DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EIK5 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00361 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) TRUMAN SENIOR LIVING (L1)245346 1. Initial 2. Recertification (L4) 400 NORTH 4TH AVENUE EAST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) **56088** 733402000 (L2)(L5) TRUMAN, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 08/19/2015 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: A. In Compliance With From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18)_1. Acceptable POC 8. Patient Room Size 50 ___ 9. Beds/Room 5. Life Safety Code Not in Compliance with Program 50 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12) * Code: A 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)50 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Date: Kamala Fiske-Downing, Enforcement Specialist 09/08/2015 (L20) 09/02/2015 Kathryn Serie, Unit Supervisor PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 10/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (1.24)(1.41)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245346

September 8, 2015

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 August 10, 2015 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 bed.

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 2, 2015

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

RE: Project Number S5346026

Dear Ms. Craig-Paulson:

On July 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 1, 2015. 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 August 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 30, 2015 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 July 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 1, 2015. and therefore remedies outlined in our letter to you dated July 14, 2015, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245346	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/19/2015
Name of Facility		Street Address, City, State, Zip Code	
TRUMAN SENIOR LIVING		400 NORTH 4TH AVENUE EAS	Т

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	(Y:	5) Date	(Y4) Item		(Y5) Date	(Y4)	Item	(Y5)	Date
ID Prefix	F0248	Correction Completed 07/31/2015	ID Prefix	F0274	Correction Completed 08/10/2015		ID Prefix	F0278	Correction Completed 07/31/2015
	483.15(f)(1)	_ _		483.20(b)(2)(ii)				483.20(g) - (i)	
		Correction Completed			Correction Completed				Correction Completed
ID Prefix	F0280	07/31/2015	ID Prefix	F0323	08/10/2015		ID Prefix	F0325	08/10/2015
Reg. # LSC	483.20(d)(3), 483.10(k)	(2) 	Reg. # LSC	483.25(h)			Reg. # LSC	483.25(i)	
10.0 %		Correction Completed	15.5 %		Correction Completed		ID D . ((Correction Completed
ID Prefix	-	_08/10/2015	ID Prefix		08/04/2015				
	483.25(I)	<u>-</u> .		483.60(b), (d), (e)			Reg. # LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. #			Reg. #						
		Correction Completed			Correction Completed				Correction Completed
ID Prefix Reg. # LSC			Reg. #				Reg. #		
Reviewed	By Reviewe	d By	Date:	Signature of	of Surveyor:			Dat	e:
State Agen	cy KS/kfo	d	09/02/20	15	0:	3048			08/19/2015
Reviewed I	By — Reviewe	d By	Date:	Signature o	of Surveyor:			Dat	e:
Followup	to Survey Completed of 7/1/2015	n:			Uncorrected Def Deficiencies (C				S NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245346	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 7/30/2015
Name of Facility		Street Address, City, State, Zip Code	
TRUMAN SENIOR LIVING		400 NORTH 4TH AVENUE EAS' TRUMAN, MN 56088	Т

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
		(Correction				Correction					Correction
ID Prefix			Completed 07/02/2015	ID Prefix			Completed 07/02/2015		ID Prefix			Completed 07/02/2015
Reg. #	NFPA 101			Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0029			LSC	K0154				LSC	K0155		_ _
			Correction				Correction					Correction
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LSC		-		LSC					LSC			_
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				LSC				<u> </u>	LSC			
Reviewed I	ByRe	viewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen		/kfd		09/02/20	015			35	482		(07/30/2015
	By Rev	viewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
CMS RO												
Followup t	o Survey Comple		:		Check for any Uncorrected	Uncor	rected Deficiencies (CM	cienci	es. Was a	Summary o	•	NO
	7/2/201	כ			22230100				. ,		YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	EJK5
Faci	ility ID: 00361

MEDICARE/MEDICAID PROVIDE (L1) 245346 2.STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) TRUMAN S (L4) 400 NORTH	ENIOR LIVIN	NG		4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 733402000		(L5) TRUMAN, I	MN		(L6) 56088	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	1/2015 (L34)(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	' IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	50 (L18)	•	cceptable POC			
13.Total Certified Beds	50 (L17)	X B. Not in Con Requireme	npliance with Prog ents and/or Appli		* Code: B	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Holly Kranz, HFE NE I	I		07/24/2015	(L19)	Kamala Fiske-Downing	Enforcement Specialist 07/30/2015 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P 2. Facility is not Eligible	articipate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22 ODIGDIAL DATE						
22. ORIGINAL DATE	23. LTC AGREEN		4. LTC AGREEN		26. TERMINATION ACTION VOLUNTARY	. ,
OF PARTICIPATION 10/01/1986	BEGINNING	DAIE	ENDING DA	IE	VOLUNTARY 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
	(120)			(1.01)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	Posted 08/03/2015 C	0.
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 14, 2015

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

RE: Project Number S5346026

Dear Ms. Craig-Paulson:

On July 1, 2015, 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>Electronic 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 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.

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, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233

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 August 10, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 October 1, 2015 (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

Truman Senior Living July 14, 2015 Page 5

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 January 1, 2016 (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.

