: heart failure, chronic obstructive pulmonary disease (COPD), anxiety and bi-polar disease. Identified R2 was dependent on staff for dressing, personal hygiene, toilet hygiene, and transfers. R2's comprehensive care plan revised 11/20/25, identified R2 was not able to self administer medications due to cognitive impairment related to not interested in self administration of medication. Nursing staff to administer all medications per physician orders. R2's Self-Administration of Medication (SAM) assessment dated [DATE], identified R2 was unable to self administer as unable to obtain medications from package due to fine motor need. Not interested in self administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Medication Review Report signed 12/2/25, identified the following orders: -Budesonide Inhalation Suspension (nebulized medication to decrease inflammation of airways) 1 milligram (MG)/2 milliliters (ML) 1 application inhale orally two times a day by nebulization related to COPD. Rinse mouth with water after use. -Formoterol Fumarate Inhalation Nebulization Solution (nebulized medication to relax airway muscles to ease breathing) 20 micrograms (MCG)/2ML 1 application inhale orally via nebulizer two times a day related to COPD. -Ipratropium-Albuterol Solution (nebulized combined medication that relaxes lung muscles and reduces mucus) 0.5-2.5 (3) MG/3ML 1 unit inhale orally three times a day related to COPD. Rinse mouth after use. R2's Medication Review Report lacked an order to self-administer medications. During observation on 1/12/26 at 7:36 p.m., R2 was sitting in recliner in his room with a nebulizer mask covering his mouth and nose, while the machine was running. Registered nurse (RN)-A had just exited R2's room and left the wing. No other staff were noted in the hallway. At 7:43 p.m., nursing assistant (NA)-A exited a room across the hall from R2's room. NA-A leaned into R2's doorway, looked towards R2 in his recliner, then left the area, and walked down the hallway. At 7:45 p.m., RN-A entered R2's room, checked on R2's roommate. RN-A shut off R2's nebulizer, administered another nebulizer medication into the cup, then replaced the mask and turned on R2's nebulizer machine and left R2's room and area. During interview on 1/13/26 at 4:08 p.m., RN-A verified his usual practice for nebulizer medications, was to start the nebulizer, leave, then return ten minutes later to remove them. RN-A verified R2 received three different nebulizer medications, and he would administer one right after the other. RN-A verified he had administered the three nebulizer medications to R2 on 1/12/26, and had left after set up of each nebulizer medication. RN-A confirmed R2 did not have an order to SAM nebulizer medication. RN-A indicated he was unaware if R2 had a SAM assessment completed. During interview on 1/13/26 at 4:18 pm., with administrator, assistant administrator, nurse consultant and director of nursing the following was discussed. Administrator indicated expectation was if a resident was deemed competent for SAM, an assessment was completed, including what route of medication would be self administered. If a resident did not have a SAM assessment completed and was not deemed competent to administer the nebulizer medication, nursing staff would stay with the resident while the medication was administered. This was to assure proper administration of the medication. Policy title Resident Self-Administration of Medications, not dated, identified that a resident may only self-administer medications after the facility's interdisciplinary team has determined which medication may be self-administered safely.