DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 28JT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00361

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245346**

2.STATE VENDOR OR MEDICAID NO.
(L2) **733402000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRUMAN SENIOR LIVING**
(L4) **400 NORTH 4TH AVENUE EAST**
(L5) **TRUMAN, MN** (L6) **56088**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/20/2017**

6. DATE OF SURVEY **09/10/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 09/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 09/22/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/13/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 22, 2021

CMS Certification Number (CCN): 245346

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 10, 2021 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 22, 2021

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

RE: CCN: 245346
Cycle Start Date: July 28, 2021

Dear Administrator:

On September 10, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 28JT

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(L3) **TRUMAN SENIOR LIVING**
(L4) **400 NORTH 4TH AVENUE EAST**
(L5) **TRUMAN, MN** (L6) **56088**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/20/2017**

6. DATE OF SURVEY **07/28/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Alisha Jordan, HFE NE II 09/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 09/10/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :

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10/01/1986
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 19, 2021

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

RE: CCN: 245346
Cycle Start Date: July 28, 2021

Dear Administrator:

On July 28, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by October 28, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 28, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/26/21-7/28/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 7/26/21-7/28/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5346036C (MN00066504) H5346037C (MN00066192) H5346038C (MN00065628) H5346039C (MN00056159) H5346040C (MN00059595). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/27/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		9/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 2 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-1005) to 2 of 3 residents (R178, R179) reviewed whose Medicare A coverage ended and the residents remained in the facility. Findings include: The admission record printed on 7/27/21, indicated R178 was admitted on 1/29/21 and discharged on 7/16/21, diagnosis included femur fracture, diabetes, and weakness. The brief interview for mental status dated 5/5/21, indicated R178 was cognitively intact. R178's medical record identified on 3/12/21, R178 received and signed the Notice of	F 582	F582 Medicaid/Medicare Coverage/Liability Notice The corrective action was taken for R178, and R179 was to educate the Business Office staff on the importance and requirements of distributing the Skilled Facility Advanced Beneficiary Notice (SNFABN, form CMS-1005). The appropriate forms are available. The form was given to R178 and R179. The facility identified all residents have the potential to be impacted by not providing the CMS-1005 to those residents who remain in the facility after their Medicare A coverage has ended. An audit was completed to see if further residents were impacted.	

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 582	Continued From page 3 Medicare-Non-Coverage (CMS-10123) form. The form indicated R178's coverage of current skilled services would end on 3/15/21 and would remain in the facility. R178's record lacked evidence that R178 received the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, Form CMS-10055) as required. R178's Census List printed on 7/27/21, identified on 3/16/21, R178's payer source changed from Medicare Part A to Medicaid and remained in the facility. The admission record printed on 7/27/21, indicated R179 was admitted on 5/25/21 and discharged on 7/6/21, diagnosis included rib fractures and shoulder fracture. The brief interview for mental status dated 7/6/21, indicated R179 was cognitively intact. R179's medical record identified on 6/29/21, R179 received and signed the Notice of Medicare-Non-Coverage (CMS-10123) form. The form indicated R179's coverage of current skilled services would end on 7/1/21, and would remain in the facility. R179's record lacked evidence that R179 received the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, Form CMS-10055) as required. R179's Census List printed on 7/27/21, identified on 7/2/21, R179's payer source changed from Medicare Part A to private pay and remained in the facility. On 7/27/21, at 12:06 p.m. and interview with the business office manager indicated R178 and 179 had not received The Skilled Nursing Facility Advanced Beneficiary Notice and further	F 582	The measure that was put into place is a systemic change requiring incorporation of the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-1005) notice given along with the Medicare Denial letters moving forward. The facility developed a flow sheet to assure the proper forms were presented to the residents in compliance with Medicare guidelines. Education was completed with staff responsible for delivering notifications as required by Medicare. The facility will monitor its performance by documenting and auditing the delivery of the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-1005) for those residents whose Medicare A coverage has ended. Audits will continue weekly for three months after or until compliance is achieved. The audit findings regarding personalized interventions that have been utilized will be reviewed and evaluated by the IDT at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021 The above corrective action measures will be completed on or before September 7, 2021	

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	245346	A. BUILDING _____ B. WING _____	C 07/28/2021

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F 582	Continued From page 4 indicated it was not the facility's practice to provide the notice. The business office manager indicated going forward residents will receive the form. On 7/28/21, 11:15 a.m. an interview with the administrator stated she was not aware the beneficiary notices were not provided to the residents. A facility policy related to beneficiary notices was requested and not provided.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		9/7/21