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 pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Truman Senior Living July 14, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fishe Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 07/27/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ATE SURVEY OMPLETED	
		245346	B. WING _		01/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 COMMEN	ΓS	F 00	00		
	as your allegation of Department's acceptoriolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 248 SS=D	on-site revisit of you validate that substa		F 24	.8	7/31/15	
	of activities designed the comprehensive	ovide for an ongoing programed to meet, in accordance with assessment, the interests and al, and psychosocial well-being				
	by: Based on observative review the facility faindividualized activitimplemented to me			It is the Facility's intent to ensure an individualized activities program is developed and implemented to meet our resident's psychosocial needs.		
	Findings include:			The staff will continue to develop individualized activity programs that will meet the resident's psychosocial needs.		
				R37 is no longer a resident. Care plan for R2 has been updated to reflect individual interests (See Attachment A).		
ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

Electronically Signed

07/24/2015

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245346	B. WING			07/0	01/2015
	PROVIDER OR SUPPLIER	,		40	REET ADDRESS, CITY, STATE, ZIP CODE ONORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	R37's admission M 5/11/15, revealed a of interest was not R37. The MDS ide animals and snack: cognitively impaired Mental Status (BIM completed. R37's Care Area As dated 6/29/15, directinformation was in Review of the social address R37's activities as people's belonging identify R37's activities as identified R37 enjoy Chicken Noodle Social liked to keep her has further identified may were of interest as During observation was noted to be lying cows on her lap an She did not appear and was unable to questions but smiles.	linimum Data Set (MDS) dated a self-assessment for activities able to be completed with entified that R37 enjoyed in the evening, was severely dand a Brief Interview for RS) was unable to be seessment (CAA) for activities a 5/20/15 social services note. The location of the a 5/20/15 social services note. The all services note did not wity needs nor preferences. Ited 6/5/15, revealed R37 was activities to discourage wandering and taking other is. The care plan did not ity interests. The seesment dated 5/4/15, yed sewing, being read to from our for the Soul books and ands busy. The assessment anicures and hand massages well as pet therapy. On 6/28/15, at 1:04 p.m. R37 ang in bed with a picture book of d was holding a baby doll. To be interested in the objects respond verbally to any	F 2	248	Individualized 1:1 plan developed a implemented for R2. Participation i monitored on Activity Participation (See Attachment B). All appropriate staff has been educ on the importance of individualized programs. Monthly audits will be completed to ensure ongoing progractivities to meet the interests and physical, mental, and psychosocial well-being of each resident. The Activity Director or designee w conduct audits of five random residerecords per month for three months. Results of these audits will be reviewed monthly Quality Improvement meet ensure substantial compliance with applicable regulations and Facility phas been achieved. All audit results reviewed at quarterly Quality Assurteam meetings.	s being Record rated activity rams of the ill dent s. ewed at ting to l poolicy s will be	

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F 248	interest in the doll. During further obsep.m. R37 was obsethe doll on her lap. During observation was observed in the nursing station and was eating another moved out of the arand escorted close there. R37 proceed and at one point be dependent resident activities nor attempre meaningful stimulating the afternoon shift of the dice shaking activity however R37 did now as wheeling about hymnal in her lap at the dining room tab. During interview on staff (AS)-A indicate person worked in her and management in funds to hire a replay was difficult to get a no one to fill in for working interview on During interview on Duri	rvation on 6/29/15, at 5:09 rved in the dining room with on 6/29/15, at 6:42 p.m. R37 activities area of the main had wheeled up to a table and resident's food. R37 was activities area of the main had wheeled up to a table and resident's food. R37 was activities area by registered nurse (RN)-Ar to the nurses station and left ded to wheel about the lobby gan pulling on another 's wheelchair. No 1:1 but to engage R37 in the tion were observed throughout on 6/29/15. on 6/30/15, at 9:46 a.m. R37 activities and had taken some butter off le. 6/30/15, at 9:57 a.m. activities and had taken some butter off le. 6/30/15, at 9:57 a.m. activities and had taken some other er department. There had ember that retired recently had indicated there were no accement. AS-A indicated it activities done and there was	F 2	48			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			E SURVEY PLETED
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TRUMAN SENIOR LIVING X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 3 other than looking at a book and received no activities she was aware of. During interview on 6/30/15, at 11:04 a.m. nure assistant (NA)-D stated R37 generally was keen the lobby when not lying down, and did not receive any 1:1 activities. NA-D further stated did not feel the facility was meeting R37's need as she needed a lot of attention and seemed like tactile stimulation and to touch things with hands. During interview on 6/30/15, at 12:52 p.m. the activities director (AS)-B indicated that R37 hidentified interests of scrapbooking and liked being read to from Chicken Soup books; however, this was done in the afternoons whi R37 was in bed. Massage was not available as part of the standard activity services. AS-I further indicated no sensory activities were be provided for R37 other than she liked to look old magazines and would rip them up. AS-B further indicated their staffing budget had received been cut and it was "Tricky," to get 1:1 activitien. When interviewed on 7/1/15, at 12:45 p.m. the administrator indicated she felt there needed be more activities for cognitively impaired residents and verified an activities staff members.			STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088				
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFI TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	other than looking a activities she was a During interview on assistant (NA)-D stin the lobby when not receive any 1:1 activities as she needed a look like tactile stimulation hands. During interview on activities director (A identified interests of being read to from however, this was on R37 was in bed. Mas part of the stand further indicated no provided for R37 ot old magazines and further indicated the been cut and it was in. When interviewed administrator indicated the been cut and it was in. When interviewed administrator indicated the been cut and it was in. When interviewed administrator indicated the been cut and it was in. R2's significant chance be more activities for residents and verification and retired recently R2 R2's significant chance between cognitive in the stand of the stand	at a book and received no 1:1 aware of. 6/30/15, at 11:04 a.m. nursing ated R37 generally was kept oot lying down, and did not ivities. NA-D further stated she lity was meeting R37's needs to fattention and seemed to on and to touch things with her as)-B indicated that R37 had of scrapbooking and liked Chicken Soup books; done in the afternoons while assage was not available for lard activity services. AS-B is sensory activities were being ther than she liked to look at would rip them up. AS-B eir staffing budget had recently is "Tricky," to get 1:1 activities on 7/1/15, at 12:45 p.m. the ated she felt there needed to or cognitively impaired		48			

