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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 429D

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 **10/05/2018** (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 **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
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
	50			
(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 :
Laura Ducharme, HFE NE II 10/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 11/02/2018 (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
(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
(L33)

DETERMINATION APPROVAL

Electronically Submitted

October 22, 2018

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

RE: Project Number S5346029

Dear Administrator:

On September 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 5, 2018, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a survey, completed on August 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 2, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on October 5, 2018. The deficiencies not corrected are as follows:

F880 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control

In addition, at the time of this revisit, we identified the following deficiencies:

F583 -- S/S: E -- 483.10(h)(1)-(3)(i)(ii) -- Personal Privacy/confidentiality Of Records
F695 -- S/S: J -- 483.25(i) -- Respiratory/tracheostomy Care And Suctioning
F726 -- S/S: F -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and

addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on October 4, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care

deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective October 27, 2018. (42 CFR 488.422)

Also, As a result of the revisit findings that your facility was not in substantial compliance, this Department imposed the following remedies:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective November 23, 2018. (42 CFR 488.417 (b))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your

receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Truman Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 5, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing

request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 November 23, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 23, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	R 10/05/2018

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}	INITIAL COMMENTS An onsite post-certification revisit was completed on 10/03/18 through 10/5/18, to determine the status of Federal deficiencies issued during a recertification survey exited on 8/23/18. The facility was found to have NOT corrected all deficiencies issued and additional deficiencies were identified. As a result, the facility has not achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The findings are delineated in this document. An Immediate Jeopardy (IJ) at 695 was also identified, which began on 9/26/18, and was identified on 10/3/18 when it was determined the facility failed to: (1) Ensure a resident had appropriately working respiratory equipment potentially failed, (2) Ensure facility staff were trained in the use of the critical respiratory equipment, (3) Perform critical nursing assessments in the presence of life-threatening abnormal oxygen blood levels and level of conscious changes. The IJ was removed on 10/4/18 at 7:15 p.m, when the facility implemented staff training and education, revised policies and procedures and put guidelines for monitoring of oxygen levels in place to remove the immediacy, however, non-compliance remained at the lower scope and severity level of G, which indicated actual harm that is not immediate jeopardy. An extended survey was conducted by the Minnesota Department of Health on 10/04/18. Because you are enrolled in ePOC, your	{F 000}		

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

Electronically Signed | 10/29/2018

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 _____	R 10/05/2018

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 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		10/25/18

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 _____	R 10/05/2018

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 583	Continued From page 2 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 7 of 39 residents (R23, R400, R401, R402, R403, R404, R405 and R406) had medical exams performed in the privacy of their rooms rather than in a public space. Findings include: During observation on 10/5/18 at 8:45 a.m., and again at 9:35 a.m. and 9:55 a.m., the medical director was observed to examine residents at the nurses' station: Registered nurse (RN)-A confirmed R404 was the resident observed to be examined at 9:35 a.m. RN-A confirmed R23 was the resident examined at 9:55 a.m. RN-A also said R400, R401, R402, R403, R405 and R406 had been examined at the nursing station. When observed, the medical director, accompanied by the facility's Minimum Data Set (MDS) assessment nurse, listened to lung sounds, examined a patient's legs, interviewed the residents about their eating and bowel habits, and discussed other private information. During observation on 10/5/18, at 10:12 a.m. the	F 583	The corrective action taken for R23, R400, R401, R402, R403, R404, R405 and R406 was accomplished by creating a policy requiring all providers to perform medical exams in the privacy of the resident room or in the examination room. Education was provided to all of the providers regarding this policy change on 10/23/2018. The facility identified that all residents have the right to have medical exams, assessments, lab draws, and treatments performed in the privacy of their rooms rather than in a public area. The measures that were put into place- The facility implemented the Resident Examinations, Treatments, Lab Draws, and Assessments policy. A designated examination room was developed on Blue Bell Wing to accommodate resident examinations, assessments, lab draws, and treatments. All providers were verbally notified when on site and all participating providers were educated and contacted 10/23/2018 by fax regarding our change in policy and procedure effective immediately.	

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 _____	R 10/05/2018

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 583	Continued From page 3 director of nursing (DON) was observed to walk by the nurses' station while the medical director's examinations were in progress but did not intervene. During interview on 10/5/18, at 10:15 a.m. the DON confirmed she was aware of the medical director's practice of observing patients at the nurses' station. The DON also stated residents could have been taken to their rooms, or the facility had other empty rooms available to use for medical exams. The DON stated she was unsure why staff had not taken the residents to their own rooms, or a vacant room so the medical director could conduct their exams in private. During interview with the director of operations (DOO) on 10/5/18 at 10:50 a.m., the DOO stated she had not observed the medical director performing examinations in public at the nurses station. The DOO said her expectation was for residents to see their physicians in a private area. The DOO said the DON should have intervened when she saw the medical director examining residents at the nurses' station. Although requested, no policy related to privacy during physician exams at the facility was provided during the survey.	F 583	The facility will monitor it performance by completing weekly audits. Audits will continue for 2 months or until 12/26/2018. This plan of correction was reported to the QAA on 10/31/2018. The corrective action was completed on 10/25/2018.	
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		11/16/18

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 _____	R 10/05/2018

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 695	Continued From page 4 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff appropriately monitored, assessed and intervened, for 1 of 2 residents (R25) reviewed for respiratory care, who displayed significantly reduced oxygen saturations with a decline in physical condition requiring emergency care. The facility's lack of assessment, staff education and failure to implement appropriate interventions, resulted in an Immediate Jeopardy (IJ) with the potential for serious harm, injury or death. In addition to R25, 1 other resident (R283) who currently resided in the facility at the time of the revisit survey was identified as at risk due to respiratory issues requiring a CPAP (continuous positive air pressure) equipment to be used to assist with breathing. The Immediate Jeopardy (IJ) began on 9/26/18, when R25 was sent to the emergency room by ambulance due to respiratory distress, low oxygen saturation, related to potential malfunctioning equipment, lack of nursing assessment and intervention. The administrator and director of nursing (DON) were notified of the IJ situation on 10/3/18, at 5:10 p.m. The IJ was removed on 10/4/18, at 7:15 p.m. however, non-compliance remained at the lower scope and severity of (G) isolated with actual harm that is not Immediate Jeopardy. Findings include: Review of R25's medical record indicated he was	F 695	The corrective action taken for R25 and R283 was accomplished by immediately ensuring residents who receive respiratory care are monitored, assessed, with appropriate interventions to ensure safety by providing in-service training to all licensed staff on 10/4/2018. The training on CPAP consisted of the purpose, an explanation of how CPAP works, and how to correctly operate the CPAP equipment. All Licensed Staff were competency trained on CPAP which included- change in condition and notification to the medical provider, with competency testing completed on 10/19/18. (The two licensed staff who were unable to attend the initial training on 10/4/2018 completed the CPAP Educare Module on 10/4/2018 and were competency tested on 10/19/2018.) Additional education was provided on what constitutes normal vital sign range and steps to take for abnormal vital sign range. All staff had competency check offs to recognize compromised respiratory status on 10/19/18 which included monitoring and notification of the primary medical provider. Nursing Assistant CPAP training was initiated on 10/11/2018 that included their responsibilities with residents on CPAP. INTERACT training was initiated on 10/29/2018, which included SBAR communication and Care Path training for identification of change in condition and	

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 _____	R 10/05/2018

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 695	Continued From page 5 admitted on 7/5/18, with diagnoses including: morbid obesity, anxiety, type 2 diabetes, high blood pressure, atrial fibrillation with pacemaker (abnormal heart rhythm requiring pacing of the heart), chronic respiratory failure (CRF) with hypoxia (low oxygen level in blood), chronic kidney disease, edema, dependence on supplemental oxygen, chronic obstructive pulmonary disease (COPD), chronic anti-coagulation (thinning of the blood to reduce clotting), muscle weakness and ordered CPAP (continuous positive airway pressure machine, a device used to prevent the airways closing during sleep). There was no mention of an assessment involving R25's knowledge or capability of using his CPAP. R25's physician's orders included entries on 7/10/18 for use of a CPAP at current setting: On at night (HS) and off in the morning (AM). Staff were to clean the CPAP mask weekly and check the reservoir tank for the CPAP every HS shift. R25 was ordered to have Oxygen delivered via nasal cannula at 2 liters per minute (LPM) continually every day and night shift. Review of R25's progress notes indicated: (1) 9/17/18 at 11:07 a.m., a nurse was called to the therapy department after a fall. R25 was sitting on his buttocks on the floor at the time the nurse arrived. R25 denied he had any discomfort or pain. His blood pressure (BP) was 141/72, pulse was 84, respiratory rate was 22, and O2 sats were 88% off oxygen. R25 was assisted to his wheelchair by a mechanical lift, and O2 was placed back on. Vital signs were to be monitored for 72 hours along with any changes the resident may have. There was no documentation in the nurses notes to indicate vitals were monitored for	F 695	provider follow through training for all Licensed staff. INTERACT Stop and Watch training will be given to all NARS by 11/15/2018. R25 was discharged. A self-administration assessment was completed for R283 to determine if the R283 can safely place and remove the CPAP independently on 10/4/2018 and 10/29/2018. The facility will identify other residents having the potential to be impacted with respiratory care concerns ie CPAP by-Screening new admission referrals, hospital returns, new orders and by following through with assessing change in condition as it relates to respiratory status. The INTERACT SBAR Communication & Progress note along with the Care Path system for identifying change in condition have been implemented. The INTERACT Stop and Watch was also implemented at the NAR level in order to assure that communication regarding change in condition occurs. Change of shift reporting process was altered to include the provision that the Licensed Nurse review the electronic medical record ie Point Click Care (PCC) 24 hour &/or 72 hour report that reveals residents change in condition status, this will be initiated by 11/1/2018. The measures put into place that are a systemic change are requiring a CPAP Checklist for each resident admitted with a CPAP machine. This was developed and implemented on 10/11/2018.	

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 _____	R 10/05/2018

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 695	Continued From page 6 72 hours as indicated to be or therapy staff were interviewed to the cause of the fall, or injuries that may have happened. (2) 9/17/18 at 3:14 p.m., R25's Medical doctor (MD) called to see how R25 was doing after the fall. The MD asked staff to advise him of R25's condition. Nursing staff told MD R25 was doing ok with no pain or bruising. Nursing staff would continue to monitor and report changes. (3) 9/19/18 at 11:50 a.m., R25 was having increased shortness of breath (SOB) and was much more lethargic. His O2 sats were between 88-92%. R25 was now using his CPAP between meals while in his room. His color remained pale. There was no documentation or notes related to (r/t) R25's respiratory status or notification to the doctor of his decline in health. (4) 9/26/18 at 11:48 a.m., R25 continued to be lethargic. His oxygen saturations (O2 sats) were anywhere from 80-84%. Staff were unable to maintain his O2 sat at 90%. R25's MD was called and R25 was sent to the emergency room. (5) 9/26/18 at 2:26 p.m., R25 returned from the emergency room (ER) with orders to have his CPAP machine checked and to ensure there was good wave form when checking oxygen saturation. R25 was to return to the ER for new or worsening symptoms. (6) 9/26/18 at 2:40 p.m., a call was placed to R25's family member, informing her of his CPAP machine needing to be checked. (7) 9/26/18 at 6:11 p.m., R25 was having a hard time staying awake at supper. R25's tablemate was concerned and asked the nurse to check R25. The nurse had to wake R25 up several times over the course of his meal. There is no mention of any vital signs taken to include O2 sats at that time. (8) 9/26/18 at 10:59 p.m., staff noted R25's	F 695	Additionally, residents on CPAP will have their oxygen saturation levels checked as a standard of practice a minimum of every 4 hours. Residents on CPAP will have individualized O2 saturation level parameters set forth by the primary provider while on the CPAP machine with guidance on action to take should O2 saturation levels drop to specific ranges as determined by the primary provider. A change in resident condition EMR generated report will be obtained at shift change in conjunction with shift to shift report. During shift to shift report the nurses will review the 24/72 hour Point Click Care Summary Report. Ongoing training and competency for all nursing department team members including agency/pool staff will occur as a standard of practice upon hire and annually. If new equipment is utilized additional training and competency will be completed in real time. A facility CPAP checklist for residents on CPAP was created so that continuity and consistency with follow through by all nurses could be maintained. A facility resource information and guidelines binder was created and is available for all staff to reference guide which includes change in condition next steps, (INTERACT). Education was provided to all staff that any equipment utilized within nursing home setting becomes the facility□s responsibility. This education was initiated on 10/29/2018. Implementation of Nurses Orders for the purpose of nurse guidance with	

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 _____	R 10/05/2018

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 695	Continued From page 7 "machine not working". There was no mention staff checked R25's vitals or completed a thorough assessment of his condition, to ensure he had no signs or symptoms of respiratory distress. (9) 9/27/18 at 9:50 a.m., R25 needed assistance of 2 with transfers related to health decline. There was no mention of any vitals being taken at that time, nor any further respiratory assessment being completed. (10) 9/28/18 at 8:24 a.m., the MD was called to notify R25 had "coded" that a.m. and was being sent to the ER via ambulance. (11) 9/28/18 at 8:35 a.m., family was notified of R25's ER transfer. (12) 9/28/18 at 9:54 a.m., the ambulance service called to inform R25 was being airlifted to another larger hospital in Rochester, MN. (13) 9/28/18, at 10:11 a.m., nursing staff entered documentation surrounding the events from earlier that a.m.. The documentation indicated that when the licensed practical nurse (LPN)-A was entering the room that morning, she found R25 in bed without O2 or his CPAP on. When she asked R25 why he did not have his O2 and CPAP on he mumbled incoherently. LPN-A placed his O2 on at 2 LPM and elevated his head to 30 degrees. LPN-A checked his O2 sat and found it to be 60%, which was significantly below R25's expected 90%. Earlier that a.m., nursing assistant (NA)-A assisted R25 to his wheelchair (W/C) with the mechanical stand lift. NA-A stated R25 was able to assist and was speaking to her. NA-A then noticed R25 had stopped speaking and his head fell back. NA-A called for help. R25 became cyanotic (blue color of skin caused by lack of oxygen). Chest compressions were started while the resident was in his W/C and staff called 911. An automated external	F 695	monitoring was implemented on 10/25/2018. The care plan for R283 was reviewed and updated. The Facility Assessment will be updated to include caring for residents with CPAP by 10/31/2018. A policy for Medical Director Change in a Resident□s Condition Notification was implemented and educated on 10/29/2018. The facility will monitor its performance by completing a checklist of the CPAP machine via 2 nurses checking the equipment functionality at each change of shift. This will be completed as standard of practice in an ongoing manner. The checklist will be turned into the D.O.N. daily. Additionally the nurse will sign off on the MAR/TAR completion of this task. An audit of the 24 hr &/or 72 hr Summary Report for utilization and follow through on abnormal vitals &/or change in condition, will be conducted and reported to the D.O.N. 2 x□s/wk through 12/26/18. This plan to correct will be reported to QAA on 10/31/2018. The corrective action will be completed by 11/16/2018.	