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F 609	Continued From page 5 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported to the State Agency (SA), in accordance with established policies and procedures, for 1 of 1 residents (R8) reviewed for allegations of abuse. Findings include: R8's Admission Record, printed 7/28/21, included diagnosis of major depressive disorder, anxiety, panic disorder and, symptoms and signs involving cognitive functions and awareness. R8's quarterly Minimum Data Set (MDS) assessment dated 6/9/21, indicated R8 had a brief interview for mental status (BIMS) score of 8 (indicating moderately impaired cognition), was able to express her wants and needs and had verbal behaviors directed towards others that comes and goes. The MDS also indicated R8 required extensive assistance of one to two persons with activities of daily living (ADL's). R8's care plan, dated 12/23/20, indicated R8 is unable to care for herself independently and needs extensive assistance of one for dressing, personal hygiene, and toilet use. R8 is at risk for potential abuse, neglect or exploitation from others with intervention to investigate all reports of maltreatment per Office of Health and Facility Complaints (OHFC).	F 609	F609 Reporting of Alleged Violations The corrective action taken for R8 was accomplished by educating staff regarding the significance of the Abuse, Neglect, and Exploitation and Trauma-Informed Care company policies and procedures moving forward. A comprehensive internal investigation was completed addressing the potential allegations identified. A follow-up appointment was approved by the primary care provider to have the resident reassessed by the optometrist to determine if the resident is medically stable to have the procedure to restore eyesight. The resident representative, resident, and family were approached again by the Social Services Designee about mental/behavioral health resources available on-site or off-site. The facility identified the potential for all other residents to be impacted by failure to ensure allegations of any type of abuse were reported to the State Agency (SA) in accordance with established policies and procedures. Interviews were conducted with all residents which included questions about potential abuse, neglect, and exploitation, and Trauma-Informed Care. The following system changes were made	

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F 609	Continued From page 6 During interview on 7/26/21, at 2:48 p.m., when asked if any staff had made her feel afraid or humiliated/degraded, R8 stated she told a nurse yesterday she was having sharp pain in her upper left leg and left breast so she took her vital signs and told her there was nothing wrong. Awhile later when R8 was at the nurses station, the nurse brought up her complaint of pain to another nurse and they both started to laugh. R8 indicated she told them as nurses they shouldn't be laughing about things like that and they both got up and left because they knew they were in trouble. R8 further stated she did not tell anyone about it because she doesn't want anyone to get in trouble. On 7/26/21, at 6:41 p.m., the director of nursing (DON) and administrator (ADM) were notified when R8 was asked about abuse she verbalized the above issue. The DON indicated the staff would not laugh at R8's pain but she would check into it. The ADM indicated R8 has a history of hallucinations and delusions and they have been looking at possibility of starting her on antipsychotic medicaion but would prefer not to as they are on occasion and not all the time. During interview on 7/27/21, at 10:09 a.m., R8 confirmed the above incident and stated she hasn't seen the nurse since that day. R8 indicated she felt safe at the facility stating she can take care of herself. During interview on 7/27/21, at 10:18 a.m., the DON indicated she had not spoken to R8 yet as she wanted to speak to the nurses first because she knows R8 will say things that aren't true. The DON indicated if she felt like it actually happened	F 609	to ensure staff are aware of how a resident could consider comments to be abusive and would need to be reported. We put a system in place to educate and/or re-educate staff on revised policies and reporting procedures; along with the appropriateness and sensitivity regarding conversations that can occur between residents and staff. Review of reporting abuse, misappropriation, neglect, resident□s rights, and Trauma-Informed Care will be identified at each resident council meeting. Residents are monitored for issues that arise as to not trigger potential PTSD and then family members are contacted when situations are identified by staff. The facility revised and updated the Abuse, Neglect, and Exploitation Policy, Trauma-Informed Care Policy, and the Training Requirements Policy. Training content for staff must include the following areas: a. Written standards, policies, and procedures for the facility□s compliance and ethics program. b. Behavioral health. c. Dementia management and care of the cognitively impaired. d. Abuse, neglect, and exploitation prevention. e. Effective communication for direct care staff. f. The rights of the residents and the responsibilities of the facility to properly care for its residents.	