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F 248	preferences was u The staff assessm identified R2 enjoy that attending favo importance to her. R2's activities care R2 was independe goal of maintaining The care plan indic of the calendar and social activities dai R2's behavioral ca indicated R2 would during the evening diverting R2's beha in activities when a measures for basic During observation was noted to be sit and had a calm fac actively watching to had her daughter w During continued op p.m. a staff membe R2 out of the dining to her room. At 6:3 unintelligible wound At 6:41 p.m. anoth into R2's room and R2 immediately sto resident left R2 imm again, and at 6:49 her room to put he	ent for activities interests ed pets, religious activities and rite activities were of a plan dated 5/20/15, indicated nt in activities of choice with a gindependent activity choices. Cated R2 would be given a copy dencouraged to participate in ly. The plan dated 5/20/15, and activity choices are plan dated 5/20/15, and listed interventions of avior by having her participate able and to provide comfort coneeds. The on 6/29/15, at 5:47 p.m. R2 atting at the dining room table contained and with her visiting. The observation on 6/29/15, at 6:27 for (unidentified) came to take groom and brought her back 30 p.m., R2 began chanting	F 2	248			

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F 248	Complete evening of Targeted observations arrively from 6/29/13 did not participate in and called out when During interview on stated R2 called out alone. During interview on stated R2 did not did most of her called During interview on stated R2 chanted did not receive and was aware of. During interview on stated R2 was only a time and generall in between. AS-B scognitive, could car attended church on Fridays. AS-B stated R2's cand did not accurate status nor ability to self-leisure pursuits AS-B stated R2 was group activities offer but was unable to a asked or participate and state of the stat	coares. ons of R2 throughout the 5 through 7/1/15 revealed R2 n any individualized activities n left alone in her room. on 6/29/15, at 7:24 p.m. NA-E at often when in her room on 6/29/15, at 7:26 p.m. NA-A t like to be alone and generally ling out in her room. on 6/30/15, at 10:27 a.m. RN-A and called out and stated R2 individualized activities she at lindividualized activities she at lindividualized activities and slept stated R2 was not very rry on brief conversations and on Sundays and occasionally on ed no 1:1 activities were		18		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088	ZIP CODE		
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F 248	benefited from 1:1 acurrently no 1:1 act stated there was a given to her for the thought R2 enjoyed if she had a music puring interview on stated R2 chanted a sometimes redirect to reassure her. Not devotions and trivia able to be up for lim concerns with skin buring interview on stated R2 was only back down due to sconfirmed R2 called redirectable with relegioned music, how only once per week indicated the weekl structured activity s received no 1:1 vision The facility's undate Residents With Codirected the facility programs to resident to time, place, and/oprograms to reflect needs, to enhance physical and mental cognitive health. To experienced recent	attention; however, there were evities scheduled for R2. AS-B doll in R2's room that could be chanting behaviors and music, however was not sure player in her room. 6/30/15, at 1:59 p.m. NA-B repeatedly and was able if staff went into her room A-B stated R2 did not attend consistently due to only being nited amounts of time due to breakdown on her bottom. 7/1/15, at 7:23 a.m. NA-C up for meals and then laid kin concerns. NA-C dout repeatedly and was assurance. NA-C stated R2 rever received music activities when in church. NA-C y church visit was the only he was aware of, and R2 ts. ed Activity Programs For gnitive Impairments policy to offer meaningful activity hts who display disorientation or person. Provide activity each resident's individual and promote each resident's I status, and to promote Include residents who have events which may have ided disorientation into reality	F 2	48			

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F 274 F 274 SS=D	AFTER SIGNIFICATION A facility must concassessment of a refacility determines, that there has been resident's physical purpose of this second as a major decresident's status the itself without further implementing standinterventions, that I one area of the resident's status the interventions, that I one area of the resident's status the implementing standinterventions, that I one area of the resident's status the interventions of the resident status and status area.	MPREHENSIVE ASSESS ANT CHANGE duct a comprehensive esident within 14 days after the or should have determined, a a significant change in the or mental condition. (For a significant change cline or improvement in the at will not normally resolve r intervention by staff or by dard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the	F 2				8/10/15
	by: Based on docume the facility failed to reassessment at th in resident conditio reviewed who had nutritionally at risk. Findings include: R25's most recent diagnoses which in congestive heart fa pressure ulcers (3) R25 experienced a related to further de (heel and coccyx).	nt review and staff interview conduct a comprehensive to time of a significant change in for 1 of 1 (R25) resident pressure ulcers and was admission was 1/27/15, with cluded: Diabetes type II; allure (CHF), anxiety disorder, pneumonia and hypertension. I significant change in condition evelopment of pressure ulcers The significant change (MDS) was completed on			It is the Facility's intent that the Interdisciplinary team conducts a comprehensive assessment of each resident is needs. The staff will continue to complete comprehensive assessments for all residents per the RAI manual. Registered Dietitian will review R25 Pressure Ulcers and recommendati will be implemented. Registered Dietitian will review all residents with Pressure Ulcers and recommendations will be implemented. Prior to Registered Dietitians month	for ions ted.	

