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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4SDX

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)

6. DATE OF SURVEY **07/17/2014** (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: * Code: **A** (L12)

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

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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/29/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/07/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5346

On July 17, 2014 a Post Certification Revisit (PCR) was completed by the Department of Health and on July 7, 2014 the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the July 7, 2014 standard survey. Refer to the CMS 2567b for both health and life safety code.

Effective July 6, 2014, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245346

July 17, 2014

Ms. Lorna Craig-Paulson, Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, Minnesota 56088

Dear Ms. Craig-Paulson:

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 July 6, 2014 the above facility is certified for or recommended 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 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 17, 2014

Ms. Lorna Craig-Paulson, Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, Minnesota 56088

RE: Project Number S5346024

Dear Ms. Craig-Paulson:

On June 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 29, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 7, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 29, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 29, 2014, effective July 6, 2014 and therefore remedies outlined in our letter to you dated June 9, 2014, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245346	A. Building B. Wing	7/17/2014

Name of Facility	Street Address, City, State, Zip Code
TRUMAN SENIOR LIVING	400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **07/06/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **07/06/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **07/06/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/06/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/06/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **07/06/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	07/14/2014	03048	07/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/29/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245346	01 - MAIN BUILDING 01	7/7/2014

Name of Facility	Street Address, City, State, Zip Code
TRUMAN SENIOR LIVING	400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	07/06/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/17/2014	19251	07/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/28/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4SDX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00361

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(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)

6. DATE OF SURVEY **05/29/2014** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Pamela Manzke, HFE NE II 06/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/03/2014 (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.
03001
(L31)

30. REMARKS
Posted 07/07/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4943

June 9, 2014

Ms. Lorna Craig-Paulson, Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, Minnesota 56088

RE: Project Number S5346024

Dear Ms. Craig-Paulson:

On May 29, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

<u>Remedies</u> - 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 a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

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 July 8, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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

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

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 August 29, 2014 (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 November 29, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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 _____	05/29/2014

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 The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159	**F 159** It is the Facility's intent to give quarterly accounting of resident's funds and provide resident's access to their accounts during weekends and evenings. All residents with trust accounts have been sent a quarterly statement. Licensed Nurses have been educated to the proper procedure for dispensing resident funds. Audits are conducted daily per Facility policy and procedure. Business Office Manager or designated staff will be responsible to ensure compliance and complete audits. Results of these audits will be reviewed at quarterly Quality Assurance team meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: July 6, 2014	

approved KMS 6/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorna L. Craig-Paulson | TITLE: Administrator | (X6) DATE: 6.20.14

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.

RECEIVED
JUN 23 2014
Minnesota Department of Health
Marshall

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 _____	05/29/2014

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

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F 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to make quarterly statements of the resident fund accounts available to residents and/or the legal representative and failed to ensure resident access to these accounts during evenings and weekends for 26 of 26 residents (R6, R45, R19, R8, R23, R24, R32, R39, R22, R13, R44, R35, R41, R1, R42, R29, R51, R28, R9, R8, R33, R46, R12, R61, R38 & R30) who had a resident account managed by the facility. Findings include: Quarterly statements of resident fund accounts were not made available to the 26 residents	F 159	**F 272** It is the Facility's intent that the Interdisciplinary team conducts a comprehensive assessment of each resident's needs. The staff will continue to complete comprehensive assessments for all residents per the RAI manual. R55 is no longer a resident. All appropriate staff will be reeducated on completion of Comprehensive assessments. Monthly audits will be completed to ensure ongoing weight loss is comprehensively assessed to minimize further weight loss. The Director of Nursing or designee will conduct chart audits for weight loss assessments of five random resident records per month for three months. Results of these audits will be reviewed at quarterly Quality Assurance team meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved.	