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F 609	Continued From page 7 she would have reported it immediately. The DON indicated the decision to not report was based on R8's history like saying she see's people, but they aren't there. The DON denied R8 has reported other incidents like this one. During interview on 7/27/21, at 10:27 a.m., the ADM indicated she did speak to R8 last evening and was told a similar variation of the above issue from R8. The ADM indicated she had been told previously about this event, but at the same time R8 indicated there was a little black boy present too. The ADM indicated this is a gray area as R8 never stated to her this was abuse and made it sound like they were joking around with her. The ADM further indicated they will file a State report and should have made the phone call yesterday but generally they will do an internal investigation within the first 24 hours. During interview on 7/28/21, at 10:59 a.m. with the DON and ADM, the ADM indicated they spoke with the nurse who was present when the event occurred who stated her and another nurse were joking around about something unrelated to R8 and R8 thought they were talking about her and she told them she was going to report them. The ADM indicated the other nurse is the one R8 has a history with and R8 does not care for her but they have not spoken to her about the event. The DON indicated R8 is a manipulator and when she doesn't like something or someone, R8 will threaten to tell on them. The ADM indicated they have attempted to get R8 mental health services but R8 and her family have both refused. The ADM indicated they did not file a state report for this as they felt it wasn't abuse because of the investigation follow up with the nurse on duty. The ADM further added if she felt this was true	F 609	Based upon the Facility Assessment it was identified the need for Trauma-Informed Care resident education and a screening process for those current residents at risk for trauma-related symptoms and/or a history of trauma. Cultural competence and linguistic competency education will be provided to the staff ensuring appropriate awareness of, attitudes toward, and actions about diverse populations, cultures, and language. This education will also involve the Abuse, Neglect, and Exploitation Policy reporting requirements as it pertains to potential allegations of abuse. The Administrator, Director of Nursing and/or designees will report any potential or suspected mental abuse or any other defined abuse regardless of previous interactions, documented behaviors, established BIMs, and/or related diagnosis to the State Agency, Adult Protective Services, and/or Law Enforcement immediately and in accordance with company policy. The facility will monitor its performance by completing weekly audits which include resident interviews for three months or until substantial compliance is determined. Thereafter, the Director of Nursing and/or designee will maintain monthly audits regarding Reporting of Alleged Violations to the State Survey Agency. The self-determinations audits will be reviewed and evaluated by the IDT at QAPI and QAA to determine appropriateness and effectiveness.	

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F 609	Continued From page 8 she would be the first person to report it. During interview on 7/28/21, at 11:15 a.m. R8 indicated she felt staff were making fun of her and felt it was inappropriate and rude. R8 stated she does joke around a lot with staff but staff went beyond joking and she felt shamed by them. A policy titled "Abuse Investigation and Reporting" last revised December 2016 included: - All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee to the following persons or agencies: - The State licensing/certification agency responsible for surveying/licensing the facility; - The local/State Ombudsman: - The Resident representative (Sponsor) of Record; - Adult Protective Services (where state law provides jurisdiction in long-term care); - Law Enforcement officials; - The resident's Attending Physician; and - The facility Medical Director - Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours. - Alleged abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours if the alleged events have resulted in serious bodily injury; - If events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours.	F 609	This written response does not constitute any admission of noncompliance with any requirement nor agreement with any findings. We wish to preserve our right or dispute these findings in their entirety at any time and in any legal action. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure ulcer (PU) interventions for 1 of 1 resident (R3) who's pressure ulcer worsened and who developed a new stage 2 pressure ulcer following a re-admission from the hospital. Findings include: During observation and interview on 7/26/21, at 7:00 p.m. R3 was in bed laying on his back. R3 stated he had a sore on his bottom that hurt when laying on it. R3 further stated staff help him reposition, but he can also reposition himself. R3 was unsure when he got the sore, but indicated it started hurting while recently in the hospital. R3's diagnosis report dated 5/3/21, included: paraplegia (impairment in motor or sensory function of the lower extremeties), body pressure induced deep tissue damage of the left and right	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer The corrective action taken for R3 was to update the resident's care plan to include the potential risks for skin breakdown due to vascular impairment, impaired mobility, hemiplegia, history of infections, and episodes of acute deterioration of the medical condition. The resident was comprehensively assessed for skin risk and the care plan was updated with current interventions and skin conditions. R3 wounds were assessed weekly with treatments completed as ordered. Both the coccyx area and the trochanter areas were officially resolved on 8/12/2021 with weekly ongoing monitoring of these areas with skin remaining intact. The resident continues to utilize wound care services for lower extremity issues and goes to the	9/7/21