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F 274	4/28/15. This MDS to pressure ulcer and documentation was Area Assessment (either triggered are When interviewed or registered nurse/clithe registered dietic comprehensive die initial assessment of confirmed that R25 reassessment, esp of further pressure coccyx. RN-D confireassessment had time of the signification. During a subseque 7/01/15, at 12:13 p R25 had not receiv admission. During interview on consultant registere no one had been or at the facility for ab Documentation obtassessments dated Wound #1-full thick 0.60 centimeters (of drainage consisten Acquisition-facility a heel; injury due to tom x 2.00 cm. Wo 4.50 cm x 4.00 cm; drainage. The most recent signata Set (MDS) da Interview of Mental	striggered care areas related and nutritional status; however, is lacking to indicate a Care CAA) had been completed for a. on 7/01/15, at 11:46 a.m. nical manager (RN)-D verified cian (RD) had not completed a stary reassessment since the dated 1/29/15. RN-D required a nutritional ecially since the development ulcers located on the heel and firmed a comprehensive not been completed at the ant change in resident nt interview with RN-D on .m. she also confirmed that ed dietary supplements since	F 2	274	Certified Dietary Manager will comprehensive who need to be seen. Copy of completed form along with any prognotes will be provided to Administrative. All appropriate staff will be reeduced completion of Comprehensive assessments. Monthly audits will be completed to ensure ongoing woun is comprehensively assessed to mit further skin breakdown. All appropriate staff will be reeduced completion of Care Area Assessment (CAA) for all areas that trigger on Manager of the Care Area Assessments of five random reside records per month for three months Results of these audits will be reviewed at quarterly Quality Assurteam meetings. The Director of Nursing or designed ensure substantial compliance with applicable regulations and Facility phas been achieved. All audit results reviewed at quarterly Quality Assurteam meetings. The Director of Nursing or designed conduct chart audits for wound care assessments of five random reside records per month for three months Results of these audits will be reviewed at quality Improvement meetings. The Director of Nursing or designed conduct chart audits for wound care assessments of five random reside records per month for three months Results of these audits will be reviewed at these audits will be reviewed at the province of these audits will be reviewed at the province of these audits will be reviewed at the province of these audits will be reviewed at the province of these audits will be reviewed at the province of these audits will be reviewed at the province of these audits will be reviewed at the province of these audits will be reviewed at the province of the pro	with of gress ator for ted on end care nimize ted on ents IDS. e will ent ing to policy is will be ance ents ewed at ing to policy is will be ance ents ewed at ing to policy in the ent ing to policy in the ent ing to policy in the ent ing to policy present the ent ing to policy policy policy present the ent ing to policy policy present the ent ing to policy policy present the ent ing to policy present the ent ing	

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F 274	bed mobility, dressi limited staff assista supervision with ea Nutrition and Press both triggered on th Care Area Assessm either area. Docum available for review	red extensive assistance with ng, and personal hygiene, with nce with toileting and ting. ure Ulcer care areas were the MDS dated 4/15/15, yet no ment (CAA) was completed on the mentation of the CAA was not the case of the	F 27	reviewed at quarterly Quality Assurteam meetings.	ance	7/31/15
SS=D	ACCURACY/COOF The assessment m resident's status. A registered nurse each assessment w participation of heat A registered nurse assessment is come assessment is come assessment is come. Each individual who assessment must state portion of the attention of the	RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate vith the appropriate Ith professionals. must sign and certify that the pleted. completes a portion of the ign and certify the accuracy of				
	Clinical disagreeme	ent does not constitute a				

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F 278	material and false something in the property of the property o	NT is not met as evidenced and document review the ure Minimum Data Set (MDS) accurate for 1 of 3 residents nutrition and 1 of 2 residents dressing. S dated 1/28/15, identified mechanical altered diet with lems. The MDS further ents weight was 112 pounds quarterly MDS dated 4/15/15, aceiving a mechanical altered ving problems. The MDS eresidents weight was 97 lb sive assistance with eating, dated 4/15/15, was coded as ving a 5% weight loss in the bugh R60 had a 15 lb weight uarterly assessment period. O a.m. registered nurse erabove MDS dated 4/15/15 had rately. RN-A further indicated we been coded as a greater is to reflect the residents and dated 1/28/15, indicated the	F 278	It is the Facility's intent to comply we Medicare and Medicaid requirement ensure that assessments accurated reflect the resident's status. R 60 quarterly MDS dated 4/15/2015 been resubmitted with corrections. R 20 MDS dated 1/28/2015 has be resubmitted with corrections. RN responsible for inaccurate coding MDS no longer is employed at the factorial appropriate staff will be reeducated completion of MDS and appropriate coding. Director of Nursing or designated sompleted and that the CAA's were completed and that the CAA's were completed accurately (See Attachm Care plans will be updated as necessults of these audits will be reviewed at compliance with applicable regulations and Facility phas been achieved. All audit results reviewed at quarterly Quality Assurteam meetings.	ents and by 15 has en ng of facility. Ited on taff will ure that enent C). Essary. Eswed at ing to coolicy s will be	
		xtensive assistance (resident staff provide weight-bearing ing.				

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F 278	Continued From pa	ge 11	F 27	8		
F 280 SS=D	discharge summary resident had met the from stand by assist when interviewed of licensed practical in completing an MDS look back period da prior to the complete assistance required review the nursing previewed R20's date the 7-day look-back MDS. LPN-A state R20 should have be related to functional also reviewed the nursing previewed R20's MDS. LPN-A state R20 should have be related to functional also reviewed the nursing look back documentation to sassistance with dreconfirmed R20's MI related to dressing. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannich changes in care and A comprehensive assinterdisciplinary teal	0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ng care and treatment or	F 28	0		7/31/15

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F 280	for the resident, and disciplines as deter and, to the extent p the resident, the resident, the resident representative and revised by a te each assessment.	d other appropriate staff in rmined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 28	30			
	by: Based on documer staff interview the faplan to include the provided for 1 of 3 activities. Findings include: R2's significant chat Data Set (MDS) da Interview for Menta (severe cognitive in identified R2 exhibit symptoms and indispreferences was undentified R2 enjoyed that attending favor importance to her. The activities care R2 was independent goal of maintaining The care plan indices to her the staff plan indices	nt review, observation and acility failed to revise the care updated activity interventions residents (R2) reviewed for activities in the care updated activity interventions residents (R2) reviewed for activities interventions residents (R2) reviewed for activities interview for activities interview for activities intervention activities interests and interview for activities and independent activity choices. atted R2 would be given a copy I encouraged to participate in		It is the Facility's intent to compregulation to develop compreher plans for our resident's including individualized interventions. The staff will continue to comple comprehensive care plans for all per the RAI manual. Care plan for R2 has been update reflect individual interests. Indivious 1:1 plan developed and implement R2 (See Attachment A). Appropriate staffs have been educed the importance of the development comprehensive care plans incluindividualized interventions and documentation of effectiveness interventions. Monthly audits will completed to ensure compreher plans are accurate and being up needed to meet the interests an physical, mental, and psychosom well-being of each resident.	ete Ited to dualized ented for ucated to ent of ding accurate of I be ensive care odated as d the		