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F 159	Continued From page 2 and/or their legal representative who allow the facility to manage their individual accounts (R6, R45, R19, R8, R23, R24, R32, R39, R22, R13, R44, R35, R41, R1, R42, R29, R51, R28, R9, R8, R33, R46, R12, R61, R38 & R30). Interview with the office manager on 5/29/14, at 11:45 a.m. confirmed the only time that residents and/or legal representatives were informed of their personal financial record had been when the total cash amount was depleted and/or the funds were low in the resident fund account. She confirmed the facility had not routinely sent out a quarterly statement but that is was a "hit or miss" process. Upon further interview the office manager stated the only time frame that money would be made available from the resident fund account was Monday through Friday during office hours. It was indicated the petty cash would not be available during evening and week-end hours. She indicated that in previous years a 'money' bag had been available in the medication room for residents to access petty cash if needed, but confirmed that system was no longer in effect. She indicated the resident would have to access the petty cash prior to the week-end if they desired money during hours when she was not available. During interview with the administrator on 5/29/14, at 11:50 a.m. she confirmed she was unaware that residents did not have accessibility of their resident fund accounts during evenings and week-ends. She verified the account should be accessible during off hours.	F 159	Date of Correction: July 6, 2014 **F 279** It is the Facility's intent to comply with the regulation to develop comprehensive care plans for our resident's including individualized interventions. The staff will continue to complete comprehensive care plans for all residents per the RAI manual. R48 is no longer a resident A whole house audit of residents with potential for skin break down was completed. Additional interventions were put in place, care plans were updated and physicians were notified as necessary, all per facility policy. Appropriate staffs have been educated to the importance of the development of comprehensive care plans including individualized interventions and accurate documentation of effectiveness of interventions.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 3 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The nursing team has reviewed the Facility's policy and protocol for skin concerns. The Director of Nursing or designated staff will conduct audits on three (3) random nurses' notes regarding changes in skin condition for appropriateness and effectiveness of interventions and for use of proper protocol per Facility policy. Audits will continue until the Facility's Quality Assurance Team determines substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: July 6, 2014 **F 312** It is the Facility's intent to comply with the regulation to provide necessary services to maintain grooming and personal cares and hygiene. R2 nails have been trimmed. Plan of care was reviewed.	

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F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure ongoing weight loss was comprehensively assessed so that interventions could be implemented to minimize further weight loss for 1 of 3 residents (R55) reviewed for weight loss. Findings include: R55's admission minimum data set (MDS) dated 12/27/13, identified the resident as being independent with eating, no problems with swallowing, receives a therapeutic diet and included a weight of 194 pounds. Review of the MDS dated 1/3/14, identified R55 as having a decline in weight at 186 pounds, had a 5% or greater weight loss, remained on a therapeutic diet and was independent with eating. Review of the 30 day MDS dated 1/18/14, identified R55 as having a continued decline in weight at 179 pounds, had a 5% or greater weight loss, remained on a therapeutic diet and was independent with eating. Review of the weight record for R55 revealed on 12/24/14, R55 weighed 194 pounds (admission weight). On 1/1/14, R55 weighed 186 pounds. On 1/7/14, R55 weighed 180 pounds and on 1/14/14, R55 weighed 179 pounds. The record indicated R55 had lost 15 pounds from 12/24/14 to 1/14/14. Review of the most current registered dietician (RD) progress notes dated 12/30/14, indicated that R55 had the ability to independently feed himself, has no problems with chewing or swallowing and has no mouth/oral problems. The note further indicated R55 receives lasix daily and	F 272	Other potential resident's plan of care were reviewed and revised. Staffs responsible for personal cares and hygiene have been educated to the importance of timely grooming. The Director of Nursing or designated staff will conduct audits weekly times 4 weeks then monthly until the Facility's Quality Assurance Team determines substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: July 6, 2014 **F 314** It is the Facility's intent to comply with the regulation regarding the provision of treatment and services to prevent the development of pressure ulcers and to promote healing of existing pressure sores. R48 is no longer a resident A whole house audit of residents with potential for skin break down was completed. Additional interventions	