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F 686	Continued From page 10 heel, pressure ulcer (injuries to the skin and underlying tissue caused by prolonged pressure) of the left buttock, respiratory failure (when lungs are depleted of oxygen), chronic obstructive pulmonary disease (COPD) (a disease that causes airflow blockage and breathing in the lungs), and muscle weakness. R3 was admitted to the hospital on 7/17/21, with acute respiratory failure and cholelithiasis (gallstones in the gallbladder). R3 returned from the hospital on 7/20/21. Review of the hospital discharge summary dated 7/20/21, indicated R3 was admitted from the nursing home with a stage 1 (reddened or discolored area of the outer layer of skin that does not blanch and is not open) pressure ulcer on the buttocks/coccyx (tailbone). R3's discharge minimum data set (MDS) assessment dated 7/17//21 identified R3 as having a brief interview for mental status (BIMS) of "15" (meaning cognition intact) The MDS identified R3 as requiring extensive assistance with mobility, that included repositioning, toileting and personal cares. The MDS identified R3 as having one or more unhealed stage 1 or greater pressure ulcer and 2 unhealed stage 2 (partial thickness skin loss) pressure ulcer, (located on the lower left leg) that was not present upon admission. The MDS did not identify if R3 was at risk for pressure ulcers nor did it include pressure ulcer interventions or treatment. R3's current care plan dated 5/20/21, identified R3 as having a history of sacral (located at the bottom of the spine) and hip pressure ulcers. The care plan did not identify any pressure ulcers to the coccyx area. R3 did have interventions in place for prevention of skin breakdown.	F 686	wound clinic as scheduled. All interventions to prevent further skin breakdown are in place with no new issues developing. The resident does have a current care plan in place for his long history of wound issues, thus making him at risk for further skin breakdown. The care plan was initiated with interventions to monitor his skin and make referrals as needed. The resident is at high risk for further issues due to his overall health condition. The facility identified the potential for all residents to be impacted by a failure to assess, monitor, and implement pressure ulcer (PU) intervention for residents whose pressure ulcer condition has worsened. A body audit was completed on all residents for visualization of any alterations in skin and for worsening pressure areas. The measure that was put into place is the Nursing Admission Checklist which was revised and updated to include Admission/Readmission Observation. This identifies to the nursing staff that a head-to-toe skin assessment Section L needs to be completed by the night shift within 24-hours of admission/readmission. The Skin Documentation Tool was revised and updated to include a comprehensive walk-through regarding observation of pressure areas, surgical incisions, skin tears, bruises, etc. weekly until resolved. The Skin Observation Tool was revised and updated to include the education to the nursing assistant staff on the	

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F 686	Continued From page 11 Interventions included: air mattress overlay, rooke boots when in bed, assist with repositioning every 2 hours per his request, follow facility policy for prevention of skin breakdown and weekly skin observations, that includes measurements/ monitoring/changes in skin status. R3's progress note dated 7/26/21, at 5:30 p.m. (late entry for 7/23/21), documented by the director of nursing (DON) indicated R3 reported he had a sore on his coccyx. There was a Mepilex dressing covering the area. When removed, the coccyx was noted to have a quarter size purplish area. The Mepilex was replaced and will be monitored. . The progress notes did not include any documentation of R3's stage 1 pressure ulcer upon return from the hospital until 7/23/21. At that time, the pressure ulcer had not been fully assessed to include measurements/monitoring or on-going treatment. Review of the progress notes and the weekly skin audits prior to R3's hospitalization on 7/17/21, did not included any skin concerns noted on the coccyx/sacral or buttocks area. Review of a weekly skin audit dated 7/26/21, (following hospitalization) did not include R3's PU's on the coccyx/buttocks area, although R3 had been identified as having a current stage 1 PU on the coccyx During observation and interview on 7/27/21, at 9:00 a.m. nursing assistant (NA)-A assisted R3 with repositioning to the left side. R3 was noted to have a stage 2 pressure ulcer on his right ischial tuberosity (lowest part of the pelvis) and a stage 2	F 686	importance of documenting old, chronic, or new skin issues on the □Skin Observation Tool that is reported to the Charge Nurse and/or Director of Nursing. The Skin Assessment and Documentation of Wound Treatments Policy and Procedure were revised and updated. All new residents since the Survey have been identified with all steps being completed. The resident□s skin assessments have been completed within the first 24 hours and any issues are documented. The DON is reviewing the admission assessment the day after admission and all have been completed to date. The Admission Checklist has been updated to have the night nurse sign off on completion and the Checklist is forwarded to the DON for final signoff. Both Nurses and Nursing assistants have been educated on the new procedure of reporting all-new skin issues via the Skin Documentation Tool, depending on the issue found the protocol is initiated with weekly monitoring until resolved. Weekly wound nurse continues to document and assess all wounds weekly with updates whether decline or improvement. In the event, any area declines the CNP Wound Nurse is contacted for evaluation and orders for treatment. The facility will monitor its performance by completing weekly audits of the Skin Documentation Tool and completion for three months or until substantial	