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F 280	indicated R2 would during the evening diverting R2's beha in activities when a measures for basic. During observation was noted to be sit and had a calm fact actively watching twhad her daughter was unable to self-did not participate it and called out when was unable to self-did not participate it and called out when was unable to self-did not participate it and generally just where was only allotted and generally just where was unable to self-durch on Sundays AS-B stated no 1:1 provided for R2. During further inter AS-B stated R2's cand did not accurate status or ability to it self-leisure pursuits AS-B stated R2 was group activities offer	re plan dated 5/20/15, make noises, especially and listed interventions of vior by having her participate ble and to provide comfort needs. on 6/29/15, at 5:47 p.m. R2 ting at the dining room table ial affect. R2 was noted to be vo other female residents and vith her visiting. ons of R2 throughout the 5 through 7/1/15 revealed R2 n any individualized activities n left alone in her room and direct her own activities. 16/30/15, at 1:38 p.m. activities as the activities director stated done hour out of bed at a time vent to meals and slept in ted R2 was not very cognitive, is conversations and attended and occasionally on Fridays. activities were currently being view on 7/1/15, at 8:58 a.m. are plan had not been updated they reflect her current activities independently direct her own s, "That's my fault on that one." is a casual observer in the ered such as news and trivial answer any of the questions	F 280	The Activity Director or designer conduct audits of five random records per month for three monthly Quality Improvement nensure substantial compliance applicable regulations and Facily has been achieved. All audit rereviewed at quarterly Quality Asteam meetings.	esident onths. reviewed at neeting to with ility policy sults will be	

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F 323 SS=D	HAZARDS/SUPER The facility must er environment remail as is possible; and		F 3	23		8/10/15	
	by: Based on observative review the facility fat factors related to fat implemented to mirfor 1 of 3 residents of falls. Findings include: R60 was admitted to Review of the resid in the medical recodiagnoses including dementia, anxiety our inary infections. Review of the quart dated 4/15/15, identextensive assistant and transfers. R60 ambulatory and has status (BIMS) of 3/R60 as requiring a	ion, interview and document illed to ensure causal risk lls and that interventions were nimize the risk of future falls (R60) reviewed with a history o the facility on 11/6/14. ents Diagnosis Report located rd indicated R 60 had ghip fracture and replacement, lisorder and a history of erly minimum data set (MDS) tified R60 as requiring the of one staff for bed mobility was identified as non-ring a brief interview of mental 10. The MDS further identified wheelchair for mobility and operiencing falls since		It is the facility's intent to provide environment free of accident had to provide supervision to resider promote a resident safety and with R 60's plan of care was reviewer revised. Falls will be reviewed each week morning by Interdisciplinary Tead determine causal factors and iminterventions to assist with the pof further falls from occurring. The notified of all falls by next but for potential recommendations. The facility's Fall Prevention Proreviewed and revised (See Attact The facility's Resident Event Rewas reviewed and revised (See Attachment E). The Facility will provide education responsible staff on the Falls Proprotocol along with the Resident Report Policy.	zards and ats to ell-being. d and aday n to plement revention nerapy will siness day tocol was hment D). cort Policy on for evention Event		

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F 323	Review the current identified R60 as rowith bed mobility. If lift to transfer into be included R60 as bedementia, weakned Interventions listed is wearing eyeglas glare and clutter, (verbal reminders rokeep personal item toileting assistance. Review of the fall a identified R60 as bevision, poor balance receives antipsych assessment further high risk for falls at the past 3 months. During observation R60's room environ have a alarm place in bed sleeping. Review in reach as we chair. When obsers R60 was transferred assistance from stalittle weight and transfer observation R60's documented reviewed: (1) Fall on 11/16/14 on the floor next to sounding. No injurity includes the control of the sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sounding. No injurity includes the control of the floor next to sound the floor next to sou	at care plan dated 2/9/15, equiring extensive assistance and outilizes a mechanical stand outilizes and poor impulse control. I included: (1) assure resident ses, (2) assure floor is free of (3) bed and chair alarm, (4) not to self transfer/ambulate, (5) as within reach, (6) provide and (6) observe frequently. Assessment dated 4/15/15, using disoriented, having poor se, impaired mobility and otic medication. The rindicated the resident was at and has a history of 1-2 falls in the set of (30/15, at 1:40 p.m. of (30/15), at 1:40 p.m. of (30/15), at 3:00 p.m. out on (6/30/15), at 3:00 p.m. out of (30/15), at 3:00 p.m. o	F3	323	audit incident reports and assessment for causative factors. The Director of Nursing or designe conduct periodic audits to ensure compliance. Results of these audit be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicate regulations and Facility policy has achieved. All audit results will be reat quarterly Quality Assurance teammeetings.	e will ongoing s will able been eviewed	