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 _____	R 10/05/2018

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 695	Continued From page 8	F 695		

defibrillator (AED) was applied, but no shock was advised. Compressions continued. A femoral pulse was noted as present. The ambulance (EMS) and sheriff's department arrived. An ambu bag was used to assist with breathing and R25's O2 was at 85%. R25 was able to move all extremities. EMS transported R25 to the ER in Fairmont. Fairmont ER called and stated R25 was being transferred to a hospital in Rochester via helicopter.
(14) 9/28/18 at 4:04 p.m., nursing staff called for an update from the hospital on R25's condition. R25 was intubated (tube into the lungs to assist with breathing). Hospital staff were continuing medical exams and were going to check a head computerized tomography (CT) and an ultrasound. R25's O2 sats were 90%. Family was present.
(15) 9/30/18 at 10:35 a.m., R25's family member called. R25 was now off sedation with hopes of removing his breathing tube. The family member asked if R25 had fallen during his respiratory arrest, as the CT showed a brain bleed, she was told was consistent with a fall. Nursing advised R25 had not fallen during the event, nor was he on the floor at that time. If R25 had fallen prior to the 9/28/18 event, he would not be able to get himself back up. R25 was unresponsive with some eye movement. The family member was quoted as saying "Things do not look that good."
(16) 10/1/18 at 2:00 p.m., R25 was off the ventilator and would now be entering hospice end-of-life care.

During interview with LPN-A on 10/3/18 at 12:30 p.m., LPN-A stated she had started her shift the morning of 9/28/18 at 6:00 a.m.. Sometime shortly after receiving report, LPN-A went to R25's room [at approximately 7:00 a.m.]. LPN-A

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 _____	R 10/05/2018

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 695	Continued From page 9 found R25 without his O2 or CPAP on. R25's sats were at 60% (normal oxygen saturations typically are 90% or above, 60% would indicate severe hypoxemia). R25 was mumbling incoherently at the time. After applying oxygen to R25, LPN-A left the room and did not return. LPN-A stated she thought since R25's O2 saturations were starting to climb back up into the middle 60's he was ok to be left alone. LPN-A verified she had not performed a respiratory assessment or checked vitals at that time. LPN-A stated because she was sure R25's O2 sats would come up, she did not return to R25's room until notified of his cardiac arrest later that morning at approximately 8:00 a.m. LPN-A said she did not call R25's physician, or procure emergency services at that time despite the critically low oxygen saturation value and change in R25's mentation. LPN- A stated if a resident's O2 sats were low, she should recheck in 1 hr. LPN-A was unaware what O2 sats level were considered critical. LPN-A stated R25's normal sats were in the "low 90's". LPN-A was unaware when to assess or reassess a resident for safety in critical situations, or when to call emergency medical services (EMS) when a resident had critically low oxygen sats and/or level of conscious changes. LPN-A stated staff check R25's oxygen at night prior to going to bed, but acknowledged she was unaware of any other routine checks. LPN-A also said she felt it was "useless to send R25 to the ER [on 9/28/18] as they would just say he was fine" after he arrived like they had done previously on 9/26/18. During further interview on 10/3/18 at 12:30 p.m., LPN-A stated on 9/26/18, R25 was sent to the ER because of low O2 sats and they [the ER] "did nothing." ER staff reportedly asked her what they were to do about his low O2, as by the time R25	F 695		

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 _____	R 10/05/2018

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 695	Continued From page 10	F 695		

arrived on 9/26/18, his oxygen was in the high 80's. LPN-A again explained the resident's tablemate had called her over to see what was the matter with R25. LPN-A said she'd asked R25 how he was doing but added, "He kept falling asleep ...He complained something was wrong, and continued to keep falling asleep." LPN-A said she'd called the MD and obtained orders to send R25 to the ER and sent R25's CPAP machine along with R25. LPN-A said, "Staff thought it was malfunctioning R/T [related to] R25's low oxygen levels. R25 was known to have mumbled speech when his oxygen got "low"." LPN-A stated she was unsure whether R25's machine was or was not functioning, and said, "I don't know how to run them." LPN-A said the ER had reported the facility needed to "get it checked" so she called the family member and told her to come get the CPAP machine, and instructed the family member to take it to the supplier. LPN-A said since it was not the facility's equipment, it was the family's responsibility to get the equipment checked for working order.

During the same interview, LPN-A stated she felt R25 was able to properly apply the mask and use the machine on his own. She said she thought he did so because he was known to independently remove his mask during the night. She was unsure exactly how to place the mask or operate the CPAP machine herself. LPN-A said she had looked at the instructions for the CPAP at the time staff thought it was malfunctioning on 9/26/18, and had not understood what to do. LPN-A stated R25's CPAP was still at the facility. Review of the record revealed there was no assessment performed on R25 to ensure he knew how to operate the CPAP, nor was he capable to do so. LPN-A stated staff had no

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 _____	R 10/05/2018

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 695	Continued From page 11	F 695		

professional references or policies to follow for abnormal vital signs or critical events. She said the DON and administrator are notified by nursing staff of every hospital transfer.

During interview on 10/3/18 at 12:45 p.m., LPN-A was observed in R25's room. R25 stated the breathing machine was not identified directly as either a CPAP, but had a sticker on the machine stating to "call with questions". LPN-A said she had never called the number on the machine for concerns related to potential malfunctioning of the equipment. LPN-A said since the equipment had not been supplied by the facility, but rather by a government agency, she (LPN-A) had called R25's family to come get the machine and have it fixed. LPN-A was unable to state how staff ensured R25 was safe with a malfunctioning machine. LPN-A confirmed staff had not had education on the use or maintenance of R25's CPAP machine. Further, LPN-A identified one other resident, R283, as a current resident who also utilized a CPAP even though staff were unaware how to ensure CPAP equipment was placed or working properly.

Nursing assistant (NA)-A was interviewed on 10/3/18 at 1:05 p.m. NA-A stated she'd been told by LPN-A, immediately after report on 9/28/18, between approximately 6:15 and 6:30 a.m. not to get R25 up for the day because his oxygen was low. NA-A stated she'd gone into R25's room to get him up at approximately 7:45 a.m. without receiving notification it was ok to do so by LPN-A. NA-A said R25 had been mumbling but was awake, so NA-A thought it was ok to take R25 over to the main bathing room to shower. NA-A explained she had used the mechanical lift on R25 to transfer him out of bed and into his

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 _____	R 10/05/2018

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 695	Continued From page 12 wheelchair. She then proceeded to wheel him across the hall into the bathing room. NA-A said she began readying R25's shower when she noticed he was not speaking anymore. NA-A said she'd looked over at R25, and noticed his eyes were rolled back into his head with his head hung back, and he was gray in color. NA-A said she then called for help and when the nurse arrived she began cardio pulmonary resuscitation (CPR). Review of R25's September 2018 Documentation Survey report indicated Vitals (Blood pressure, temperature, pulse, respirations and pain) from September 21-September 28th, 2018, showed on: (1) 9/14/18, during the hours of 2:00 p.m. to 10 p.m., all vitals were marked "N/A" (not applicable). (2) 9/19/18, during the time of 6:00 a.m. to 2:00 p.m., there is 1 notation of his respiratory rate being assessed. The score was 22 breaths per minute (BPM) (normal 12-16 PM), meaning R25 experienced shortness of breath. (3) 9/23/18, during the hours of 2:00 p.m. to 10 p.m., all vitals except pain were marked NA. Pain was assessed as "N" meaning R25 had no pain. (4) 9/9/18, 9/10/18, and 9/23/18. during the hours of 10:00 p.m. to 6:00 a.m. all vitals except pain were marked NA. R25's pain was assessed on those 3 days. There is no mention of R25's oxygen saturation having been checked by staff during the month of September on the report. R25's 10/2/18 care plan revealed he had an advanced directive for Full Code. R25 had a Physician Orders for Life-Sustaining Treatment (POLST) filled out upon admission to the facility that was to be reviewed annually and at care	F 695		

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 _____	R 10/05/2018

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 695	Continued From page 13	F 695		

conferences. R25 had a self-care deficit related to (R/T) his COPD and required extensive assist with activities of daily living (ADL). Staff were to monitor for signs of difficulty breathing. R25 was able to self-administer nebulizer medication treatments after setup by staff. R25 was at risk for neglect from others related to his nursing home placement. Staff were to identify R25's vulnerability and risk through assessment. R25 was noted use a Bi-PAP (Bi-level Positive Airway Pressure) machine HS with supplemental oxygen R/T CRF and COPD, however, R25's current treatment sheets indicated he used a CPAP. R25's goal was to have no signs or symptoms (SX) of poor oxygen absorption. There was no mention of how or how often staff were to monitor or assess R25 to ensure he had no complications from his COPD or history of CRF.

Review of R25's 9/25/18, Minimum Data Set (MDS) indicated he had a Brief Interview for Mental Status score of 14, indicating normal cognition. R25 required extensive assist with bed mobility, transfer, dressing, and personal hygiene requiring the assistance of 1 staff. R25 weighed 380 lbs. R25 was documented as receiving oxygen but was not noted to be on a CPAP or Bi-PAP while a resident.

Review of R25's Care Area Assessments (CAA) completed on 8/15/19, completed by the MDS coordinator indicated he had sever pulmonary disease, but no shortness of breath. R25 had poor memory and anxiety with an inability to perform ADLs without significant physical assistance by staff. R25 's cognitive deficits included stamina, ability to express himself, and make decisions with altered mental status. R25 had a change in communication, vision, hearing,

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 _____	R 10/05/2018

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 695	Continued From page 14	F 695		

and cognition. R25's goals indicated he was to maintain his current level of functioning and physical limitations such as weakness. There was no mention of his limited visual ability from his diagnosis of glaucoma or the use of medications that may limit his vision, such as antidepressants or narcotics.

Review of R25's 7/5/18 Medication Administration Record and Treatment Administration Record indicated he received nebulizer treatments (medication top open airways in the lungs) 4 times per day of Ipratropium-albuterol inhalation medication. There was no mention of when staff were to check R25's oxygen levels to ensure he had no adverse effects from his COPD and history of CRF.

Review of R25's 9/26/18 emergency room documentation indicated his discharge diagnosis was dyspnea (difficulty breathing). Patient instructions listed were:
(1) Continue current medications.
(2) Have your CPAP machine checked.
(3) Make sure there is a good waveform when checking oxygen saturation.
(4) Follow-up in clinic within one week.
(5) Return to the ER for new or worsening symptoms.

Review of R25's 9/28/18 at 9:38 a.m., emergency room documentation indicated he was an inpatient at that time admitted for cardiac arrest, respiratory failure, hyperkalemia (high potassium) atrial fibrillation, pacemaker, coronary artery disease (CAD), COPD exacerbation, heart failure, and diabetes. He was sedated and a mechanical ventilator to breathe for the resident was placed. MD progress notes revealed he was a

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 _____	R 10/05/2018

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 695	Continued From page 15 73-year-old male, admitted directly from the triaging hospital. R25 was reported to be suffering from worsening respiratory symptoms. He was reported found that day at the nursing home cyanotic and unresponsive. No pulse was detected and CPR was started. Upon arrival of EMS, the resident was thought to have spontaneous breathing. He was hypertensive (elevated blood pressure) and tachypneic (abnormal rapid breathing) on route to the ER. He was poorly responsive upon arrival to the ER, and would appear to open his eyes when his name was called. Due to the tachypnea and wheezing, R25 was immediately intubated. R25 did have a urinary tract infection prior to that day and was being treated by antibiotics previously. The assessment/plan indicated he had suffered cardiopulmonary arrest requiring mechanical ventilation R/T respiratory failure and suspected COPD exacerbation. Further review of R25's 9/28/18 at 11:08 a.m., ER documentation history and physical revealed R25 had suffered an unwitnessed arrest that a.m., and was successfully resuscitated at the nursing home. Staff were trying to deduce the origin of the arrest, but it was likely primarily respiratory, given his recent history and mounting respiratory complaints. Other considerations could be a massive stroke, which was not suggested by clinical exam. R25 was being paced with an underlying rhythm of atrial fibrillation. Staff were treating for COPD exacerbation and covering broadly with antibiotic [R/T his known bladder infection]. Staff plan on providing lung protective mechanical ventilation, assessing his mental status by minimizing sedation required for ventilation, and a head CT as the resident "was found down".	F 695		

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 _____	R 10/05/2018

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 695	Continued From page 16 Review R25's 9/28/18 1:44 p.m. emergency room documentation revealed R25 was diagnosed with possible systolic heart failure, CAD, atrial fibrillation, severe COPD, obstructive sleep apnea (CPAP), diabetes and morbid obesity with a direct admit from the Fairmont ED. For the past several weeks, R25 was noted to be suffering from worsening respiratory symptoms, though the hospital was unaware of documentation from those visits. Previously that a.m., R25 was found unresponsive and cyanotic. No pulse was detected and CPR was initiated. Upon arrival by EMS, it appeared R25 was spontaneously breathing, but the receiving hospital had no information on R25's heart rhythm. Nursing home staff administered basic Life support at that time. It is the hospital's understanding R25 was hypertensive and tachypneic on route to the ER. Upon arrival to the ER, R25 was poorly responsive but had appeared to open his eyes when his name was called. His rapid breathing and wheezing required intubation and mechanical ventilation. Reason for visit was listed as respiratory arrest. The assessment and plan problems for admission list cardiopulmonary arrest and suspected COPD exacerbation, heart failure, and obstructive sleep apnea on CPAP. Interview on 10/3/18 at 3:06 p.m., with the administrator regarding the above incident and care for R25 received from 9/26/28 to 9/28/28 indicated she was unaware if nurses were trained on the use of CPAP equipment. LPN-A had made them aware of the investigation into the events surrounding R25's respiratory arrest recently, and the director of nursing (DON) was checking into available education on the CPAP machines. The administrator had started her role at the facility 2	F 695		

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 _____	R 10/05/2018

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 695	Continued From page 17	F 695		

weeks prior and was unable to determine if staff were trained on abnormal vital signs, use of CPAP machines, and appropriate assessment.