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F 686	Continued From page 12 pressure ulcer on the central coccyx/buttock area. There was also an area of scar tissue (bluish in color) on the coccyx near the buttocks, that looked healed. The coccyx/buttock area was covered with a Mepilex dressing (absorbent pad used for wounds) and the ischial tuberosity was open to air. The tissue around both open areas was very reddened. The right ischial tuberosity had been bleeding with a small amount of blood on the sheets. Interview with NA-A, stated she could not recall R3 having the pressure ulcers prior to hospitalization on 7/17/21, but did indicate R3 had the pressure ulcers for at least a week. NA-A further added R3 has had pressure ulcers in these areas in the past, but had healed. NA-A did not know if the current pressure ulcers were being treated or not. On 7/26/21, when R3 complained to surveyor of a "sore bottom", observations on 7/27/21, identified the PU to have worsened from a stage 1 (identified on the hospital discharge notes) to a stage 2 pressure ulcer. R3 had also developed another stage 2 pressure ulcer on the ischial tuberosity, Interview on 7/27/21, at 9:30 a.m. registered nurse (RN)-A (wound nurse) indicated she was unaware R3 had any new open areas on his coccyx. RN-A indicated there should have been a skin assessment done by the evening nurse the day R3 returned from the hospital. When asked RN-A if she could measure R3's pressure ulcers, she declined stating R3 had an appointment at the wound clinic that afternoon. R3 has been receiving treatment at the wound clinic for vascular ulcers on the left leg, and would have the clinic staff assess R22's PU's of the coccyx/sacrum.	F 686	compliance is determined. Thereafter, the Director of Nursing and/or designee will maintain monthly audits regarding skin documentation compliance. Weekly wound rounds will be completed by the Wound Documentation Nurse. All nursing staff will be educated on the Skin Documentation Tool. The Skin Documentation Tool audits will be reviewed and evaluated by the IDT at QAPI and QAA to determine appropriateness and effectiveness. Weekly wound rounds will continue with results provide to QAPI at least monthly with pressure ulcers/skin issues added to the monthly agenda rotations. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	

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F 686	Continued From page 13 R3's wound clinic progress note dated 7/27/21, included measurements of R3's PU's. The central coccyx/buttock area measured 1.7 centimeters (cm) in length, 0.3 cm in width. The right ischial tuberosity measured 0.5 cm in length, 0..2 cm in width and 0.1 cm in depth. Treatment of Mepilex and Xerofoam. Interview on 7/28/21, at 9:00 a.m. the DON confirmed R3 should have had a skin assessment done and interventions implemented when returning from the hospital, and when identified on 7/23/21. The DON also verified R3's pressure area on the coccyx/buttock had worsened from a stage 1 to a stage 2, and also developed a new stage 2 pressure ulcer of the right ischial tuberosity. Review of the facility policy Admission Notes dated 12/2006, indicated when a resident is admitted/re-admitted to the facility, the charge nurse must record specific data according to the policy. This included a "body audit" to identify any skin lesions, burns, rashes, bruises and pressure ulcers. Review of the facility policy Pressure Ulcer Risk Assessment dated 3/2005, indicated the purpose of the policy is to provide guidelines for the assessment and identifications of residents at risk for developing pressure ulcers. These guidelines included: (1) a pressure ulcer assessment will be completed upon admission/re-admission, with each additional assessment and significant changes; (2) Skin will be assessed for the presence of the development of pressure ulcers on a weekly basis or more frequent if indicated; (3) staff will maintain a "skin alert" performing	F 686		

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	245346	A. BUILDING _____ B. WING _____	C 07/28/2021

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F 686	Continued From page 14 routine skin inspections daily or every other day as needed; (4) the at risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. The admission/re-admission data helps to define those initial approaches .	F 686		

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	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2021**

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TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST** **TRUMAN, MN 56088**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/27/2021. At the time of this survey, TRUMAN SENIOR LIVING was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/27/2021

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. TRUMAN SENIOR LIVING was constructed at 4 different times. A 1-story building with no basement was constructed in 1970 and was determined to be of Type II (000) construction. Additions were added in 1975 and 1987, those were also determined to be Type II (000) construction. In 1996 another addition was added and determined to be Type V (111) construction. Because the original building and additions are	K 000		

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K 000	Continued From page 2 compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and properly maintain exit discarge in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, and 7.7. These deficient conditions could have a patterned impact on the	K 271	K271 Discharge from Exits The corrective action taken for all residents was to implement a maintenance prevention and identification program/process that identifies the	9/7/21