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F 323	on the floor next to report indicated the transfer herself to be shoulder. No injurie factors identified no implemented to pre (3) Fall on 12/12/15 sitting on the floor we sounding. No injurie factors identified no implemented. (4) Fall on 12/22/15 sitting on the floor in implemented. (4) Fall on 12/22/15 sitting on the floor in when the staff were alarm sounding. No causal factors identified on the floor in her report of the point on the floor in her report of fl. R60 indicated bathroom. No injurit identified. Peri care (6) Fall on 3/27/15 fell out of her whee No causal factors identified and no interport of fl. R60 indicated in the floor in her whee No causal factors identified. Peri care (6) Fall on 4/17/15 was found on the flowheelchair. No injurit identified and no interport of floor floor in the floor i	4, at 8:00 p.m. R60 was found her wheelchair and bed. The resident was attempting to bed and landed on her left as were noted. No causal or were there any interventions event further falls. 4, at 6:15 p.m. R60 was found with the her wheelchair alarm as were noted. No causal or were there any interventions or were there any interventions. 4, at 1:45 a.m. R60 was found in her room with 1 shoe on a alerted to the residents bed on injuries were noted. No tified. Ativan was given. 5, at 10:20 p.m. R60 was calling for resident was found sitting from barefoot with her wet fated she needed to go to the es. No causal factors		23		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	(9) Fall on 6/22/15 found on the floor is causal factors iden listed. No further docume was found nor provabove documented lacking to indicate a assessment had be each incident relate interventions were minimize the future Interventions were their effectiveness (alarms). Review of the physical discharge note for the resident was restrengthening upon fracture repair. The being limited with prognition ability and meet her full goal processing the process of the proposition of the proposition ability and meet her full goal processing the pro	and no interventions. In at 7:20 p.m. R60 was and in the hallway. No injuries. No tified and no interventions intation in the medical record yided by staff related to the difalls. Documentation was a comprehensive fall een conducted at the time of ed to the fall and therefore no identified to prevent and/or to exisk of fall and injury. In the early related to determine and/or the need for revision in admission after a recent hip e PT/OT note identified R60 as progression due to her difference R60 was unable to potential. Intered nurse (RN)-A on 6/30/15 ated falls are discussed during ment meetings. RN-A further to one person that is powing up on falls nor all factors to implement event further falls from ancurred there was no further incorred there was no further interestings.	F 32	23		
		le for review to indicate a sessment had been conducted reviewed				

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 325 SS=D	` '		F 32	25		8/10/15		
	by: Based on interview facility failed to ensimplemented to pre 3 of 4 residents (R3 nutritional status. Findings include: R31 R31's physician's orevealed diagnoses alcoholic cirrhosis aregular diet. R31's significant ch (MDS) dated 2/16/1 planned weight loss supervision and set assessment (CAA) was not completed	NT is not met as evidenced and document review, the ure interventions were vent significant weight loss for R1, R37 & R60) reviewed for a reder sheets, dated 7/1/15 of chronic kidney failure and as well as an order for a ange minimum data set 5, revealed R31 was not on a sprogram and required and at meals. A care area for nutrition did not trigger and for R31.		It is the Facility's intent to com regulation to ensure that reside able to maintain their nutritional body weight. R37 is no longer a resident. ReDietitian will review R31 & R60 loss. Registered Dietitian will review residents at risk for weight loss Recommendations will be impliand responsible staff will be ed Weights for at risk residents will monitored weekly by Certified I Manager and presented to Qual Improvement committee weekl time the committee will review recommendations to determine appropriate or need to be adjusted.	ents are I status and egistered for weight potential emented ucated. Il be Dietary ality y at which			

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F 325	anticipated weight collection of fluid ir liver disease) and of Review of R31's with pound (lb) loss from and 4/15, which was weight loss. R31's most current completed by the concept the complete the concept the complete the com	loss due to ascites (an the abdomen associated with edema. eights (wts) revealed a 10 m 135 to 125 lbs. between 3/15 as identified as a significant as identified as a significant at dietary progress note, dietician on 4/23/15 indicated: ts wts. as they are down about ast month at this time and this nificant wt. change over 90 and address this with resident and NIP [an intervention involving provide additional calories]. Is lacked evidence the was addressed with the resident at the per recommendation. Ord lacked evidence of any essments related to nutritional etary oral intakes for the chs revealed the intakes 10% of food and 0-100% of 10 6/30/15, at 3:19 p.m. the ed dietician (RD) indicated that ompleting dietary assessments out a year. The dietician thought the administrator was and that a dietary manager y was now scheduled to visit	F3	325	Prior to Registered Dietitians mont Certified Dietary Manager will com Referrals form (See Attachment J) those who need to be seen. Copy completed form along with any pronotes will be provided to Administrator will review contract v. Registered Dietitian and clarify face expectations at next visit on 7/30/1 Policy and Procedures related to v. loss and residents nutritionally at r. been reviewed and revised (See Attachment F). The Certified Dietary Manager or designee will educate responsible the policy changes as well as audiensure all current recommendation being carried out within the dietary department. The Administrator or designee will conduct audits for compliance week Results of these audits will be reviewed at quality Improvement meetings ensure substantial compliance with applicable regulations and Facility has been achieved. All audit result reviewed at quarterly Quality Assulteam meetings.	plete a with of ogress ator for with ility's 5. weight isk have staff on t to ns are ekly. ewed at eting to n policy s will be		

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F 325	hired for one day ponting interview on indicated she had "program was. Wheresidents on the Nilcook-A provided a residents on the Nilcook-A provided a residents on the Nilcook-A provided a resident of here in the bound of the colate supplements of here. At 8:15 from the table, statice eating 50% of here from the table, statice ating 50% of here from the state of the table, statice at the table, statice at the table, statice at the table, statice and the statice and the statice and the statice at the table	uired work as she was only er month for consultation. 6/30/15, at 3:17 p.m. cook-A No idea," what the NIP en asked whether a list of P program was maintained, resident list, last updated thave R31's name listed. on 7/1/15, at 8:04 a.m. R31 preakfast table eating rice toast. A partially finished ent shake was observed in 5, R31 pushed herself awaying she was finished after boods and drinking of her supplement. A nursing entified) was nearby and had finish the supplement. 7/1/15, at 8:22 a.m. R31 er been a "big eater". R31 satisfied with what dietary was as "good" but she didn't eat 7/1/15, at 10:51 a.m. N)-D, who was R31's clinical R31 liked to snack a long in	F 3	25				

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F 325	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 3	,				
	•	of breakfast on 6/30/15, at						