At approximately 3:45 p.m., the director of nursing notified surveyors she was leaving for the day and would be unavailable for interview.

Interview on 10/3/18 at 5:02 p.m. with the director of operations (DOO) and the administrator of the immediate jeopardy; it was their expectation nursing should not have left R25 alone with the above-mentioned symptoms on 9/28/18. Furthermore, they agreed staff had not been trained on the use of the CPAP machine. They were unaware the August 2018 facility assessment, completed after R25 was admitted, made no mention of residents who required CPAP or Bi-PAP's for breathing. They were also unaware the facility had no professional standards guide or policies for assessment of residents with critically low O2 sats. They were unaware R283 had no mention of his CPAP machine, or CPAP interventions in his physician's orders on his care plan.

Interview on 10/5/18 at 9:40 a.m. with the medical director indicated he was unaware of the events surrounding the immediate jeopardy called on 10/3/18. He was at the facility, seeing patients. His expectations were staff are to notify him immediately or serious or sentinel events, deaths, and hospice and comfort care concerns. Staff need to improve on their monitoring of significant changes. A resident in respiratory distress, oxygen saturations that are severely below their norm, and level of consciousness (LOC) changes would warrant immediate notification to the provider and/or EMS. Staff should have stayed

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 _____	R 10/05/2018

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 695	Continued From page 18	F 695		

with R25 and appropriately assessed and intervened. The medical director thought staff were trained on use of CPAP, however, was unfamiliar with any training the facility provides to its staff.

Interview on 10/5/18 at 10:15 a.m. with the DON revealed when discussing the events regarding R25, she indicated staff should have stayed with the resident, performed a complete assessment, and intervened to prevent the potential respiratory arrest that followed later that day. She agreed staff should have notified EMS and the provider of R25's decline in health that day. Staff should have called the number located on a sticker on R25's machine when they thought it was potentially malfunctioning.

Interview on 10/5/18 at 10:50 a.m.with the DOO indicated it was her expectation staff should have stayed with R25, performed a complete assessment and contacted the MD and/or EMS at that time it was discovered R25 had critically low oxygen and LOC changes. She agreed staff had not been appropriately trained on CPAP usage prior to the admission of R25 and R283.

Review of R283's medical record indicated he was admitted to the facility o 8/29/18 with diagnoses of chronic atrial fibrillation, COPD, edema, anticoagulant therapy, dependence on supplemental oxygen, heart failure, and muscle weakness and a full code. R283 had no assessment performed related to his CPAP machine to determine if he was capable of knowing if the machine would be working or malfunctioning, since staff had no knowledge and looked to the resident to be in charge of the device.

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 _____	R 10/05/2018

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 695	Continued From page 19 R283's 9/4/18, MDS assessment indicated a cognitive score of 8, showing he had moderate cognitive impairment. Review of R283's physician's orders indicated no mention of R283's CPAP machine, what signs and symptoms staff should monitor for, or when to monitor vitals. Review of R283's current care plan indicated he had an ADL self-care deficit r/t impaired cognition with short-term memory loss. He was known to be resistive to cares. R283 had problems with sleep disturbance and complaints of feeling tired, dozing during activities, and statements regarding inability to sleep. R283 used oxygen therapy with his Trilogy (CPAP) brand machine whenever lying down R/T diagnosis of COPD. He was dependent on oxygen when lying down. Staff were to monitor for signs and symptoms of respiratory distress and report the MD as needed. R283 was to be on 2 LPM of oxygen while connected to his CPAP mask. Review of R283's current Treatment Administration Record indicated no mention of how often staff should check R283's vital signs, including pulse oximetry. There was also no mention of staff applying the CPAP mask for R283, who had known cognition issues and was resistive to cares. Review of R283's September 2018, Documentation Survey Report indicated his O2 sat was only recorded once on 9/18/18. All other dates noted: 9/1/18, 9/3/18, 9/5/18, 9/6/18, 9/7/18, 9/20/18, and 9/21/18 were marked N/A for all vitals except pain.	F 695		

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 _____	R 10/05/2018

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 695	Continued From page 20 Review of R283's 8/30/18, Medication Self Administration Safety Screen revealed he was deemed competent to self-administer medications and use the Trilogy C-Pap machine, although there is no mention he could identify if there were a malfunction. R283 was deemed competent based on his ability to put on and take off his mask while in bed. There was no factors/situations noted of what staff were to do to ensure R283's mask had not come off in the night, his O2 sat levels remained at acceptable parameters, or how staff were to ensure he would not become hypoxic if the mask were off, or the machine malfunctioned. Review of R283's 9/4/18, CAA indicated he had behavior symptoms identified with respiratory disease, CHF, and a history of cancer. R283's cognitive abilities were impaired by disruptive behaviors, poor memory, and resisting care. R283 triggered for difficulty with ADL's due to physical limitations and depression and had the inability to perform ADLs without significant physical assistance. R283 was identified with risk for falls related to agitation behavior and cognitive impairment. Review of the December 2016, Admissions Criteria policy indicated the facility was to admit residents who can be cared for adequately by the facility. Residents including those with COPD would be admitted as long as their nursing and medical needs can be met adequately. Review of the October 2018 Oxygen Therapy Delivered via C-PAP Machine Procedure policy revealed residents would be accepted into the facility who were dependent upon CPAP	F 695		

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 _____	R 10/05/2018

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 695	Continued From page 21	F 695		

machines for oxygen delivery. It was the nursing care team member's responsibility to assess the resident for signs and symptoms of hypoxia, such as restlessness, decreased LOC, increased heart rate, dyspnea, cyanosis, etc. and obtain vital signs as needed. If abnormalities are present, they were to be reported to the MD.

Review of the July 2014 First Aid Treatment policy indicated in addition to providing basic first aid intervention, staff were to contact EMS or advanced medical personnel immediately for altered consciousness, difficulty or absence of breathing, or a condition that was not clear or is worsening. Regardless of the nature or severity, a residents condition was to be reported to the residents physician and family and documented in the medical record.

Review of the October 2018 Abnormal Vital Signs or Acute Change in Resident Condition policy indicated abnormal resdient condition would include decreased LOC, change in skin color, and change in behavior. The charge nurse was to assess the resident and refer to the Change in a Resident's Condition or Status policy.

Review of the May 2017, Change in a Resident's Condition or Status policy indicated Staff were to promptly notify the resdient, his MD, and representative of a change in condition. The nurse was to notify the MD when:
(1) A significant change in the resident's health had occurred.
(2) There was a need to alter the resident's treatment significantly.
(3) Staff needed to transfer the resident to a hospital or treatment center.
(4) there were changes in a resdient's condition.

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 _____	R 10/05/2018

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 695	Continued From page 22 A significant change of condition was noted as a major decline or improvement in the resident's status that would not normally resolve itself without staff intervention, and impacted more than one area of a resident's health status. It was ultimately based on clinical judgement and standard disease related interventions. Prior to notification, nursing staff were to make detailed observations and gather relevant data for the MD unless instructed by the resident, staff were to notify the residents representative when there was a significant change in the resident's physical, mental or psychosocial status. The nurse was to record in the resident's medical record information relevant to the changes in the resident's condition. The immediate jeopardy that began on 9/26/18 and identified on 10/3/18, was removed on 10/4/18 at 7:15 p.m. when the facility had educated staff on proper assessment of residents with respiratory issues, how to utilize respiratory equipment, had implemented parameters for monitoring oxygen levels, and had revised facility policies and procedures related to respiratory care and significant change in a resident's condition. However, non-compliance remained at the lower scope and severity of (G), actual harm which is isolated that is not Immediate Jeopardy.	F 695		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 726		11/9/18

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 _____	R 10/05/2018

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 726	Continued From page 23 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff were competent to administer care for 1 of 2 residents (R25) reviewed for respiratory care who required consistent assessment and implementation of respiratory assistance including oxygen, and CPAP (continuous positive air pressure) equipment to assist in maintaining proper oxygen levels. Findings include: Review of R25's medical record indicated he was	F 726	The corrective action taken for R25 was accomplished by having Licensed Staff immediately attend the CPAP in-service conducted on 10/4/2018. Licensed Staff unable to attend completed the Educare module for CPAP on 10/4/2018. An additional resource was made available by creating an oxygen resource binder which is located at the nurses station. Staff were provided education on the criteria for change in condition on 10/17/2018. Training and Competency testing was completed utilizing the	

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 _____	R 10/05/2018

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 726	Continued From page 24 admitted on 7/5/18 with diagnoses of morbid obesity, anxiety, type 2 diabetes, high blood pressure, atrial fibrillation with pacemaker (abnormal heart rhythm requiring pacing of the heart). Chronic respiratory failure (CRF) with hypoxia (low oxygen level in blood).chronic kidney disease, edema, dependence on supplemental oxygen, chronic obstructive pulmonary disease (COPD), chronic anti-coagulation (thinning of the blood to reduce clotting), muscle weakness and ordered CPAP machine. Review of R25's 9/25/18, Minimum Data Set (MDS) indicated he had a Brief Interview for Mental Status score of 14, indicating normal cognition. R25 required extensive assist with bed mobility, transfer, dressing, and personal hygiene requiring the assistance of 1 staff. R25 weighed 380 lbs. R25 was documented as receiving oxygen but was not noted to be on a CPAP or Bi-PAP while a resident. R25's 10/2/18 care plan revealed he had an advanced directive for Full Code. R25 had a Physician Orders for Life-Sustaining Treatment (POLST) filled out upon admission to the facility that was to be reviewed annually and at care conferences. R25 had a self-care deficit related to (R/T) his COPD and required extensive assist with activities of daily living (ADL). Staff were to monitor for signs of difficulty breathing. R25 was able to self-administer nebulizer medication treatments after setup by staff. R25 was at risk for neglect from others related to his nursing home placement. Staff were to identify R25's vulnerability and risk through assessment. R25 was noted use a Bi-PAP (Bi-level Positive Airway Pressure) machine HS with supplemental oxygen R/T CRF and COPD. There was no mention of	F 726	Leading Age and Pathway checklists which included CPAP training for all Licensed Staff within the department of nursing on 10/19/2018. The facility will identify other residents having the potential to be impacted at the time of referral, a comprehensive review regarding individualized resident needs will be identified. A review of the current skill set of nursing team will be conducted to determine if competent prior to accepting the admission in order to meet the potential resident□s needs. If it is determined that during the referral process the potential admission has a need or care that staff have not been trained and audited on, prior to admission all staff involved in the residents□ unique cares will be trained and audited with a checklist as competent or we will decline the referral as not being able to meet their needs. The measures put into place were that the DON and/or designee conducted competency training and checked-off all licensed nursing and unlicensed nursing staff to ensure competencies were met regarding resident needs which included CPAP, abnormal vital signs and acute change in condition. Training and competency testing will be completed upon hire and annually. The facility will monitor it performance by completing weekly audits for 2 months or through 12/26/2018 for compliance. Thereafter, the DON will maintain an	

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 _____	R 10/05/2018

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 726	Continued From page 25 the ordered CPAP. R25's goal was to have no signs or symptoms (SX) of poor oxygen absorption. There was no mention of how or how often staff were to monitor or assess R25 to ensure he had no complications from his COPD or history of CRF. R25's physician's orders had an entries on 7/10/18 for use of a CPAP at current setting: On at night (HS) and off in the morning (AM). Staff were to clean the CPAP mask weekly and check the reservoir tank for the CPAP every HS shift. R25 was ordered to have Oxygen delivered via nasal cannula at 2 liters per minute (LPM) continually every day and night shift. Review of R25's progress notes indicated on: (1) 9/26/18 at 2:26 p.m., R25 returned from an emergency room (ER) visit with orders to have his CPAP machine checked and to ensure there was good wave form when checking oxygen saturation. R25 was to return to the ER for new or worsening symptoms. There is no evidence R25's CPAP was ever checked by the vendor after this ER visit. (2) 9/26/18 at 6:11 p.m., R25 was having a hard time staying awake at supper. R25's tablemate was concerned and asked the nurse to check R25. The nurse had to wake R25 up several times over the course of his meal. There is no mention of any vital signs taken to include O2 sats at that time. (3) 9/26/18 at 10:59 p.m., staff noted R25's [CPAP] "machine not working". There is no mention staff checked R25's vitals to ensure he had no signs or symptoms of respiratory distress. (4) 9/28/18, nursing staff entered documentation surrounding the events from earlier that a.m.. When the licensed practical nurse (LPN)-A was	F 726	ongoing checklist to assure that new hires and all hires within the nursing department have an annual training and competency checklist. This plan to correct will be reported to QAA on 10/31/2018. The corrective action will be completed by 11/9/18.	

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 _____	R 10/05/2018

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 726	Continued From page 26	F 726		

entering the room that morning, she found R25 in bed without O2 or his CPAP on. When she asked R25 why he did not have his O2 and CPAP on he mumbled incoherently. LPN-A placed his O2 on at 2 LPM and elevated his head to 30 degrees. LPN-A checked his O2 sat and found it to be 60%, significantly below R25's expected 90%. Earlier that a.m., certified nursing assistant (NA)-A assisted R25 to his wheelchair (W/C) with the mechanical stand lift. NA-A stated R25 was able to assist and was speaking to her. NA-A then noticed R25 had stopped speaking and his head fell back. NA-A called for help. R25 became cyanotic (blue color of skin caused by lack of oxygen). Chest compressions were started while the resident was in his W/C and staff called 911. An automated external defibrillator (AED) was applied, but no shock was advised. Compressions continued. A femoral pulse was noted as present. The ambulance (EMS) and sheriff's department arrived. An ambu bag was used to assist with breathing and R25's O2 was at 85%. R25 was able to move all extremities. EMS transported R25 to the ER in Fairmont. Fairmont ER called and stated R25 was being transferred to a hospital in Rochester via helicopter.
(14) 9/28/18 at 4:04 p.m., nursing staff called for an update from the hospital on R25's condition. R25 was intubated (tube into the lungs to assist with breathing). Hospital staff were continuing medical exams and were going to check a head computerized tomography (CT) and an ultrasound. R25's O2 sats were 90%. Family was present.