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K 271	Continued From page 3 residents within the facility. Findings include: 1. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed that the exit door in " A " corridor required more than 30 pounds of force to open and had a vertical transition to grade greater than one-half inch - associated to concrete separation and settle from building. 2. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed that the Chapel exit had a vertical transition to grade greater than one-half inch - associated to concrete separation and settle from building. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 271	facility's failure to inspect and properly maintain exit discharges in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, and 7.7. The facility identified that all residents have the potential to be impacted by not proactively identifying the facility's failure to inspect and properly maintain exit discharges. The measure that was put into place is the Environmental Services Director (ESD) and/or designee will visually observe/measure, physically test doors required excessive force to open and identify any exits that may be out of compliance. These results will be documented on a monthly identification schedule and any results, not in compliance will be brought to the Director of Nursing, and Administrator immediately. The governing Board of Directors and management team will be informed of these issues pertaining to the severity of the exits concrete separation and settling from the building regarding the cost of repair and/or replacement involved. The ESD had the concrete repair/replacement company on-site on August 25, 2021, to obtain a quote to repair and/or replace the exit doors concrete issues that were found to be in deficient practice at the time of the survey. The facility will monitor its performance by conducting monthly audits for two months or until compliance is achieved.	

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K 271	Continued From page 4	K 271	Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the Discharge from Exits compliance factors are kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to implement a fire watch policy for the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.6. This deficient condition could have an widespread impact on the residents within the facility. Findings include:	K 346	K346 Fire Alarm System □ Out of Service The corrective action taken for all residents was to revise the fire watch policy for the fire alarm system in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.6. The facility identified that all residents	9/7/21

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K 346	Continued From page 5 On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review that the Fire Alarm Out-of-Service Plan was incorrect in its time to implement Fire Watch protocol which stated in an 8 hour time period. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 346	have the potential to be impacted by the failure to implement a Fire Watch Out-of-Service Plan when the fire alarm panel is out of service for more than 4 hours in 24 hours. The measure that was put into place is the Environmental Services Director (ESD) and/or designee will actively monitor all fire panel outages and a Fire Watch shall be initiated when the fire alarm is out of service beginning when it has been shut down for 4 hours within 24 hours. The appropriate authority having jurisdiction shall be notified and the building shall be evacuated or an approved fire watch shall be initiated for all residents and employees left unprotected by the shutdown until the fire alarm system can be returned to service. The Fire Alarm Out-of-Service Plan was updated to reflect that a 4-hour requirement to implement the Fire Watch during the fire alarm outage. Staff will be educated on the updated Fire Alarm Out-of-Service Plan regarding the 4-hour protocol to implement a Fire Watch while the fire alarm system is shut down. The facility will monitor its performance by conducting monthly audits for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the Fire Alarm Panel documentation and out-of-service compliance factors are kept current and accurate regarding reporting. The audit will be reviewed and evaluated by the	

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K 346	Continued From page 6	K 346	Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the	K 353	K353 Sprinkler System □ Maintenance and Testing The corrective action taken for all residents was to implement a	9/7/21

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K 353	Continued From page 7 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, and 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed the sprinkler heads in RM B-56 exhibited signs of corrosion and oxidation. 2. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed the sprinkler heads in RM D-58 exhibited signs of corrosion and oxidation. 3. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed the sprinkler heads in Kitchen Dishwashing Area exhibited signs of corrosion and oxidation. 4. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed the sprinkler heads in Kitchen Dry Goods Storage Area had storage within 18 inches of the sprinkler deflector. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 353	maintenance prevention and identification program/process that identifies the facilities failure to inspect and properly maintain the sprinkler system in accordance with NFPA 101(2012 edition), Life Safety Code, sections 9.7.5,9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, and 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6,8.5.6.1. The facility identified that all residents have the potential to be impacted by sprinkler heads that are corroded, oxidized, and deficient storage practices. The Environmental Services Director and Food Services Director reconfigured the Kitchen Dry Goods Storage Area so that dry goods are not within 18 inches of the sprinkler deflector. Dietary staff was educated on the deficient practice and where dry goods are to be stored moving forward in the Kitchen Dry Goods Storage Area. The measure that was put into place is the Environmental Services Director and/or designee will continue to audit for compliance in the Kitchen Dry Goods Storage Area. The Sprinkler System and Maintenance company was contacted on August 25, 2021, for a quote regarding the replacement of the corroded and oxidized sprinkler heads that were found to be in deficient practice at the time of survey.	