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F 325	8:18 a.m. R37 was breakfast and fluids During interview on indicated R37 gene During interview on stated R37 would e of her," and was un supplement ordered started. RN-D states she came monthly weights. During interview on dietician indicated from the NIP program not able to state who R60 R60's physician orderevealed diagnoses or or pharyngeal phasmechanical altered. The quarterly minim 4/15/15 revealed Riveight loss program assistance with eat R60 experienced a from the previous of 1/28/15. Review of the care R60 had a nutrition mechanically altere of dysphasia. Review of R60's log	observed to eat all of her with supervision of staff. 6/30/15, at 10:14 a.m. RN-A rally ate well at meals. 6/30/15, at 1:43 p.m. RN-D at Everything you put in front sure why there had not been a d for R37 or the NIP program and the dietician handled that, and reviewed resident 6/30/15, at 3:19 p.m. the R37 should have been started a effective 5/19/15, and was bether this occurred. der sheet dated 7/1/15, including dysphasia and se as well as an order for a diet with thickened liquids. The MDS further identified weight loss of 15 pound (lb) uarterly assessment dated plan dated 5/2715, revealed al status of requiring a d diet related to the diagnosis of weights revealed a 15 lb lbs. between 1/15 and 4/15.	F3	25				

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F 325	completed by the di-Reviewed resident weight loss of -9.8% will be added to NIF fortifying foods to possible to the progress notes RD's recommendated addressed nor implied record lacked evide assessment related Review of R60's diamonths revealed in meals. Average dain During interview on indicated a dietary accompleted for R60. provides her recompatiff, but is unsure During observations on 6% breakfast the reside independently with served. Observation of during breakfast the with no additional for During interview on indicated she had "program was. Whe maintained a list of	dietary progress note, letician on 3/4/15 indicated: secondary to significant in the past 93 days. Resident [an intervention involving rovide additional calories]. If or R60 lacked evidence the tion for the NIP program was emented. R60's medical ence of any further dietary. It to nutritional status. It is a set and in the previous 3 takes ranging from 0-100% at ally intake of food is 25-75%. If a sessessment had not been assessment had not been and the facility if they are addressed. If a so no 6/29/15 at 5:30 p.m. heal, R60 ate all of her meal ortified foods served. If a so no food in a served	F3	25			

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F 329 SS=D	not received addition breakfast nor with lead to be added to breakfast nor with a dietician was to recommendations where the dietician was to recommendations where the facility policy, and the facility. The pole expectations will neat the facility and the decactly what will be review of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not as a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not as a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not as a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not as a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not as a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogress notes and nutritional risk as not a decay of the Consangreement dated 5 was to complete nuprogre	A further confirmed R60 had anal fortified foods for unch. 7/1/15, at 9:00 a.m. the sted the current dietary certified dietary manager he administrator was administrator further indicated expected to ensure that RD were implemented. Intitled Dietitian review of dents, dated 6/3/13, revealed II be to ensure each resident sutritional care possible while in icy further stated the dietitian sed to be clearly stated so that consultant dietitian know expected to be accomplished. Sultant Dietitian Services /15/13, revealed the dietitian stritional assessments, address residents at eeded. EGIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any		329		8/10/15	

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F 329	resident, the facility who have not used given these drugs therapy is necessal as diagnosed and crecord; and resider drugs receive gradibehavioral interven	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug by to treat a specific condition documented in the clinical states who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 329			
	by: Based on interview facility failed to ense R60) received side receiving an antips: Findings include: R47's Diagnosis Referedord, indicated Referedord, indicated Referedord, included: panic distribution orders day was prescribed Ristribution and the surrent care place of the current care place of the	eport obtained in the medical 47 had diagnosis that order, depressive disorder and ated 6/15/15, indicated R47 perdal 1.0 milligrams(mg)		It is the Facility's intent that all reside receiving antipsychotic medications of get side effect monitoring. R47 & R60 Abnormal Involuntary Movement Scale (AIMS) Assessment have been completed. Director of Nursing or designee will repharmacy Consultant monthly report all recommendations will be address according to facility policy and procedures related to side effect monitoring of medications have been reviewed and revised (See Attachments G & H). The facility will provide education for responsible staff on these Policies and Procedures.	will eview as and ed dure.	

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F 329	6/22/15, identified I mg twice a day with pharmacist recomma Abnormal Involunta assessment to be or Risperidal. The pharmacist monitored as a basa antipsychotic medicathereafter. Interview with the E 7/1/15, at 9:20 a.m assessment for TD completed since Romassessment for TD completed for the pharmacist further should be monitored for pharmacist further should be monitored for the Romassessment for the Romassessment for TD completed for pharmacist further should be monitored for pharmacist further should be monitored for the Romassessment for TD completed for pharmacist further should be monitored for the Romassessment for TD completed for pharmacist further should be monitored for the Romassessment for TD completed for the Romassessm	macy consultant report dated R47 as receiving Risperidal 1 in a start date of 6/15/15. The mendations included a ary Movement Scale (AIMS) completed for the use of armacist further indicated (TD) symptoms should be seline with a start of an cation and every 6 months DON (director of nursing) on confirmed that a baseline symptoms should have been 47 is receiving Risperidal.	F 329	Director of Nursing or designated audit Consultant Pharmacists drug monthly and implement recommendations. Director of Nursing or designated a conduct audits for compliance. Rethese audits will be reviewed at mondational compliance with applications and Facility policy has achieved. All audit results will be reat quarterly Quality Assurance team meetings.	staff will sults of onthly nsure able been eviewed	