Interview and medical record review on 10/3/18 at 12:30 p.m., with LPN-A indicated LPN-A had started her shift the morning of 9/28/18 at 6:00

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 _____	R 10/05/2018

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 726	Continued From page 27	F 726		

a.m.. Sometime shortly after receiving report, LPN-A went to R25's room [at approximately 7:00 a.m.]. She found R25 without his O2 or CPAP on. R25's sats were at 60%. R25 was mumbling incoherently at the time. After applying oxygen to R25, LPN-A left the room and did not return. LPN-A felt since his O2 was starting to climb back up into the middle 60's he was ok to leave alone. LPN had not performed a respiratory assessment or checked vitals at that time. LPN-A was sure his O2 sat would come up so she did not return to R25, until his arrest later that morning at approximately 8:00 a.m. LPN- A stated if a resident's O2 sats were low, she should recheck in 1 hr. LPN-A was unaware what level O2 sats were considered critical. LPN-A stated R25's normal sats were to be in the "low 90's". LPN-A was unaware when to assess or reassess a resident for safety in critical situations, or call EMS when a resident had critically low oxygen sats and/or level of conscious changes. LPN-A stated staff check R25's oxygen at night prior to going to bed, but had not routinely done any other checks that she was aware of. LPN-A felt it was "useless to send him to the ER [on 9/28/18] as they would just say he was fine" after he arrived like they did previously on 9/26/18. LPN-A was unsure if R25's machine was or was not functioning, as she "didn't know how to run them". The ER stated the facility needed to "get it checked" so LPN-A called the family member and told her to come get CPAP and instructed the family member to take it to the supplier. Since it was not facility equipment, LPN-A stated it was the family's responsibility to get the equipment checked for working order.

Interview on 10/3/18 at 3:06 p.m., with the administrator regarding the above incident and

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 _____	R 10/05/2018

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 726	Continued From page 28	F 726		

care for R25 received from 9/26/28 to 9/28/28 indicated she was unaware if nurses were trained on the use of CPAP equipment and the director of nursing (DON) was checking into available education on the CPAP machines. The administrator had started her role at the facility 2 weeks prior and was unable to determine if staff were trained on abnormal vital signs, use of CPAP machines, and appropriate assessment.

Interview on 10/3/18 at 5:02 p.m. with the director of operations (DOO) and the administrator stated it was their expectation nursing should not have left R25 alone with the above-mentioned symptoms on 9/28/18. Furthermore, they agreed staff had not been trained on the use of the CPAP machine.

Interview on 10/4/18 at 6:45 p.m. with registered nurse (RN)-A and LPN-B indicated they had just received formal training on CPAP's and Bi-PAPs from a respiratory therapist from the local hospital. They were glad to receive education as they were never trained on the machines or appropriate usage. They were unaware they now had a professional reference to assist them, now placed at the nurses station, with medical situations that may arise in the facility. They were unaware of the last 2 items on the removal plan: Change of Condition and Abnormal Vital signs. LPN-B had worked all day and no one told her or educated her on those. LPN-B stated she was made aware, through the education provided tonight by the respiratory therapist from the local hospital, they would be a point of reference for machine questions and concerns, or resident assessment concerns.

Interview on 10/5/18 at 9:00 a.m. with LPN-B

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 _____	R 10/05/2018

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 726	Continued From page 29	F 726		

indicated staff failed to have the necessary training in working with patients who were on CPAP or Bi-PAP machines, or what to do if an emergency situation arose with abnormal vital signs that could be severe or critical. LPN-B was glad they received a professional reference to follow. LPN-B felt there was an inadequate amount of training with new residents and they may be over the level of care of the experience nursing was educated on. Management at the facility had not involved direct care staff with concerns or potential solutions that arose from resident concerns."Leadership does not communicate with us [staff] or ask us how to make things better [for the residents]."

Interview on 10/5/18 at 9:40 a.m. with the medical director indicated he was unaware of the events surrounding R25. The medical director thought staff were trained on use of CPAP, however, was unfamiliar with any training the facility provided to its staff.

Review of the 8/18/18, Facility Assessment Tool for Heartland Senior Living-Truman, indicated the facility would conduct, document, and annually review a facility wide assessment, including the resident population and resources needed to care for residents. Its purpose was to determine what resources were necessary to care for residents competently during day to day operations and emergencies. Using a competency based approach focuses on ensuring that each resident is provided care that allows them to maintain or attain their highest practical physical, mental, and psychosocial well being. The intent was to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents

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 _____	R 10/05/2018

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 726	Continued From page 30 require. Sections were as follows: (1) Part 1- Resident Profile, included diseases of respiratory origin such as COPD and Respiratory Failure were listed as being admitted to the facility. The facility was to have a discussion between the nursing department and social services to determine what diagnoses was, to determine if staff were competent to care for them. Any new diagnosis staff were unfamiliar with were to be looked up in a reference book or online to determine the amount of new training that would be needed prior to a residents admission. Training was to be requested from provider resources as warranted. Under the section Special Treatments noting CPAP/BiPAP indicated he facility had no residents admitted at the time of the resdient assessment update in August 2018. R25 had been admitted prior to this date and should have been included in the number. (2) Part 2: Services and Care We Offer Based On Our Resident's Needs indicated assessment, early identification of problems, deterioration [of the resident], and management of medical conditions such as COPD were part of services to be provided to residents. (3) Part 3: Facility Resources Needed to Provide Competent Support and Care for Our Residents Every Day and During Emergencies indicated it was to be based on the resident population and needs for care and support and evaluation of overall number of staff needed to ensure a sufficient number of qualified staff available to meet the resdients needs. When the assessment procedure indicated the facility describe staff training, education, and competencies, the facility was to ensure the observation of competency was to be ongoing, provided upon hire, routine cares and annual evaluation. The facility indicated	F 726		

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 _____	R 10/05/2018

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 726	Continued From page 31 evaluations of the need to update policies is ongoing and based off resident needs. "To date, census has remained fairly basic LTC [long term care] level of care with no significant challenging new admissions..." Review of the December 2016, Admissions Criteria policy indicated the facility was to admit residents who can be cared for adequately by the facility. Residents including those with COPD would be admitted as long as their nursing and medical needs can be met adequately. Refer to F695 for additional information.	F 726		
{F 880} SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	{F 880}		11/16/18

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 _____	R 10/05/2018

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 880}	Continued From page 32 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	{F 880}		

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 _____	R 10/05/2018

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 880}	Continued From page 33 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a complete and thorough infection control program had been implemented to include tracking and trending, surveillance, and antibiotic stewardship through to resolution. This has the potential to affect all 39 residents currently in the facility. Findings include: Review of the facility infection control documention for the plan of correction indicated the infection control program was being overseen and completed by the director of nursing (DON). The DON was logging a Daily Review of Resident Progress notes for potential infectious process. In those daily logs was the resident name, significant findings and the date. One example was dated 10/2/18 with the resident's initials, "check for UTI [urinary tract infection] D/T [due to] increased confusion." This was signed by the DON as complete. There was no evidence of tracking and trending the infection, appropriate surveillance to include resolution of symptoms or the need to alter therapy, or antibiotic stewardship. Interview on 10/3/18 at 3:07 p.m. with the infection control nurse (ICN) indicated she was not part of the facility's infection control plan of correction. She was required to continue to work as a staff nurse on the floor. The ICN was told the director of nursing was managing the program.	{F 880}	The corrective action was taken for R25, R283 and all residents was accomplished by re-establishing the Infection Control Nurse/Infection Preventionist position and duties. The job description for Infection Preventionist was updated as were the facility policies and procedures that include an Antibiotic Stewardship Program and the core elements provided by CDC. The facility will identify other residents having the potential to be impacted by assuring that there will be a daily review of progress notes to monitor for signs and/or symptoms of potential infectious process of all residents. The Infection Preventionist will review new orders to identify antibiotic use within the facility. New referrals for admission will also be reviewed for current antibiotic use or infectious disease processes so appropriate interventions can be implemented prior to admission to the facility. The systemic changes that were initiated to ensure the deficient practice does not reoccur is reviewing, revising, and updating procedures on cleaning and disinfecting resident equipment such as CPAP, have been reviewed, revised and updated. Flow sheets for tracking and trending of	

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 _____	R 10/05/2018

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 880}	Continued From page 34 Interview on 10/5/18 at 10:15 a.m. indicated financial constraints prohibited the infection control nurse from performing her duties in the infection control program. She was needed to work as a staff nurse. The facility had a contract with agency staff to fill in for nursing, however, due to lack of funding, that was not being performed. The DON had no formal training in IC and stated she would look online if she had questions. The DON was unaware of what documentation would be needed to accurately and thoroughly perform all aspects of the infection control program to include all necessary information and guidance. There was no policy provided on the facility's infection control program when requested during the survey.	{F 880}	resident infections have been established and implemented. Flow sheets for tracking and trending appropriate use of antibiotics has been established. Obtaining culture results and taking appropriate actions regarding current antibiotic treatment workflow has been established. Staff education on on the Infection Prevention Control and Antibiotic Stewardship will be implemented on 11/2/2018. Monitoring guidelines for those residents taking antibiotic, such as daily temperature monitoring, side effect monitoring, improvement in signs and symptoms of infection being treated will be established and implemented on 11/2/2018. The Infection Preventionist notification of the initiation of an antibiotic will be completed by running the Order Summary report within Point Click Care (PCC) which will reveal the antibiotic use at any point in time. This will allow for real time ongoing management of the antibiotic use for the facility. Vaccination history for Prevnar, Pneumovax, Influenza of all current residents will be reviewed by Infection Preventionists. All new admissions will be screened for the need for Prevnar, Pneumovax and Influenza as per CDC recommendations. Flow sheets will be implemented for tracking resident vaccinations by 11/5/2018. Flow sheets for tracking and trending staff illness has been established and implemented on 10/24/2018.	

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 _____	R 10/05/2018

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 880}	Continued From page 35	{F 880}	The facility will monitor its performance by conducting Environmental rounds, which includes hand hygiene for Infection Control purposes. The rounds have been conducted by the Interdisciplinary team (IDT) as designated by the LNHA on a weekly basis for 2 months or through 12/26/19 and have been established and implemented on 10/31/2018. The Infection Preventionist or the D.O.N. will audit the Infection control flow sheets for tracking and trending for residents and staff for compliance on a weekly basis for 2 months or through 12/26/18. This plan to correct will be reported to QAA on 10/31/2018. The corrective action will be completed by 11/16/2018.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 429D

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 **11/19/2018** (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 **50** (L18)
13.Total Certified Beds **50** (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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Lisa Carey, HFE NE II 11/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 11/27/2018 (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
(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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245346

November 27, 2018

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 November 16, 2018 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

November 27, 2018

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

RE: Project Number S5346029

Dear Administrator:

On October 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective October 27, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 23, 2018. (42 CFR 488.417 (b))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V office for imposition.

- Civil money penalty. (42 CFR 488.430 through 488.444)

Also, we notified you in our letter of October 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on August 23, 2018, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 5, 2018. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On November 19, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on October 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 16, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 19, 2018, as of November 16, 2018. As a result of the revisit findings, the Department is

discontinuing the Category 1 remedy of state monitoring effective November 16, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 22, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 23, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 23, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 23, 2018, is to be rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter dated October 22, 2018:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 429D

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: **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 **08/23/2018** (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 **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
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
	50			
(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 :
Laura Ducharme, HFE NE II 10/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/03/2018 (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
(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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2018

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

RE: Project Numbers S5346029, H5346034

Dear Administrator:

On August 23, 2018, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. In addition, at the time of the August 23, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5346034 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 2, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 2, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 23, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 23, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

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 _____	08/23/2018

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/20/18 through 8/23/18 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On August 20, 2018 through August 23, 2018, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. At the time of the survey, an investigation of complaint H5346034 was also completed and was found to be unsubstantiated. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's 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.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		10/2/18

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

Electronically Signed | 09/19/2018

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 _____	08/23/2018

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 623	Continued From page 1	F 623		

representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

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 _____	08/23/2018

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 623	Continued From page 2	F 623		

transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide

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 _____	08/23/2018

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 623	Continued From page 3 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State of Minnesota's Office of Ombudsman was notified of facility initiated discharges for 1 of 1 resident (R33) reviewed for hospitalization, the failure to implement systems to ensure Ombudsman notification of facility initiated discharges including hospitalizations, had the potential to affect any residents who might be discharged to the hospital. Findings include: Review of R33's medical record indicated he was admitted on 6/19/18 with diagnoses including: muscle weakness, hyperlipidemia (high cholesterol) , dementia, nutritional anemia (low iron in blood), hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm). The medical record further revealed R33 was discharged to the hospital on 7/29/18. The record did not include any documented notice to the Ombudsman's office of this discharge. During interview on 8/22/18 at 2:55 p.m., registered nurse (RN)-C verified there was no documentation to verify the State Ombudsman's office had been notified of R33's discharge to the hospital. RN-C stated the facility's licensed social worker (LSW)-A, or the charge nurse working on	F 623	It is the Facilities intent to comply with the regulation to inform all residents/responsible parties of their right to hold their bed when they are transferred from the facility. Resident/responsible party are provided a copy of the bed hold form upon admission to the facility. When a resident is transferred from the facility the resident/responsible party is given the choice to hold the bed or not. A verbal confirmation is received unless the resident/responsible party is in the facility and the form is signed at the time of transfer. Resident #33 had an Emergency Transfer to the hospital. Bed hold was not given. Notification to the Ombudsman was not completed in a timely manner i.e., monthly. Bed Hold Policy and Procedure was updated to reflect new notification process. A copy of the bed hold will be sent with the resident attached to the Transfer form indicating the reason for transfer from facility. Bed Holds will be obtained, put into electronic chart and	