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F 272	Continued From page 5 has been exhibiting some pain due to recent hernia repair surgery on 12/12/13. The record lacked physicians orders related to a planned weight loss for R55 nor did the notes include that R55 had exhibited any edema. Further review of the medical record revealed an initial nutritional assessment for R55 had not been conducted. The administrator/acting dietary director was interviewed on 5/29/14, at 10:00 a.m. and confirmed R55's significant weight loss had been identified but had not been assessed to identify causal factors so that interventions could be developed to prevent further weight loss. The administrator also verified that a dietary assessment had not been completed for R55.	F 272	were put in place, care plans were updated and physicians were notified as necessary, all per facility policy. Appropriate staffs have been educated to the importance of following Resident Plan of Care and about the importance of complete and accurate documentation of effectiveness of interventions.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	The nursing team has reviewed the Facility's policy and protocol for skin concerns. The Director of Nursing or designated staff will conduct audits on three (3) random nurses' notes regarding changes in skin condition for appropriateness and effectiveness of interventions and for use of proper protocol per Facility policy. Audits will continue until the Facility's Quality Assurance Team determines substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: July 6, 2014	

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F 279	Continued From page 6 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that care plan interventions related to pressure ulcers had been developed for 1 of 1 resident (R48) reviewed who had a stage 3 pressure ulcer. Findings include: R48 was admitted on 1/3/14 with a diagnosis that included a pressure ulcer of the right outer foot. R48 was discharged to another long term care facility on 5/9/14. Review of the admission skin assessment dated 1/3/14 identified R48 with a stage 3 pressure ulcer of the right outer foot. The measurements were: 0.5 cm in length by 1.0 cm width. The assessment did not include any interventions to promote healing of the pressure ulcer. Review of the admission minimal data set (MDS) dated 1/10/14, identified R48 as having a stage 3 pressure ulcer on the outer right foot that measured 1.0 cm length by 0.3 cm width and 0.2 cm. depth with slough. Review of the quarterly MDS dated 4/30/14, identified R48 as having a stage 3 pressure ulcer on the right outer foot that measured 2.8 cm length, by 2.0 cm width with no depth measurements due to eschar covering the ulcer. Both MDS's identified R48 as requiring extensive assistance of staff with bed mobility that included re-positioning. Review of the admission "Braden Scale For Prediction of Pressure Sore Risk" assessment	F 279	**F 325** It is the Facility's intent to comply with the regulation to ensure that residents are able to maintain their nutritional status and body weight. R55 is no longer a resident Registered Dietitian reviewed potential residents at risk for weight loss. Facility policy for review of at risk residents was reviewed by Registered Dietitian. The Director of Nutritional Services or designee will conduct weekly audits times 4 weeks. Registered Dietitian will audit monthly. Random audits will be completed thereafter until such time as the facility's Quality Assurance Team determines substantial compliance with applicable regulations and Facility Policies has been achieved. Date of Correction: July 6, 2014	

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F 279	Continued From page 7 dated 1/21/14, identified R48 as having potential problems with friction and shearing and as being at risk for pressure ulcers. The assessment indicated R48 had a pressure relieving mattress for his bed/chair and ulcer care was provided daily to the outer right foot. Review of the most current Braden Scale dated 5/6/14 continued to indicate R48 was at risk for pressure ulcers with the same interventions as identified in the admission assessment on 1/21/14. Review of the most current care plan identified R48 as requiring extensive assistance with bed mobility. The care plan further identified R48 as having a pressure ulcer to the right foot. The care plan did not include interventions to promote healing of the pressure ulcer, other than to administer skin treatment. Interview with the assistant director of nursing (ADON) on 5/29/14 at 8:30 a.m., confirmed a care plan had not been developed for R48 to include nursing interventions to promote healing of the residents pressure ulcer located on the outer right foot. Interview with the director of nursing (DON) on 5/29/14 at 10:00 a.m. confirmed the above findings and could not provide any additional information.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 8	F 312		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to provide grooming needs for 1 of 2 dependent residents (R2) who were dependent upon staff for grooming needs (nail care).

Findings include:

During an initial interview with R2 on 5/27/14 at 7:13 p.m., it was observed the resident's finger nails on the contracted right hand were approximately 1/2 inch long. In addition, the fourth and fifth fingernails were soiled. When R2 was asked whether his fingernails were too long he stated "yes, I don't like it". When questioned how often his nails were trimmed he replied, "not very often". R2 had diagnosis included cerebral vascular accident (CVA-stroke) with right hemiparesis (weakness or paralysis on one side of the body).