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K 353	Continued From page 8	K 353	The facility will monitor its performance by conducting monthly audits for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the sprinkler system documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 372	K372 Subdivision of Building Spaces □	9/7/21

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K 372	Continued From page 9 facility failed to inspect and test facility smoke and fire dampers in accordance with NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4, NFPA 90A (2021 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, sections 5.4.8.1, 5.4.8.2, NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 19.4.1.1, NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review that smoke dampers were lasted inspected and tested on 07/26/2019, but deficiencies noted in the vendor report have not been corrected. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 372	Smoke Barrier The corrective action taken for all residents was to implement an inspection and testing of the facilities smoke and fire dampers in accordance with NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4, NFPA 90A (2012 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. The facility identified that all residents have the potential to be impacted by a failure to correct deficiencies identified in the Smoke Damper vendor report in a timely manner. The measure that was put into place is the Environmental Services Director contacted the Smoke Damper company on August 24, 2021, as they were the vendor who inspected and tested the dampers on 07/26/2019 regarding a bid for follow-up repair and/or replacement of the deficient dampers listed in the 2019 vendor report. The facility will monitor its performance by conducting completion audits regarding dampers listed on the follow-up vendor report post-repair and/or replacement for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the damper documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine	

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K 372	Continued From page 10	K 372	appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain proper interspace width of the smoke barrier doors in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.4, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 6.3.1.7. These deficient conditions could have a widespread impact on the residents within the facility.	K 374	K374 Subdivision of Building Spaces □ Smoke Barriers The corrective action taken for all residents was to implement an inspection and maintenance program that identifies proper interspace width of the smoke barrier doors in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.4, and NFPA 80 (2010 edition), Standard for Fire Doors	9/7/21

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	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST** **TRUMAN, MN 56088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 11 Findings include: 1. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed upon testing Smoke Barrier door assembly " Z " did not close properly, they bound and stayed ajar. 2. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed upon testing Smoke Barrier door assembly " V " did not close properly, they bound and stayed ajar. 3. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed upon testing Smoke Barrier door assembly " CC " did not close properly, they bound and stayed ajar. 4. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed upon testing Smoke Barrier door assembly " O " exhibited a vertical air gap greater than one-eighth inch. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 374	and Other Opening Protectives, section 6.3.1.7. The facility identified that all residents have the potential to be harmfully impacted by Smoke Barriers door assemblies that do not close properly, stay ajar, or allow a vertical air gap. The measure that was put into place is the Environmental Services Director and Maintenance Assistant adjusted the closer and repaired the deficient Smoke Barrier door assemblies that were not closing properly and ajar on August 12, 2021. The ESD in the process of collecting bids from the Smoke Barrier Door replacement companies to replace the Smoke Barrier door assemblies with the vertical air gap revealed to be in deficient operation identified during the survey process. Due to the value regarding the replacement cost of the Smoke Barrier door, we are scheduled to have the Board of Directors review bids for replacement at the September 2021 Board Meeting since this is outside traditional spending parameters. The facility will monitor its performance by conducting monthly audits for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the smoke barrier door documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine	

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K 374	Continued From page 12	K 374	appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security and physical accessibility to an electrical panel in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient condition could have an isolateed impact on the residents within the facility. Findings include:	K 511	K511 Utilities □ Gas and Electric The corrective action taken for all residents was to implement an inspection and maintenance program that identifies the facility failed to maintain proper security and physical accessibility to an electrical panel in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section	9/7/21

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K 511	Continued From page 13 On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed upon testing the Chapel electrical panel that it was unsecured in a resident accessible corridor. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 511	6.3.2.2.1.3. The facility identified that all residents could have the potential to be impacted by an unsecured electrical panel in a resident-accessible corridor. The measure that was put into place is the Environmental Services Director and/or designee will continue to audit compliance regarding locking of the electrical panels. The key for the unsecured electrical panel identified during the survey process has been located and is being used to secure the electrical panel in the resident-accessible corridor. The facility will monitor its performance by conducting monthly audits of electrical panel security for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the generator documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		9/7/21

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K 914	Continued From page 14 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing in patient bed locations in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed that the provided documentation was generic in information content, not providing	K 914	K914 Electrical Systems □ Maintenance and Testing The corrective action taken for all residents was to implement an inspection and maintenance program that identifies the facility failed to properly document the annual electrical receptacle testing inpatient bed locations in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. The facility identified that all residents	