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 _____	08/23/2018

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 623	Continued From page 4 the day of R33's hospitalization would have been responsible to ensure notification of the Ombudsman. However, RN-C stated LSW-A had been on vacation the week of R33's hospitalization and that she (RN-C) had been assigned to LSW duties while LSW-A was absent. RN-C stated she had previously not been aware she needed to contact the State of Minnesota's Office of Ombudsman for a facility initiated transfer including hospital transfers. During interview on 8/22/18 at 3:55 p.m., LSW-A stated she takes care of notification to responsible parties regarding discharges during the week. LSW-A stated the nurse in charge may also perform this duty during the week, but for sure on weekends the responsibility would fall to the RN in charge. In addition, LSW-A stated she had been unaware of the requirement to report emergent hospitalizations to the State Ombudsman as facility initiated discharges. During interview on 8/22/18 at 10:58 a.m., the State Regional Ombudsman (RO) verified she had not received notification of R33's hospitalization. The RO then contacted the State's Office of Ombudsman to verify whether there had been any discharge notifications received from the facility for any facility initiated transfers. The RO stated their office had not received any reports of facility initiated discharges yet for 2018. When requested, no policies related to notification of the Ombudsman related to facility initiated transfers including hospitalizations was provided.	F 623	then mailed to the family with each occurrence. See Attachment 1 Social Worker will fax the notification with each transfer and upload in residents electronic record monthly. Resident chart audits were completed, and no other residents were affected. The Social Worker did update the Ombudsmen of all transfers on 08/30/2018 and will perform monthly. See Attachment 3 By 09/27/2018 Social Worker and nursing staff re-educated on the proper procedure. Audits will be completed by the Social Worker or designee with each transfer, at IDT meetings, weekly and quarterly with results to the QAA for review. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		10/2/18

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 _____	08/23/2018

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 625 SS=D	Continued From page 5 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident and/or resident's representative were informed of the facility's bed hold policy at the time of hospitalization for 1 of 1 resident (R33) reviewed for hospitalization.	F 625	It is the Facilities intent to comply with the regulation to inform all residents/responsible parties of their right to hold their bed when they are transferred from the facility. Resident/responsible party are provided a	

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 _____	08/23/2018

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 625	Continued From page 6 Finding include: Review R33's medical record indicated R33 was admitted to the facility on 6/19/18, from another nursing home facility. Diagnoses at the time of admission were identified as nutritional anemia, hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Review of progress note dated 7/29/18 at 8:33 p.m., indicated the resident had an acute episode of shortness of breath. Following notification of the provider, physician assistant (PA)- F and family members, the decision was made to hospitalize R33. At 9:15 p.m., R33 was transferred to the hospital by ambulance. On 7/31/18 at 7:33 a.m., the facility received notification from the hospital that R33 had passed away. During interview with Registered Nurse (RN)-C on 8/22/18 at 2:55 p.m., RN-C confirmed there was no documentation in R33's record of a bed hold having been provided to the resident or the resident's responsible party at the time of hospitalization. During interview with Licensed Social Worker (LSW)-A on 8/22/18 at 3:55 p.m., she verified she takes care of bed holds during the week, but on weekends it would be the nurse's responsibility. LSW-A confirmed there was no bed documentation to verify the information had been provided when R33 was hospitalized. The facility's Bed-Hold and Return Policy revised March 2017, indicated prior to transfers and therapeutic leaves, residents or resident	F 625	copy of the bed hold form upon admission to the facility. When a resident is transferred from the facility the resident/responsible party is given the choice to hold the bed or not. A verbal confirmation is received unless the resident/responsible party is in the facility and the form is signed at the time of transfer. Resident #33 had an Emergency Transfer to the hospital. Bed hold was not given. Notification to the Ombudsman was not completed in a timely manner i.e., monthly. Bed Hold Policy and Procedure was updated to reflect new notification process. A copy of the bed hold will be sent with the resident attached to the Transfer form indicating the reason for transfer from facility. Bed Holds will be obtained, put into electronic chart and then mailed to the family with each occurrence. See Attachment 1 Social Worker will fax the notification with each transfer and upload in residents electronic record monthly. Resident chart audits were completed, and no other residents were affected. The Social Worker did update the Ombudsmen of all transfers on 08/30/2018 and will perform monthly. See Attachment 3 By 09/27/2018 Social Worker and nursing staff re-educated on the proper	

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 _____	08/23/2018

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 625	Continued From page 7 representatives will be informed in writing of the bed-hold and return policy.	F 625	procedure. Audits will be completed by the Social Worker or designee with each transfer, at IDT meetings, weekly and quarterly with results to the QAA for review. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		10/2/18

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 _____	08/23/2018

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 655	Continued From page 8 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours, and failed to ensure a copy was provided to the resident and/or representative for 1 of 2 residents (R25) reviewed who was a new admission. Findings include: R25's face sheet indicated he was admitted on 7/5/18, with diagnoses including: hypertension (high blood pressure), atrial fibrillation (A-fib, irregular heart beat), edema (excess fluid), chronic respiratory failure with hypoxia (low blood oxygen level), constipation, dependence on oxygen, hypothyroidism (low thyroid level) , type 2 diabetes, diabetic neuropathy (nerve damage as a result of diabetes), long term use of anticoagulants (blood thinners), chronic	F 655	It is the Facilities intent to comply with the regulation to develop and implement a baseline care plan within 48 hours. It is the Facilities intent to provide the resident and their representative with a summary of the baseline care plan. R25□s Comprehensive Care Plan has been reviewed, revised and updated. By 10/2/2018 audits on resident□s individual baseline care plans will be reviewed, revised & updated as needed. Policy & Procedures on Baseline Care Plans will be reviewed, revised & updated as needed. See Attachment 5 & 6 By 09/27/2018 all staff who utilizes resident baseline care plans will be educated on the need to follow	

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 _____	08/23/2018

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 655	Continued From page 9 obstructive pulmonary disease (disease of the lung), low back pain, presence of a cardiac pacemaker (medical device placed to regulate the heart rate), morbid obesity (overweight), and anxiety disorders. R25's admission orders dated 7/5/18, indicated an allergy to bees and included orders to administer medications including coumadin (a blood thinning medication to prevent blood clots), pain control, diabetes, depression, A-fib, hypoxia, infection, high cholesterol, and constipation. R25's initial care plan was dated 7/9/18, 4 days after admission. The initial care plan indicated R25 had been admitted to the facility on 7/5/18 and included focus, goals and interventions for the following areas: advance directive, emotional and social needs, self care, discharge planning, pacemaker, hypertension, diabetes, med (medication) administration, nutrition, pain, incontinence, vulnerability and oxygen use. R25's care plan did not include any mention of R25's use of anticoagulants or signs and symptoms of adverse reaction, or precautionary steps to take during cares. On 8/23/18, at 10:03 a.m. registered nurse (RN)-C stated staff would post the information from the discharging entity (ex: hospital) for nurses to use during report with staff regarding any new residents. However, RN-C stated she was not aware of what a baseline care plan was supposed to include. On 8/23/18, at 8:51 a.m. the minimum data set (MDS) assessment coordinator stated she tried to create residents' initial care plans within 24 hours of admission. MDS coordinator stated all	F 655	interventions as outlined in the baseline plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. Policy & Procedures on Baseline Care Plans will be review with all staff. DON or Clinical Team designees will conduct weekly audits of baseline care plans to assure they are accurate, updated and current. Thereafter, audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 655	Continued From page 10 pertinent information was then placed into the electronic medical record (EMR), which would include R25's coumadin use, which would have been marked with a 'k' which would mean it would be on the kardex. In that way staff would be notified to watch for bruising and bleeding. MDS-coordinator stated she was not aware of the requirement for a baseline care plan to be given to the resident within any specified time period. During a follow up interview with the MDS coordinator on 8/23/18 at 12:56 p.m., she stated, "I try to get it on the care plan [use of anticoagulant Coumadin]. It would be in the care plan but I see it is not in there." The facility's Care Planning policy dated September 2013, directed staff to develop a care plan within 7 days of the completion of the resident assessment. There had been no revision to the policy to identify the newly revised Federal requirements from 2017, to complete a baseline care plan within 48 hours of admission, and to provide the base line care plan to residents and /or their families.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		10/2/18

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 _____	08/23/2018

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 657	Continued From page 11 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 3 of 12 residents (R10 and R23) whose care plans were reviewed, to ensure contact precaution interventions, modification of recreational activities, modifications of range of motion, and/or medication monitoring were included. Findings include: R23's medical record indicated an admission to the facility of 8/23/18, with diagnoses including: anxiety, legal blindness, spinal stenosis (narrowing of the spine), osteoarthritis (degenerative joint disease), osteoporosis (loss of bone density), hypertension (high blood pressure) and macular degeneration (disease of the eye that leads to blindness).	F 657	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident□s needs that are identified in the comprehensive assessment. R5, R10□s Care Plans have been reviewed, revised and updated. See Attachment 7 R5, order obtained an 9/12/2018 for therapy OT/PT to assess and treat. See Attachment 8 R23, Isolation precautions were resolved on 8/27/2018. By 10/2/2018 audits on resident□s individual care plans will be reviewed, revised & updated as needed. Policy &	

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 _____	08/23/2018

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 657	Continued From page 12 R23's 7/17/18, quarterly Minimum Data Set (MDS) assessment indicated a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The MDS further indicated R23 required extensive assistance of one person for transfers, bed mobility, dressing, toileting, personal hygiene, and was occasionally incontinent of bladder, and frequently incontinent of bowel. Review R23's 8/14/18 progress note indicated pathology report documentation showed R23 was positive for Methicillin Resistant Staphylococcus Aureus (MRSA, a bacterial infection) and Klebsiella Aerogenes (bacteria infection) originating from sores on her chin and arms. R23 was placed on Bactrim (an antibiotic) and contact precautions (glove and gown needed when providing cares) had been initiated. Documentation indicated R23 was advised to stay in her room as she was known to continuously touch her face and other objects without appropriate handwashing. R23's 8/23/18 care plan, made no mention of the above bacterial infections, nor was there indication she was to be placed on precautions, including staying in her room. The care plan also indicated R23 routinely participated in activities 3-5 times a week, enjoyed socializing with others, and doing crafts and other activities. The care plan did not identify interventions for how staff would continue to provide R23 social activities while confined to her room due to the infections. During interview with R23 on 8/20/18 at 6:19 p.m., R23 stated she has to stay in her room "because of an infection" and added she "hates" being in her room all the time.	F 657	Procedures on Development/Revision of Comprehensive Care Plans will be reviewed, revised & updated as needed. See Attachment 9 & 10 By 09/27/2018 all staff who utilizes resident care plans will be educated on the need to follow interventions as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. Policy & Procedures on Development/Revision of Comprehensive Care Plans will be review with all staff. DON or Clinical Team designees will conduct weekly audits of comprehensive care plans to assure they are accurate, updated and current. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 657	Continued From page 13	F 657		

During interview on 8/21/18 at 3:10 p.m., R23's family member (FM)-A, stated R23 didn't like "being stuck in her room, because she likes BINGO and Bible study." FM-A stated, "once we are told by staff [R23's] infected chin wounds and arm wounds have healed, she will be able to go to regular activities."

During interview on 8/21/18 at 3:19 p.m., activity director (AD)-A, stated activity staff sat outside of R23's room and read to her, providing one-on-one visits. AD-A also stated R23's family visited daily. AD-A stated, "It must be awful for her not to be able to go to Bible study."

During a follow up interview with AD-A on 8/22/18 at 9:47 a.m., AD-A stated R23 was a very social person and it was important to R23 to participate with activities. AD-A said she should have revised the care plan with new activity interventions upon notification of R23 having to remain in her room due to the infections.

During interview on 8/22/18 at 7:07 a.m., the infection control nurse (RN)-B stated the reason R23 was staying in her room was due to infected wounds on her arms and chin. RN-B said R23 would continuously take the dressings off and "touch everything". RN-B felt there was a concern for the spread of infection.

During interview on 8/22/18 at 9:58 a.m., the MDS coordinator (RN)-C stated she'd developed R23's initial care plan and would update care plans quarterly, annually and with any significant change. RN-C said staff nurses were expected to update the care plan with any day-to-day changes in the absence of a timed scheduled assessment.

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 _____	08/23/2018

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 657	Continued From page 14	F 657		

During interview on 8/22/18 at 2:06 p.m., RN-B stated she did not know whether the care plan had been revised to reflect R23's current infections, contact precautions, and confinement to her room. RN-B stated she thought it was RN-C's responsiblity to update R23's care plan.

R5's medical record indicated the resident had been admitted to the facility on 8/15/17, with diagnoses including: monoplegia (form of paralysis of one limb) of left leg from stroke, arthritis, hyperlipidemia, history of stroke, diabetes, obesity, depression, anxiety, hypertension (high blood pressure) and dystonia (movement disorder in which muscles contract involuntarily).

R5's quarterly Minimum Data Set (MDS) assessment dated 5/22/18, identified R5 as cognitively intact, with a history of verbal behaviors directed towards others, requiring extensive assist with activities of daily living (ADL) cares, independent in the use of his electric wheelchair, occasionally incontinent of bladder, had constant chronic pain, and had a functional limitation in the range of motion in one leg.

R5's care plan goals and interventions dated 5/31/18, also identified the resident had a contracture in his left leg as a result of impaired range of motion and monoplegia caused by history of a stroke. The goals for R5 included:
(1) Remain free of complications related to contracture formation through the review date.
(2) Have had staff perform passive range of motion (PROM) to his left leg twice daily.
(3) Change his position frequently, able to do so independently.

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 _____	08/23/2018

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 657	Continued From page 15	F 657		

During interview on 8/21/18 at 9:51 a.m., nursing assistant (NA)-F stated R5 was able to do AROM (active range of motion) at will (independently).

During interview on 8/21/18 at 1:49 p.m., NA-B stated she was unaware R5's care plan required PROM excercises to be performed by staff. NA-B explained she was a restorative aide, but stated the restorative therapy department had been eliminated about one year ago.

During interview on 8/22/18 at 8:18 a.m., R5 stated he does his own upper body exercises but was unable to to do lower body exercises on his own without staff assistance.

During interview and document review on 8/23/18 at 9:58 a.m., NA-F verified the care plan for R5 indicated direct care staff were to complete PROM to R5's left leg twice a day while in bed. NA-F stated she had never performed PROM for R5, and stated there should have been a scheduled task for staff to perform PROM for R5. NA-F stated she did not review resident care plans during her routine day-to-day resident care at the facility, but relied on triggered tasks to complete the resident care.