During a subsequent interview with R2 on 5/29/14, at 7:50 a.m. he confirmed his fingernails had not been trimmed, even after the whirlpool bath provided the previous evening. When R2 opened his contracted right hand there was notable dead skin that had not been removed during his daily care or bath. It was again noted the finger nails on the right hand remained untrimmed and soiled.

During review of the minimum data set (MDS) dated 3/5/14, the notes indicated that R2 required extensive assist for grooming and the resident has the ability to understand others clearly. After

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F 312	Continued From page 9 review of the daily Resident Care Sheet, it revealed that R2 required 1 assist for personal hygiene. During an interview and observation on 5/29/14 at 9:10 a.m., the director of nursing (DON) verified that R2 needed a manicure and would expect the staff to trim the nails weekly at the time of the bath. She further verified that R2's nails appeared as if they had not been trimmed for weeks. The DON reported that R2 had received a bath the previous evening and confirmed there had been no documentation and/or communication that R2 had refused nail care.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 (R48) resident who was identified with a stage 3 pressure ulcer was provided interventions/treatment to promote healing of the pressure ulcer. Findings include:	F 314		

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F 314	Continued From page 10 R48 was admitted on 1/3/14 with a diagnoses that included a pressure ulcer of the right outer foot, peripheral vascular disease and congestive heart failure. R48 was subsequently discharged to another long term care facility on 5/9/14. Review of the admission skin assessment dated 1/3/14 identified R48 with a stage 3 pressure ulcer of the right outer foot. The measurements were: 0.5 cm in length by 1.0 cm width. The assessment lacked any follow-up interventions necessary to promote healing of the pressure ulcer. Review of the admission minimal data set (MDS) dated 1/10/14, identified R48 as having a stage 3 pressure ulcer on the outer right foot that measured 1.0 cm length by 0.3 cm width and 0.2 cm. depth with slough. Review of the quarterly MDS dated 4/30/14, identified R48 as having a stage 3 pressure ulcer on the right outer foot that measured 2.8 cm length, by 2.0 cm width with no depth measurements due to eschar covering the ulcer. Both MDS's identified R48 as requiring extensive assistance of staff with bed mobility that included re-positioning. Review of the admission "Braden Scale For Prediction of Pressure Sore Risk" assessment dated 1/21/14, identified R48 as having potential problems with friction and shearing and as being at risk for pressure ulcers. The assessment indicated R48 had a pressure relieving mattress for his bed/chair and ulcer care was provided daily to the outer right foot. Review of the most current Braden Scale dated 5/6/14 continued to indicate R48 was at risk for pressure ulcers with the same interventions as identified in the admission assessment on 1/21/14.	F 314		

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F 314	Continued From page 11 Review of the most current care plan identified R48 as requiring extensive assistance with bed mobility. The care plan further identified R48 as having a pressure ulcer to the right foot. The care plan did not include interventions to promote healing of the pressure ulcer, other than to administer skin treatment. Review of the weekly wound documentation for the pressure ulcer on the outer right foot included measurements listed below: 1) 2/7/14- 0 .3 cm length by 0.4 cm width by 0.1 cm depth. The ulcer was identified as a stage 2 pressure ulcer. Treatment of silver alginate dressing to ulcer. 2) 2/14/14- 0.5 cm length by 0.4 cm width. Identified as an unstageable pressure ulcer due to having blackened eschar tissue covering the wound. The documentation further identified the ulcer as being "mushy". 3) 2/19/14- 0.6 cm length by 1.0 cm width. Noted maceration of the tissue around the ulcer. 4) 3/14/14- 1.4 cm length by 1.6 cm width. Treatment of betadine dressing to ulcer. 5) 3/18/14- 1.4 cm length by 1.6 cm width. 6) 3/31/14- 1.4 cm length by 1.4 cm width. 7) 4/16/14- 3.0 cm length by 2.5 cm width and 8) 4/29/14- 2.8 cm length by 2.0 cm width. When the nursing assistant care sheet (NA) was reviewed for R48, it did not identify the pressure ulcer nor did it include specific interventions for staff to implement. Review of the nursing progress notes from admission on 1/3/14 to discharge on 5/9/14, failed to identify interventions implemented for R48's pressure ulcer on the outer right foot.	F 314		