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K 914	Continued From page 15 detailed information associated to the duplex and quad outlets located in resident rooms. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 914	have the potential to be impacted by not providing detailed inspection and maintenance logs regarding duplex and quad outlets located in the resident□s rooms. Documentation and auditing of resident rooms have been implemented with every outlet in every room being identified as a pass or fail then replaced based upon testing results. The measure that was put into place is the Environmental Services Director and/or designee will continue to audit and document the resident room outlets throughout the facility and replace outlets that are identified as failures during the testing process. The Fire Marshall provided the ESD with a comprehensive Receptacle Tests (Patient Care Areas) form to ensure compliance. The facility will monitor its performance by conducting monthly audits of resident room outlet inspections and corrective action for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the outlet documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7,	

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K 914	Continued From page 16	K 914	2021.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have a patterned impact on the residents	K 920	K920 Electric Equipment □ Power Cords and Extension The corrective action was taken for all residents to identifies the facility's failure to only have power strips in a patient care vicinity are only used for components of movable patient-care-related electrical	9/7/21

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K 920	Continued From page 17 within the facility. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in corridor " A " that extension cords were in use to power appliances (portable air conditioner units). 2. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in corridor " A " that an extension cord was routed through the ceiling to power an appliance (portable air conditioner units). 3. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Solarium that extension cords were in use to power an appliance (portable air conditioner unit). 4. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in RM D1 that an extension cord was in use to power an appliance. 5. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Copy Room an extension cord was in use to power an appliance (copy machine). 6. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Activities Office that power strips were daisy-chained together and supplying power to devices. 7. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Activities Storage Room that power strips were daisy-chained	K 920	equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. The facility identified that all residents have the potential to be impacted by utilizing extension cords and not removing them immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5. The extension cords that were in use to power portable air conditioning units, a copy machine, refrigerator, and daisy-chained together are either removed from the operation or the device is plugged directly into the wall outlets. The measure that was put into place the Environmental Services Director (ESD) and/or designee will continue to conduct auditing of extension cords usage within the facility to ensure compliance regarding temporary usage and immediate removal of extension cords. The facility will monitor its performance by conducting monthly audits regarding extension cord usage is within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Director will maintain an ongoing checklist to assure that the generator documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and	

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K 920	Continued From page 18 together and supplying power to devices. 8. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Nurses Station Med Room that a power strip was in use to power an appliance (copy machine). 9. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Physical Therapy Area power strips were daisy-chained together and supplying power to devices. 10. On 07/27/2021 between 10:00 AM to 03:00 PM, it was revealed in the Social Services Director Office that a power strip was in use to power an appliance (refrigerator). These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 920	effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		9/7/21

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K 923	Continued From page 19 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.4, 11.6.5 These deficient conditions could have an widespread impact on the residents within the facility. Findings include: 1. On 07/27/2021 between 10:00 AM to 03:00 PM,, it was revealed that the Med Gas Storage Room - " A1 " had cylinders that were unsecured, and no in-room signage to identify placement location for empty / full cylinders. 2. On 07/27/2021 between 10:00 AM to 03:00	K 923	K923 Gas Equipment □ Cylinder and Container Storage The corrective action was taken for all residents to identify the facility's failure to maintain medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.4,11.6.5. The facility identified that all residents have the potential to be negatively impacted by having cylinders unsecured, mixed storage areas, and lack of signage to identify placement and locations for empty/full cylinders.	

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K 923	Continued From page 20 PM,, it was revealed that the Med Gas Storage Room in B-Wing had no in-room signage to identify placement location for empty / full cylinders. 3. On 07/27/2021 between 10:00 AM to 03:00 PM,, it was revealed that the Med Gas Storage Room - " D56 " had cylinders that were unsecured, and no in-room signage to identify placement location for empty / full cylinders. 4. On 07/27/2021 between 10:00 AM to 03:00 PM,, it was revealed that the Med Gas Storage Room (between RM E7 and E9) had mixed storage of cylinders and no in-room signage to identify placement location for empty / full cylinders. These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 923	The measure that was put into place is the Environmental Services Director (ESD) and/or designee relocated the grill and cylinder to a secure outside storage area. All Oxygen cylinder rooms are locked and signage was provided to distinguish between empty and full cylinder placement locations. The facility will monitor its performance by conducting monthly audits regarding oxygen placement and security for two months or until compliance is achieved. Thereafter, the Environmental Services Director and/or designee will maintain an ongoing checklist to ensure the oxygen storage areas are within compliance and documented. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. This plan of correction will be reported to the QAA on September 15, 2021. The above corrective action measures will be completed on or before September 7, 2021.	