During interview on 8/23/18 at 12:08 p.m, the facility's MDS coordinator (registered nurse (RN)-C) stated R5 could perform his own exercises. However RN-C reviewed R5's care plan and agreed the care plan indicated R5 was to have staff assistance with PROM. RN-C also stated R5 was currently in a 7 day lookback period for assessment. RN-C stated although she was aware R5 could more than likely do his own AROM, staff should have been completing

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 _____	08/23/2018

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 657	Continued From page 16	F 657		

the PROM as care planned up to this point, and should have notified her of changes to the resident's abilitites.

Follow up review of R5's care plan, printed later on 8/23/18, revealed RN-C had modified R5's care plan so it no longer included R5's need for staff to provide PROM.

R10 was admitted on 2/5/16 with diagnoses of severe major depression with severe psychotic symptoms and phobic (fear) anxiety disorder.

R10's 8/6/18 revised care plan included the use of medications including: Zyprexa (antipsychotic) and Wellbutrin (anti-depressant), however theese medications had been discontinued in January of 2018.

During interview on 8/23/18 at 10:30 a.m., the director of nursing (DON) stated care plans were to be completed and revised by the minimum data set (MDS) nurse (registered nurse (RN)-C). The DON said her expectation was for care plans to be updated within 48 hours of changes.

Review of the facility's policy Care Plan-Comprensive dated September 2010, indicated an assessment of the resident was ongoing, and the care plan was to include measurable objectives to meet each resident's medical and nursing needs. Areas of concern that were triggered during the resident assessment, including the CAA (care area assessment), should have been evaluated before interventions were added to the care plan. Staff were to identify problem areas and develop interventions. Care plans were to be revised as necessary.

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 _____	08/23/2018

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 657	Continued From page 17 Review of the facility's August 2006 policy, Using the Care Plan, indicated the care plan shall be used in developing daily care routines and was to be available to staff providing care. Changes in the resident's condition must be reported to the MDS assessment coordinator so that a review of the current resident's assessment and care plan could be made and modified if needed.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to help residents maintain or improve range of motion (ROM) for 1 of 2 residents (R5 and R12) reviewed for ROM. Findings include:	F 688	It is the Facilities intent to comply with the regulation to implement interventions to help residents maintain or improve range of motion. R12 is currently receiving therapy services with internal Therapy Company.	10/2/18

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 _____	08/23/2018

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 688	Continued From page 18 During interview with R12 on 8/20/18 at 3:36 p.m., R12 stated he would like some kind of therapy to help maintain his strength, but did not receive any. Throughout the survey, R12 was not observed to receive staff assistance with any range of motion (ROM) exercises. R12's face sheet printed 8/22/18, indicated he was admitted on 6/17/14, with the following diagnoses: paraplegia, muscle spasms of calf, chronic pain, atrial fibrillation, heart failure, anemia, hypertension, chronic obstructive pulmonary disease (lung disease), history of urinary tract infections, and dependence on supplemental oxygen. R12's 5/15/18 annual Minimum Data Set (MDS) assessment indicated R12 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated R12 required extensive assist of 1 staff with dressing and personal hygiene, was totally dependant on staff for toileting, required only supervision with bed mobility, was independent after set up with eating and did not walk due to his diagnosis of paraplegia. The MDS further indicated R12 had no impairment of ROM to upper extremities, but had impairment of ROM to both lower extremities, experienced almost constant pain that makes it hard for him to sleep, and used scheduled and as needed pain medications. R12's physical therapy plan of care evaluation dated 6/19/18, indicated R12 had minimally contracted knees, and limited ankle motion. R12's care plan last revised on 8/7/18, directed	F 688	By 9/18/2018 audits on resident□s who are on restorative programs will be reviewed, revised & updated as needed. Policy & Procedures on Range of Motion will be reviewed, revised & updated as needed. See Attachment 11 By 09/27/2018 all staff who are responsible for Range of Motion will be educated on the need to follow individualized restorative nursing program regarding performing ROM exercises as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. Policy & Procedures on Range of Motion will be review with all staff. DON or Clinical Team designees will conduct weekly audits time 4 weeks of Range of Motion documentation to assure they are accurate, updated and current. Thereafter, Range of Motion documentation shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 688	Continued From page 19 staff to perform active range of motion (AROM-where the resident participates) and passive range of motion (PROM-staff assisted) with morning and evening cares daily. During interview on 8/21/18 at 1:49 p.m., nursing assistant (NA)-B stated she was a restorative aide, but stated the restorative therapy department had been eliminated about one year ago. During interview with NA-F on 8/23/18 at 10:21 a.m., NA-F stated she didn't think R12 had a therapy program. NA-F stated being unaware whether the facility had any therapy programs that involved AROM or PROM, but was aware the facility did have a couple of walking programs currently. A facility policy on ROM was requested by not provided.	F 688		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		10/2/18

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 _____	08/23/2018

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 712	Continued From page 20 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's physician completed the initial 30 day visit for 1 of 2 (R20) newly admitted residents reviewed. Findings include: R20's medical record indicated an admission date of 6/22/18, and indicated the resident's admitting diagnoses included: Parkinson's disease, atrial fibrillation (irregular heart beat), and diabetes mellitus. R20's physician progress notes indicated an initial 30 day visit had been conducted on 7/19/18 by physician assistant (PA)-F. The subsequent visit, conducted 8/20/18, was also documented as having been completed by PA-F. During an interview on 8/22/18 at 9:51 a.m. with the director of nursing (DON), the DON stated she was unaware of any policy on physician's visits specific to initial requirements following admission. The facility's April 2013 Physician Visits policy, included: "The attending Physician will visit residents in a timely fashion, consistent with applicable State and Federal requirements. After the first 90 days, if the attending physician determines that a resident need not be seen by	F 712	It is the Facilities intent to comply with the regulation to ensure that residents be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. R20 has been seen by physician on 9/17/2018. See Attachment 12 By 10/2/2018 audits will be completed for compliance on all residents. Policy & Procedures on Physician Visits will be reviewed, revised & updated as needed. See Attachment 13 By 09/27/2018 all staff who are responsible for scheduling Physician visits will be educated on the need to follow Facilities Policy & Procedure on Physician Visits. DON or Clinical Team designees will conduct weekly audits times 2 weeks for compliance. Thereafter, Audits will be completed monthly. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 712	Continued From page 21 him/her every 30 days, an alternate schedule of visits may be established, but not to exceed every 60 days. A physician assistant or nurse practitioner may make alternate visits after the initial 90 days following admission, unless restricted by law or regulation."	F 712		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		10/2/18

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 _____	08/23/2018

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 755	Continued From page 22 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely periodic reconciliation and prompt destruction of discontinued controlled medications awaiting destruction for 10 of 10 residents (R26, R29, R382, R383, R384, R385, R386, R387, R388, R389), or of the use of controlled substance from the facility's emergency kit (E-Kit) to prevent potential diversion. Findings include: Observation on 8/21/18, at 1:14 p.m., of the medication refrigerator located in the medication room, revealed 2 vials of lorazepam (an anti-anxiety medication) 2 milligrams (mg) per milliliter (ml) stored in the emergency kit (E-kit). The E-kit was closed with an unnumbered purple colored zip tie. During interview on 8/21/18 at 1:16 p.m., licensed practical nurse (LPN)-A stated when medications are taken out of the E-kit, the kit was zip tied shut. LPN-A stated the zip tie is used to prevent diversion of medications and stated the pharmacy is notified whenever medication are taken out of the E-kit. LPN-A further added, the consultant pharmacist visits the facility once per month regarding the replacement of items in the E-kit, and the current process has no reconciliation between the date pharmacy visits, or the date medication was removed from the E-kit. "There is no way to tell if one vial was taken and there is no process for medication reconciliation." LPN-B confirmed staff would not	F 755	It is the Facilities intent to have systems in place to ensure timely periodic reconciliation and prompt destruction of discontinued controlled medications to prevent potential diversion. Policy & Procedure for Discarding and Destroying Medications has been reviewed, revised and updated. See Attachment 14 All discontinued controlled medications have been destroyed as of 9/1/2018. The 2 vials of lorazepam have been logged in the narcotic book for future ability to reconcile. By 09/27/2018 all licensed staff will be educated on the work flow process. Policy & Procedure will be reviewed. Director of Nursing or designated staff will audit the destruction log and narcotic book weekly to ensure compliance with applicable regulations and Facility policy. Audit findings will be reported to Facility□s Quality Assurance Team.	

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 _____	08/23/2018

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 755	Continued From page 23	F 755		

be aware if something went missing until the consultant pharmacist arrived.

During an observation on 8/21/18 at 1:21 p.m., medications awaiting destruction were observed in a medication cupboard inside the medication room. A more detailed review identified 12 controlled medications were currently stored in the cupboard awaiting destruction including:
(1) R26 had one blister pack of lorazepam 0.5 mg originally dispensed to facility on 12/24/16.
(2) R29 had Morphine Sulfate 100mg/5 ml dispensed to facility on 2/1/18,
(3) R382 had one bottle of hydromorphone 1 mg/1ml.
(4) R382 had one blister pack of lorazepam 0.5 mg, dispensed on 7/25/18.
(5) R383 had one bottle of hydromorphone 1gm (gram)/1ml. The bottle had been dispensed to the facility on 7/25/18.
(6) R383 had one blister pack of lorazepam 0.5 mg. The blister pack was dispensed on 7/25/18.
(7) R384 had one bottle of methadone 10 mg/1 ml, dispensed to the facility on 5/8/18, and placed in the cupboard on 6/6/18.
(8) R385 had one bottle of hydromorphone liquid 1gm/1ml dispensed to the facility on 5/30/18, and placed in the cupboard on 6/7/18.
(9) R386 had one bottle of Morphine Sulfate 100mg/5ml.
(10) R387 had one bottle of Morphine Sulfate 100 mg/5 ml dispensed to the facility on 4/11/18.
(11) R388 had one bottle of Morphine Sulfate 100mg/5 ml dispensed to the facility on 6/20/18.
(12) R389 had one bottle of Morphine Sulfate 100mg/5ml was dispensed to the facility on 2/1/18.

During interview with LPN-A on 8/21/18 at 1:23

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 _____	08/23/2018

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 755	Continued From page 24 p.m., LPN-A stated when a medication is discontinued, or a resident passes, the medication was placed in the cupboard for destruction, and staff stopped conducting any reconcilliation. LPN-A confirmed staff did not reconcile these medications periodically while waiting for them to be destroyed. During interview with the pharmacy consultant (RPH-D) on 8/22/18 at 10:48 a.m., RPH-D verified controlled medications "should be counted" if stored in the facility. RPH-D also said the controlled medications should be destroyed in a timely manner. During Interview on 8/23/18 at 10:30 a.m., the DON confirmed staff had not been reconciling the controlled medication in the E-Kit, or the controlled medications awaiting destruction in the locked cupboard. The DON stated staff would be encouraged to monitor the E-kit, and the destruction cupboard. The DON stated there was otherwise no way to know when medications were potentially diverted. The DON Stated she would confer with RPH-D to develop appropriate destruction of medication policies. Review of the facility's April 2007, Storage of Medications policy, revealed there was no mention about the appropriate disposition of controlled medications.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		10/2/18

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 _____	08/23/2018

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 761	Continued From page 25 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reconcile in-use over the counter (OTC) medications with physician orders and medication labeling for 1 of 7 resident (R19) reviewed during medication administration. Findings include: During medication administration observation on 8/21/18 at 8:39 a.m., with licensed practical nurse LPN-B it was noted the electronic medication administration record (eMar) had an order for Calcium 600 milligrams (mg) + vitamin D, 200 international units (IU) to be given twice (2x) per day. The OTC bottle of calcium used for the administration contained Calcium aspartate	F 761	It is the Facilities intent to comply with the regulation to ensure medications are reconciled with physician orders and medication labeling. R19□s medication was reconciled with the physicians order. Physician notified of the incident. See Attachment 17 Policy & Procedure for Reconciling Medications with Physicians Orders has been reviewed, revised and updated. See Attachment 18 By 10/2/2018 audits will be completed for compliance on all residents. Policy &	

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 _____	08/23/2018

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 761	Continued From page 26 anhydrous, 1120 mg and Calcium Elemental 146 mg with a manufacturer's suggested serving size of 2 capsules. Review of R19's 9/22/17 physician order revealed calcium 1,000mg 1 capsule 3x per day. During interview on 8/21/18 at 3:19 p.m., with LPN-A revealed she agreed the physician's order and the OTC bottle dosage had not matched. The facility's procedure was to verify the physician's order against the label of medication. "If the label and physician's order do not match, staff should not administer the medication (meds). During interview on 8/22/18 at 10:48 a.m., with pharmacy consultant (P)-D, revealed facility staff should have been completing the rights of medication administration, including right dose with each medication pass. It was is very common to find medication order entry errors transcribed onto the eMar. During interview on 08/23/18 at 10:30 a.m., with director of nursing (DON) indicated it was her expectation if staff had noticed a discrepancy between the administration record and physician's order, the physician should have been notified immediately. In December and January they were changing from one electronic medical record (EMR) to another and inferred that was likely the source of the transcription error. Review of the December 2012, Administration Medication policy indicated licensed staff administering the medication must check the label three times to verify: right resident, right medication, right dosage, right time and right method (route) of administration, before	F 761	Procedures on Reconciling Medications with Physicians Orders will be reviewed, revised & updated as needed. By 09/27/2018 all staff who are responsible for scheduling Physician visits will be educated on the need to follow Facilities Policy & Procedure on Reconciling Medications with Physicians Orders. DON or Clinical Team designees will conduct weekly audits times 2 weeks for compliance. Thereafter, Audits will be completed monthly. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 761	Continued From page 27 administering the medication.	F 761		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure administration was managing facility resources to ensure resident needs were being met with respect to essential equipment repairs, physical plant repair concerns and infection control plan development to promote the resident's highest practicable physical and mental function and well-being. This deficient practice had the potential to affect all 31 residents in the facility. Findings include: Refer to F880. The facility failed to ensure an infection control program was in place to ensure the risk for spread of infectious illness in the facility was minimized. Refer to F908. The facility failed to ensure mechanical lifts were maintained in working order and failed to ensure tub lift equipment was maintained in functional working order for patient care. Refer to F921. The facility failed to ensure the facility ceiling tiles were being maintained to	F 835	It is the Facilities intent to comply with the regulation to ensure administration was managing facility resources to ensure resident needs were being met with respect to essential equipment repairs, physical plant repair concerns and infection control plan development to promote the resident□s highest practicable physical and mental function and well-being. Refer to F880 Refer to F908 Refer to F921	10/2/18

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 _____	08/23/2018

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 835	Continued From page 28	F 835		

ensure water leakage did not occur in resident care areas and common living spaces.