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(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 314	Continued From page 12 Interview with the assistant director of nursing (ADON) on 5/29/14 at 8:30 a.m., confirmed R48 did not have pressure ulcer interventions in place other than to elevate the residents feet on a pillow and to wear a special shoe when R48 was up. Although the ADON indicated these were interventions implemented, documentation was lacking to verify they had been implemented by staff. The ADON also confirmed a plan of care had not been developed for R48 which included interventions necessary to promote healing of the pressure ulcer. Interview with the director of nursing (DON) on 5/29/14 at 10:00 a.m. confirmed the above findings and no further information was provided.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R55) reviewed who had a significant weight loss, was comprehensively assessed to determine weight	F 325		

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	245346	A. BUILDING _____ B. WING _____	05/29/2014

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F 325	Continued From page 13 loss, and implement a nutritional program to prevent further weight loss. Findings include: Review of the admission face sheet for R55, identified the resident as having diagnoses which included: esophageal reflux, diaphragmatic hernia and irritable bowel syndrome. R55 was admitted on 12/20/13 and discharged on 1/21/4 to an assisted living facility. The admission minimum data set (MDS) dated 12/27/13, identified R55 as being independent with eating, no problems with swallowing, receives a therapeutic diet and included a weight of 194 pounds. Review of the MDS dated 1/3/14, identified R55 as having a decline in weight at 186 pounds, had a 5% or greater weight loss, remained on a therapeutic diet and was independent with eating. Review of the 30 day MDS dated 1/18/14, identified R55 as having a continued decline in weight at 179 pounds, had a 5% or greater weight loss, remained on a therapeutic diet and was independent with eating. Review of the weight record for R55 revealed on 12/24/14, R55 weighed 194 pounds (admission weight). On 1/1/14, R55 weighed 186 pounds. On 1/7/14, R55 weighed 180 pounds and on 1/14/14, R55 weighed 179 pounds. The record indicated R55 had lost 15 pounds from 12/24/14 to 1/14/14. Review of the most current registered dietician (RD) progress notes dated 12/30/14, indicated that R55 had the ability to independently feed himself, has no problems with chewing or swallowing and has no mouth/oral problems. The note further indicated R55 receives lasix daily and	F 325		

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F 325	Continued From page 14 has been exhibiting some pain due to recent hernia repair surgery on 12/12/13. The record lacked physicians orders related to a planned weight loss for R55 nor did the notes include that R55 had exhibited any edema. Further review of the medical record revealed an initial nutritional assessment for R55 had not been conducted. The administrator/acting dietary director was interviewed on 5/29/14, at 10:00 a.m. and confirmed R55's significant weight loss had been identified but had not been assessed to identify causal factors to that interventions could be developed to prevent further weight loss. The administrator also verified that a dietary assessment had not been completed. The administrator was unable to provide any additional information relating to R55 weight loss.	F 325		

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

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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 _____	05/28/2014

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K 000	INITIAL COMMENTS 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, on May 28, 2013. At the time of this survey, Truman Senior Living was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 By e-mail to:	K 000	POC ok B 6-26-14 **K 056** It is our intent to comply with the Life Safety Code standards. One of the sprinkler heads located in the Medical Records office has been capped. Date of Correction: July 6, 2014	

DE: 7-8-14
EXIT: 5-29-14

RECEIVED
JUN 25 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

RECEIVED
JUN 23 2014
Minnesota Department of Health
Marshall

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorna L. Craig-Paulson	Administrator	6.20.14

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.

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

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K 000	Continued From page 1 Marian.Whitney@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 capacity of 50 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow damage to the sprinkler piping that would cause failures in the system and affect 10 residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 12:30 PM on 5/28/2014, observations revealed that there was two sprinkler heads located in the Medical Records room that were 3 feet apart. The activation of the sprinkler head could cause cold soldering of the sprinkler heads causing a lack of adequate fire suppression coverage and would delay the fire alarm activation and notification for	K 056		

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K 056	Continued From page 3 the facility in the event of a fire. This deficient practice was verified by the Maintenance Supervisor.	K 056		