During interview on 8/22/18, at 2:18 p.m. nursing assistant (NA)-C stated, "A couple of months ago, the facility did not have enough hot water for baths for the residents in the tub rooms related to a need for a new water heater which the facility did not have the money to repair." NA-C further stated, "Every lift we have is broken. Many are missing controls and do not have properly functioning batteries to ensure the machine can go up and down during resident transfers. Staff repeatedly have to push a manual button to eventually lower the patient onto whatever surface they are being moved to." NA-C stated she had worked at the facility a number of years and stated, "This is the worst we have downfallen" with respect to the quality of resident care. NA-C stated, "Recently, all the resident laundry had to be washed at the assisted living in coin-operated machines because the laundry equipment was not functioning for an extended period of time." NA-D, also present during the interview, stated that she had been so concerned about the function of the equipments such as the lifts on her her wing that she'd written a note directly to maintenance and put it on the door. NA-D stated she felt unable to do her job due to broken equipment and stated she had been reprimanded at a nursing staff meeting for writing up the concerns list and providing it to maintenance. NA-D stated, "Something's going on, it's not right."

During interview on 8/23/18, at 10:52 a.m. the environmental service director (ESD) stated one of the tubs in the facility was completely out of service due to repairs that could not be

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 _____	08/23/2018

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 835	Continued From page 29	F 835		

completed due to lack of approval for funds. The ESD also verified he was aware the lift machines were in need of batteries however, stated he had been waiting a couple of months for approval to purchase them. The ESD stated the administrator worked with the corporate director (CD) to authorize purchases, but stated all requests for equipment repair and purchases were primarily verbal, and he could not produce written evidence of them. He further verified that recently, the facility's washers were down for over three weeks and he had been unable to repair them due to inability to immediately pay an electrician to come fix them. The ESD stated in the interim, all resident laundry had to be washed in the coin-operated machines at the neighboring assisted living facility. The ESD further stated, "We have been operating like this for a long time now."

During interview on 8/23/18, at 11:20 a.m. the administrator confirmed the facility had a difficult time making necessary repairs to equipment and the physical plant due to some reimbursement issues surrounding a change in their national provider identification (NPI) number and were "playing a lot of catch up" with respect to repairs. The administrated stated things had "improved to a degree." The administrator stated she had not been aware the infection control tracking and trending had not been conducted for several months at the facility however, was aware that the responsible party had been pulled to the floor for direct patient care duties at times, and stated she would have to look into why the infection control duties had otherwise not been completed. The administrator also confirmed it had been difficult to get authorization from corporate for purchases, and although she was invited to the recent board

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 _____	08/23/2018

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 835	Continued From page 30	F 835		

meeting for the skilled nursing facility to give a brief report, she had not received any feedback from the board related to her comments or concerns. The administrator stated if resident equipment became a safety issue she did have the authority to authorize purchases, however indicated that she did periodically audit, by walk-through of the facility or otherwise, to monitor for equipment in need of repair. The adminsitrator said she had never been in the tub room on the Bluebell Wing.

During interview on 8/23/18, at 1:51 p.m. the CD stated he was not aware significant equipment repairs were required at this time until he had been informed by one of the facility staff 8/22/18 that the survey team had concerns about the physical plant and resident care equipment. The CD did indicate he was aware of a water heater issue and as this was a larger dollar item to replace, he approved the purchase. The CD also acknowledged having been aware of some concerns previously with the laundry equipment not working however, stated they currently had a bid out to inquire about having the laundry work outsourced to an offsite location. The CD indicated he would have expected any broken patient care equipment to have been replaced at the time it was noted to be broken, and indicated the entire physical plant was going to be renovated, further stating the building "has not had any money put into it in years." The CD confirmed the concerns with the mechanical lifts and physical plant issues were an "immediate concern."

Review of the Arjo Century Tub repair and routine maintenance invoices available at the time of the survey indicated the Bluebell Wing Tub had not

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 _____	08/23/2018

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 835	Continued From page 31 been serviced since 2009. The facility service call reports for the Bluebell Wing whirlpool tub showed the last service maintenance work was performed on the tub in 2009. Review of the facility preventive maintenance logs for the previous six months did not list the Bluebell Wing whirlpool on them. In addition, the preventive maintenance logs listed the mechanical lifts were checked for proper function monthly however, did not indicate if they were functioning or required repairs. The facility's EZ Way Stand Safety Checklists, and EZ Way Lift Safety checklists, were provided by the ESD however, none were provide for 2018. The most recent documentation was dated 6/27/17, and did not include any check or mention of whether the batteries for the lifts were functional or in need of replacement. Invoices and maintenance requests for the previous year were requested and reviewed, no invoices or repair slips were provided indicating any servicing in the prior 12 months or parts replacements completed on the EZ Way Lift or EZ Way Stand Lifts or Arjo Century Tubs, nor did the repair slips and invoices contain purchasing order requests for new ceiling tiles.	F 835		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/2/18

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 _____	08/23/2018

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 880	Continued From page 32 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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 _____	08/23/2018

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 880	Continued From page 33 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate infection control measures were implemented to prevent potential spread of infection, failed to ensure appropriate disinfection of bathing equipment and resident mechanical lifts, failed to ensure oxygen equipment was properly maintained in a sanitary manner and failed to implement trending and tracking of infections. These deficient practices had the potential to affect all 31 residents residing in the facility. The findings include: 1. The facility failed to ensure appropriate cleaning and disinfection of 1 of 1 equipment including the whirlpool tub, humidifiers, E-Z stand (mechanical) lifts, and oxygen tubing. 2. The facility failed to ensure personal laundry	F 880	It is the Facilities intent to comply with the regulation to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and to help prevent the development and transmission of communicable diseases and infections. Policy and Procedure on cleaning and disinfecting resident equipment has been reviewed, revised and updated as needed. See Attachment 19 Resident□s personal laundry was appropriately cleaned. Contract has been signed to out source laundry services.	

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 _____	08/23/2018

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 880	Continued From page 34 was appropriately cleaned. 3. The facility failed to ensure the infection control program included ongoing trending and analysis of resident infections. During interview with nursing assistant (NA)-C on 8/23/18 at 11:30 a.m., NA-C described the facility's process for cleaning and disinfecting the whirlpool tub and jets. NA-C stated after a resident's bath, the nursing assistant would spray the whirlpool down with a mist of Whirlbath Lemon Kleen Disinfectant Cleaner, scrub the surface of the inside of the whirlpool tub with a brush, and complete the process by immediately rinsing the whirlpool tub down. There was not a process to clean the jets of the whirlpool. NA-C further verified there were no posted instructions in the whirlpool tub room about the appropriate use of the chemical used to disinfect the whirlpool tub and jets between resident use. NA-C stated she was unaware the whirlpool jets that circulated the water in the whirlpool had not been being appropriately disinfected. NA-C stated she had been giving whirlpool baths to R23, who had open wounds which had been cultured to be positive for a colonized bacterial infection of methicillin-resistant staphylococcus aureus (MRSA), a drug resistant organism. During interview on 8/23/18 at 11:45 a.m., NA-F stated she used the same process as NA-C to clean the whirlpool tub. NA-F stated there had been no no formal training on appropriate disinfection of the whirlpool tub between resident use. Review of the manufacturer's instruction for the Whirlbath Lemon Kleen disinfectant product, (on the label of the bottle), indicated staff must use 2	F 880	Tracking and trending process has been established for residents. Daily review of progress notes by DON or designee for signs/symptoms of potential infectious process of all residents. Tacking and trending process has been established for staff. See Attachment 20 Signs are posted in front of facility provided by MDH. Policy and Procedure for Infection Control During Visitation has been review, revised and updated as needed. See Attachment 21 By 10/2/2018 audits will be completed for compliance on all resident equipment used. Policy & Procedures on cleaning and disinfecting resident equipment will be reviewed, revised & updated as needed. By 09/27/2018 all staff who are responsible for the cleaning of resident equipment will be educated on the need to follow Facilities Policy & Procedure on cleaning and disinfecting resident equipment. By 09/27/2018 all staff will be educated on infection control Policy and Procedures for reporting staff, resident, visitor, and vendor illness□. DON or Clinical Team designees will conduct weekly audits times 2 weeks for compliance. Thereafter, Audits will be completed monthly. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with	

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 _____	08/23/2018

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 880	Continued From page 35 oz (ounces) of the disinfectant per gallon of water to clean the whirlpool tub. The directions further indicated once formulated appropriately, there should be a 10 minute contact time, allowing the jets and surfaces of the whirlpool tub to be disinfected appropriately. Review of the facility's July 2014, Cleaning and Disinfection of Resident Care Items and Equipment policy, indicated reusable resident equipment was to be disinfected between resident use. During interview on 8/23/18 at 1:10 p.m., the infection control nurse, registered nurse (RN)-B, confirmed R23 had been taking a whirlpool bath during the time she had open areas on her chin and arms, and had since tested positive for MRSA infection. Following review of the manufacturer's guidance on the disinfectant bottle, and after having been notified about staff described practice, RN-B verified the whirlpool tub was not being disinfected appropriately. She stated she was unaware of instructions or procedures for staff to follow regarding appropriate disinfection of the whirlpool tub, and verified she had not conducted any staff competency or auditing related to appropriate disinfection of the whirlpool tub. RN-B stated she'd started overseeing the infection control program (ICP) one day per week in December 2017. However, RN-B stated she had not actively performed infection control oversight since the middle of May 2018 at which time she had been pulled from her duties to work in direct patient care. RN-B indicated she had done some on-line training for tracking/trending/analyzing and also had some textbook training on infection control. RN-B verified there was limited	F 880	applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 880	Continued From page 36	F 880		

trending/tracking/analyzing that had been done throughout the facility, and confirmed she had not actively done any since May 2018. RN-B further verified there was no tracking of symptoms of infection for residents, or staff, prior to a diagnosis of illness. RN-B stated she thought the director of nursing (DON) had been monitoring staff illness. RN-B indicated although some staff illness had been reported to the DON, documentation showed there was no follow-up to indicate cessation of symptoms or the appropriateness for staff to return to work.

Review of the facility's Antibiotic Surveillance Forms indicated the type of infections that had been noted in the past six months included aspiration pneumonia, urinary tract , respiratory, and eye infections. There was no mention of R23 in the documentations who had a colonized MRSA infection. R23 was on isolation/contact precautions related to that illness. RN-B agreed without appropriate infection control measures used to disinfect the whirlpool tub, other residents would be at risk for potential like infection from R23.

During interview on 8/23/18, at 2:18 p.m. DON indicated she had not completed any competency related to the appropriate use of the whirlpool tub disinfection and thought training was part of orientation upon hire. The DON planned to ensure staff had been appropriately trained within the next six months.

The July 2016, Antibiotic Stewardship policy indicated documentation in the electronic medical record (EMR) should include the resident's response to the infection, and interventions and treatments specific to the resident and infection.

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 _____	08/23/2018

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 880	Continued From page 37 Review of the July 2016, Surveillance for Infections policy indicated staff were to monitor residents for signs and symptoms that may suggest infection, and will document and report to the charge nurse and infection control (IC) nurse immediately. If transmission-based precautions were implemented, the IC would collect data to determine effectiveness of interventions. There was no mention of monitoring the prevention, identification, reporting, investigation, and control of infections and communicable diseases for staff, volunteers, visitors, and other individuals providing any service within the facility. Review of the July 2014 Policies and Practices-Infection Control policy indicated the facility's was intended to maintain a safe, sanitary and comfortable environment, and to help prevent and manage transmission of infections. The objectives were to prevent, detect, investigate, and control infections in the facility. The facility was to have maintained records of incidents and corrective actions implemented. All personnel would be trained on infection control policies and practices upon hire, and periodically thereafter including where and how to find and use pertinent procedures and equipment. R25's face sheet indicated he was admitted on 7/5/18, with diagnoses that include hypertension (high blood pressure), atrial fibrillation (irregular	F 880		

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 _____	08/23/2018

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 880	Continued From page 38	F 880		

heart beat), edema (excess fluid), chronic respiratory failure with hypoxia (low blood oxygen level), constipation (hard stools), dependence on oxygen, hypothyroidism (low thyroid level) , type 2 diabetes (blood sugars), diabetic neuropathy, long term use of anticoagulants (blood thinner), chronic obstructive pulmonary disease (disease of the lung), low back pain, presence of a cardiac pacemaker (medical device placed to regulate heart rate), morbid obesity (overweight), and anxiety disorders.

On 08/22/18 at 8:44 a.m. humidifier bottle attached to his oxygen concentrator was not dated, but oxygen tubing was dated 8/19.

R12's face sheet printed 8/22/18, indicates he was admitted on 6/17/14, with the following diagnoses: paraplegia, muscle spasms, chronic pain, atrial fibrillation, heart failure, anemia, hypertension, chronic obstructive pulmonary disease (lung disease), history of urinary tract infections, and dependence on supplemental oxygen.

R12's physician orders noted 6/25/18, indicate oxygen at 1 liter per minute (LPM) during the day and 2 LPM at night via nasal cannula related to diagnosis of chronic obstructive pulmonary disease.

R12's care planned interventions last revised on 4/13/18, for use of oxygen indicates to change oxygen tubing weekly on Sunday and distilled water container monthly.

On 8/20/18 at 3:26 p.m., humidifier bottle hooked attached to R25's oxygen concentrator was dated 6/18/18, oxygen was in use

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 _____	08/23/2018

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 880	Continued From page 39 8/22/18 at 7:17 a.m., humidifier bottle dated 6/18/18, oxygen was in use On 8/22/18 at 7:15 a.m., LPN-B stated during interview bubbler (humidifier bottles) were changed once a month and the oxygen tubing weekly, verified that R25's bubbler was not dated, therefore did not know when it was changed last. On 8/22/18 at 10:00 a.m., LPN-B stated that they do change the bubblers once a month but do not document it anywhere, the tubing changes come up on the computer but the bubblers do not. "I usually like to change them the first week of the month". On 8/23/18 at 10:42 a.m., interview with the DON revealed the bubblers should be replaced weekly. DON confirmed that the humidifier bottle for R25 was dated 6/18/18 and stated, "oh my, they should have been changed a long time ago". MED-PASS, Inc. policy named Oxygen Administration last revised 3/04 proved by the facility does not indicate how often the humidifier bottle or other oxygen supplies should be replaced. Observations on 8/20/18 through 8/22/18 of the EZ stand mechanical lifts revealed: (1) On 8/20/18 at 4:10 p.m. EZ-stand down blue hall, missing safety clip, with white substance and heavily soiled with food particles on feet platform. (2) On 8/20/18 05:50 p.m. EZ-stand down blue hall, filthy with food and white powder appearing	F 880		

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 _____	08/23/2018

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 880	Continued From page 40 substance on feet platform. (3) On 08/21/18 08:14 a.m., EZ-stand down red hallway has obvious food and a yellow like dried liquid on feet platform. (4) On 08/21/18 08:16 a.m., EZ-stand down green hallway food particles, heavily soiled on foot pedestal. (5) On 08/21/18 10:08 a.m., EZ-stand down green hall, heavily soiled with chunks of food and yellow dried on substance on feet platform. (6) On 8/21/18 at 2:52 p.m., R24 was observed being assisted out of his room in his wheelchair (WC). Nursing assistant (NA)-D proceeded to push the EZ stand, used by R24 from his room into the hallway. The same heavily soiled debris remained on the E-Stand that had been present prior to staff assisting R24. (7) On 08/21/18 03:29 p.m., EZ-stand down red hallway continues to be heavily soiled with food particles on the foot pedestal. (8) On 08/21/18 04:57 p.m., EZ-stand down blue hallway continues to have food particles on platform and white substance on feet platform. (9) 8/22/18 at 9:50 a.m., EZ-stand and lifts stands were clean. Interview on 8/22/18 at 2:23 p.m., with nursing assistant (NA)-A revealed stands and lifts should be cleaned every day, but there not, they are cleaned now because your here. Interview on 8/23/18 at 10:30 a.m., with director of nursing (DON) stands and lifts should be cleaned every night in the wheel chair wash station. There is no log to monitor this and my expectation is they are cleaned every day. Review of the revised July 2014. Cleaning and Disinfection of Resident-Care Items and	F 880		

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 _____	08/23/2018

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 880	Continued From page 41 Equipment policy indicated Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the whirlpool tubs used for resident bathing were maintained in proper working repair. Additionally, the facility failed to ensure mechanical lifts utilized for resident transfers were kept in proper working repair. This deficient practice had the potential to affect 13 of 31 residents in the facility who utilized a tub for bathing and 12 of 31 residents who utilized the mechanical lift for transfers. Findings include: During interview on 8/22/18, at 2:18 p.m. nursing assistant (NA)-C the facility had been without hot water for resident baths for nearly a month and a half recently because the facility needed a new water heater and the facility did not "have enough money to fix it." Additionally, NA-C stated the facility's lift machine batteries were "pretty shot," and many of the mechanical lifts were missing their remote controls, which made resident transfers more difficult for the staff. NA-A was also present and confirmed the concerns with lift batteries not working and also indicated one of the whirlpool tubs hadn't been in use for quite some time as it was broken, and the other	F 908	It is the Facilities intent to comply with the regulation to maintain all mechanical, electrical, and patient care equipment in safe operating condition. Hot water heater was replaced on 6/1/2018. ESD attempted various procedures to fix hot water heater prior to replacing hot water heater. This was over a one-week span; we had intermittent periods with short supply of hot water at times. This contradicts the statement of what was reported by ((NA)-C. Mechanical lift equipment batteries, controllers, and safety tabs were replaced on 08/31/2018. See Attachment 22 At the time of survey, the Bluebell wing whirlpool tub was the only operational tub in the facility. On 8/23/2018, the Bluebell whirlpool tub was taken out of operation. On 8/24/2018, the Daisy wing whirlpool tub was repaired and put into operational use. Operational whirlpool tubs have	10/2/18

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 _____	08/23/2018

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 908	Continued From page 42 working tub did not always have hot water. During observation and interview with the facility administrator on 8/22/18, at 4:20 p.m., the Bluebell Wing tub was noted to have worn straps which were utilized to secure the residents in the tub chair while it was being raised with an electronic foot control to lift the resident into the tub. The administrator stated she was not sure if the straps were in proper working order, and stated she would need to "look at the manufacturer's guidelines." During further observation and interview on 8/22/18, at 4:25 p.m. mechanical lift B on the Bluebell Wing had was noted to be missing a remote, which NA-G stated had been gone for "maybe a year." Additionally, the full body lift on the Bluebell Wing was noted to have damaged foam on the head of the lift arms which had been taped together with electrical tape. The Daisy wing standing lift was noted have an indicator light displaying "change battery." During interview on 8/23/18, at 8:13 a.m. R75 stated she was transferred with a mechanical lift on a daily basis and the lift batteries died often, it was "ridiculous." R75 further stated this happened on almost a daily basis, today the lift battery had to be changed because it was getting too hot and R75 had been waiting to be transferred back off the commode. R75's quarterly Minimum Data Set, dated 7/3/18 indicated she was cognitively intact, with a Brief Interview for Mental Status score of 15/15 points. During interview on 8/23/18, at 8:57 a.m. NA-C stated the batteries on the mechanical lifts were "horrible beyond horrible," and half the time were	F 908	been placed on a monthly preventative maintenance program. Preventative Maintenance program has been reviewed, revised and updated as needed. Mechanical lift equipment are now on the monthly safety checks. See Attachment 23 & 24 Repair orders will be submitted to ESD and Administrator, when completed signed orders will be turned into Administrator. All repair orders will be reviewed monthly at QAPI. By 10/2/201/8 audits will be completed for compliance on all resident equipment used. Policy & Procedures on preventative maintenance for resident equipment will be reviewed, revised & updated as needed. By 09/27/2018 all staff who are responsible for the use of resident equipment will be educated on the need to follow Facilities Policy & Procedure on use of resident equipment. ESD, DON or designee will conduct weekly audits times 2 weeks for compliance. Thereafter, Audits will be completed monthly. Audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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 _____	08/23/2018

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 908	Continued From page 43	F 908		

not charging properly. NA-C reported problems with the lift batteries on a daily basis.

During observation and interview on 8/23/18, at 9:51 a.m. NA-C showed survey staff the whirlpool tub located on the Bluebell Wing, which she stated was the only working tub utilized for baths in the facility. The bathtub had a lift chair had a set of three straps which NA-C stated were used to secure the resident into the chair. One strap was noted to be hanging off the back of the chair, the vinyl covering was noted to be heavily cracked with a blackened discoloration to the strap, and the nylon underneath was noted to be fraying. A second strap which ran between the resident's legs was also noted to have the vinyl covering peeling off with some fraying near the edges. A third strap which was utilized around the resident's waist was noted to be in good repair. Additionally, the water control mixing knob was noted to be missing, and NA-C stated that she had to utilized valves on the piping to try to adjust the water temperature for the resident. A sheet of dycem was noted to be on the tub seat which NA-C stated was used to help ensure the resident did not slide off the seat of the tub chair during movement, and was also noted to be in a worn condition.

During interview on 8/23/18, at 10:52 a.m. the environmental services director (ESD) confirmed the Bluebell Wing whirlpool was the only tub currently in use for resident baths. A second newer whirlpool tub in the facility had been down since "the beginning of the year," as it needed parts and authorization had not yet been received to purchase the parts for repair. The ESD stated he had not been aware the straps on the Bluebell Wing whirlpool were damaged, and should have

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 _____	08/23/2018

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 908	Continued From page 44	F 908		

had the tub chair straps on a preventive maintenance program. The ESD stated he was aware of the lift machines needing new batteries and remotes, however, had been waiting at least a couple of months for authorization to purchase new ones. The ESD stated the facility administrator used to approve such purchases, however, they now had to go through corporate and the facility had trouble paying vendors to fix essential equipment, "We have been operating like this for a long time now."

During interview on 8/23/18, at 11:20 a.m., the administrator stated she had more difficulty authorizing purchases for equipment repairs, there had been "a lot of issues," with funding since the facility had changed ownership within the past year and believed it may have had something to do with delays in funding and a change in national provider identification number. The administrator thought this "glitch," had been fixed, however, the facility was "playing a lot of catch up," related to needed repairs. The administrator stated she was not aware of the need for new tub straps or lift batteries and had not observed the tub room on environmental rounds. The administrator stated the corporate director (CD) was responsible for authorizing funding for repairs of equipment.

During interview on 8/23/18, at 1:51 p.m. the CD stated he was not aware the facility lift machines or tub equipment was in need of repair, until it was called to his attention last evening after survey staff identified a concern, and stated the building had "not had money put into it for years," by the prior owners and he would be making a rounds of the facility next week to ensure essential equipment was repaired as necessary.

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 _____	08/23/2018

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 908	Continued From page 45 A facility policy regarding purchase orders was requested, none was provided. The facility service call reports for the Bluebell Wing whirlpool tub showed the last service maintenance work was performed on the tub in 2009. Review of the facility preventive maintenance logs for the previous six months did not list the Bluebell Wing whirlpool on them. In addition, the preventive maintenance logs listed the mechanical lifts were checked for proper function monthly, however, did not indicate if they were functioning or required repairs. Facility EZ Way Stand Safety Checklists and EZ Way Lift Safety checklists were provided by the ESD, however, none were provide for 2018. The most recent documentation was dated 6/27/17. Review of the undated manufacturer's Operation Guide for the Bluebell Wing whirlpool tub, indicated that the safety straps on the tub chair should be checked weekly to ensure they were in place and undamaged.	F 908		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain ceiling tiles in a clean and sanitary manner in 1 of 1 kitchen, 1 of 1 kitchenette, 1 of 1 dining room, 2 of 4 halls (Aster & Daisy), 1 of 1 day room, 1 of 1 nurses station,	F 921	It is the Facilities intent to comply with the regulation to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	10/2/18

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 _____	08/23/2018

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 921	Continued From page 46 and 1 of 1 activity room. This had the potential to affect all 31 residents, families and visitors in the facility. Findings include: Observation on 8/23/18 at 1:50 p.m., the following areas were noted to have what appears to be water stains on the ceiling tiles and walls: (1) The activities room had 12 ceiling tiles that had varying degrees of staining (ranging from tan to brown in color) as well as water streaks on the south wall. 2 of the ceiling tiles that appeared wet and sagging, and had a large garbage can placed underneath them. 2 "wet floor" signs hung on the edges of the can. (2) The dining room had 5 stained (tan colored) ceiling tiles near ventilation vents. (3) The nurses station had 3 water-stained ceiling tiles. (4) The kitchenette had 6 water-stained stained ceiling tiles. (5) The kitchen had 3 stained tiles near the stove hood, 1 stained tile over the staff's hand washing sink, and 5 ceiling tiles surrounding an air condition vent directly over the food preparation counter. (6) The red hall had 5 stained tiles with adjacent bubbled wall paint and water streaks visible. 2 of 5 tiles were visibly sagging. (7) The day room at the end of the red hall had a large area of wallpaper that was loose and falling off of the wall. (8) the yellow wing had 2 stained ceiling tiles near ceiling vent with water stains on the adjacent wall. Interview on 8/23/18 at 1:57 p.m. with housekeeper- A, revealed staff placed the garbage can placed in the activities room as they	F 921	Ceiling tiles were purchased on 09/16/2018. See Attachment 25 Preventative Maintenance program has been reviewed, revised and updated as needed. See Attachment 23 By 10/2/2018 audits will be completed for compliance. By 09/27/2018 all staff who are responsible for the reporting facility equipment/maintenance needs will be educated on the facilities Policy & Procedure. ESD or designee will conduct weekly audits. Audits will be reported to Facilities Quality Assurance team for review.	

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 _____	08/23/2018

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 921	Continued From page 47 could hear water dripping. Housekeeper A had not known where the water had been leaking from and was concerned the ceiling tile was going to fall down. During an interview on 8/23/18 at 3:10 p.m., the maintenance supervisor (MS) declined to observe the stained ceiling tile to verify existing damage. The MS indicated the facility needed a new roof. The roof had exceeded its expected time frame as it needed to be fully replaced as it had been patched numerous times. MS reported using a case of ceiling tiles for replacements of damaged tiles after every rain. There was no policy provided on preventative maintenance by the end of the survey.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2018**

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 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Truman Senior Living was found not to be 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 Occupancies.

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to:

Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/19/2018

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 **01 - MAIN BUILDING 01** B. WING _____	**08/23/2018**

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 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Truman Senior Living is a one-story building with no basement, and is fully sprinklered. The original 1970 building along with the 1975 and 1987 building additions were determined to be of Type II(000) construction. The 1996 building addition was determined to be of Type V(111) construction.

The nursing home is separated from an outpatient medical clinic and an assisted living facility by rated 2-hour fire wall assemblies, which include opening protectives consisting of factory labeled, self-closing, positive latching 90-minute fire door assemblies.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2018**

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 000	Continued From page 2 capacity of 40 beds and had a census of 31 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could effect 31 of 31 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE:	K 345	It is the Facilities intent to comply with the Life Safety Code standards. As of 8/27/2018, The Annual Inspection of Fire Alarm System was completed. See Attachment 1 ESD has put in place a tracking system to ensure inspections are completed as required per regulations.	9/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2018**

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 345	Continued From page 3 On facility tour between 10:00 AM and 1:00 PM on 08/23/2018, during documentation review, documentation could not be located to show that the smoke detector sensitivity inspection had occurred with the last 2 years. This deficient practice was verified by the Facility Maintenance Director.	K 345		
K 353 SS=F	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 interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 31 out of 31 residents.	K 353	It is the Facilities intent to comply with the Life Safety Code standards. As of 9/10/2018, The Annual Inspection of Fire Alarm System was completed. See	9/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2018**

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 353	Continued From page 4 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 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 08/23/2018, during documentation review, documentation could not be located to indicate that an Annual Fire Sprinkler Inspection had occurred within the required time frame, of at least annually. The last documented inspection occurred on 07/11/2017. This deficient practice was verified by the Facility Maintenence Director.	K 353	Attachment 2 ESD has put in place a tracking system to ensure inspections are completed as required per regulations.	