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245346	B. WING		07/	01/2015
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F 329 F 431 SS=E	indicated that the labeen completed on re-assessed on 5/1. Interview with the D 7/1/15, at 9:30 a.m. assessment for tarc should have been cuse and had not be. The facility was unamonitoring side effect antipsychotic medic 483.60(b), (d), (e) D LABEL/STORE DR. The facility must enalicensed pharmacof records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological abeled in accordan professional princip appropriate accessinstructions, and the applicable. In accordance with	The pharmacist further st AIMS assessment had 11/14 and should have been 5. ON (director of nursing) on confirmed that a AIMS dive dyskenesia symptoms ompleted after 6 months of en assessed since 11/14 able to provide a policy for ects for the use of eations. ORUG RECORDS, UGS & BIOLOGICALS anploy or obtain the services of eist who establishes a system that an account of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the	F 329			8/4/15
	locked compartmer	its under proper temperature to only authorized personnel to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH 4TH AVENUE EAST FRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distriquantity stored is in be readily detected. This REQUIREMED by: Based on observate failed to ensure on access to the keys rooms located in the potential to affect a reside in the facility. Findings include: On 7/1/15, from 8: noted that medical the medication room. It was noted prescription medical across from where boxes of both narce prescription drugs, while MRC-A was working the medical of th	rovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit libution systems in which the ninimal and a missing dose can libution and interview, the facility ly authorized personnel had for 1 of 1 medication storage in facility. This had the any of the 50 residents who	F 431	It is the Facility's intent that all drug biologicals are stored in locked compartments under proper tempe controls, and permit only authorized personnel to have access to the ke The facility's policy and procedure to medication storage was develop (See Attachment I). The facility will provide education for responsible s All medications will be stored in loc cabinets in a centralized location to ensure safe secure placement. Training was completed with medic records clerk on 7/1/2015. The faci provide education for responsible s 7/28/2015. New sign with regulation posted on medication door. The faci provide education with all new hires annually with all staff.	rature d ys. related ed taff. k ral lity will taff on n cility will	
	It was observed on	7/1/15, at 8:28 a.m. that		Only licensed staff will have access	s to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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	A BUILDING 245346 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO Continued From page 29 MRC-A used a key to enter the medication room and propped open the medication room nor at the nurses station. Both nurses were observed passing medications in the dining and the hallway and MRC-A was not visible from the dining room. At 8:41 a.m. MRC-A exited the medication room and pulled the door shut. During interview on 7/1/15, at 8:24 a.m. registered nurse (RN)-B stated the nurses, the director of nursing and the medical records staff					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 431	MRC-A used a key and propped open nurse was present the nurses station. passing medication and MRC-A was not at 8:41 a.m. MRC-A and pulled the door During interview on registered nurse (R director of nursing all have keys to the reported the medication rorecords job duties at the medication ror into the electronic r RN-B confirmed the medications on the including narcotics RN-B stated that M prescription medications where. During interview on records clerk (MRC a key to the medication records clerk (MRC a key to the medication medication in resident records and electronic medical in confirmed she enter multiple times each job duties. MRC-A cartridges of prescription the counters and c	to enter the medication room the medication room door. No in the medication room nor at Both nurses were observed as in the dining and the hallway of visible from the dining room. A exited the medication room shut. 7/1/15, at 8:24 a.m. EN)-B stated the nurses, the	F 4:	keys for the locked medica Only appropriate authorize access to medication room The Director of Nursing or ensure all staff is educated	d staff will have n. designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 431	During interview on director of nursing (herself were the on room key. The DO the MRC-A had pos room key. During interview on administrator confir possession of the none", the DON and ones that have the	7/1/15, at 12:06 p.m. the (DON) stated the nurses and ly staff to have a medication N stated she was not aware ssession of the medication 7/1/15, at 12:17 p.m. the med the MRC-A has had nedication room key from "day the two nurses are the only key.	F4	31				

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PRINTED: 07/24/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 01 - MAIN BUILDING 01 245346 B WING 07/02/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **400 NORTH 4TH AVENUE EAST** TRUMAN SENIOR LIVING **TRUMAN, MN 56088** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 July 2, 2015. 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 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

program participation.

TITLE

07/23/2015

(X6) DATE

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

If continuation sheet Page 1 of 6

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING 0		(X3) DATE SURVEY COMPLETED		
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K 000	Marian.Whitney@s <mailto:marian.wh 1.="" 1970="" 1987="" 2.="" 3.="" <mailto:angela.kap="" a="" actual,="" addit="" and="" angela.kappenmar="" basement,="" building="" buildit="" co="" constr<="" corr="" correct="" defici="" deficiency="" description="" following="" for="" i="" ii(000)="" info="" livi="" mus="" name="" no="" o="" of="" or="" original="" plan="" pr="" prevent="" reoccurre="" responsible="" senior="" td="" the="" to="" truman="" type="" v=""><td>otate.mn.us itney@state.mn.us> and in@state.mn.us openman@state.mn.us> RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date.</td><td>K 000</td><td></td><td></td><td></td></mailto:marian.wh>	otate.mn.us itney@state.mn.us> and in@state.mn.us openman@state.mn.us> RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date.	K 000				
	outpatient medical facility by rated 2-he include opening pro	is separated from an clinic and an assisted living our fire wall assemblies, which otectives consisting of factory g, positive latching 90-minute s.					
	detection in the cor corridors which is department notifica	re alarm system with smoke ridors and spaces open to the monitored for automatic fire ation. The facility has a s and had a census of 50 at		*	i de		

PRINTED: 07/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
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K 000	Continued From pa	ge 2	Κ¢	000			
K 029 SS=D	NOT MET as evide NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved auton option is used, the a other spaces by sm doors. Doors are s field-applied protect	construction (with 3/4 hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K	029			7/10/15
	Based on observation failed to maintain a accordance with NF Section 19.3.2.1 and Section 8.2.3.2.3.2. deficient practice corresidents. FINDINGS INCLUE On facility tour betwon 07/02/2015, observed on the Laundry being held open by This deficient practice.	s not met as evidenced by: tion and interview, the facility hazardous area door in FPA 101 (00), Chapter 19, d 19.3.6.3.2, and Chapter 8, In a fire emergency, this build adversely affect 10 of 50 DE: The even 9:00 AM and 12:30 PM ervation revealed the corridor of Room, B-50 was observed an un-approved device. The even was confirmed by the te Director (CS) at the time of			It is our intent to comply with the Life Safety Code standards. Appropriate signage has been placed the corridor door to the Laundry Room stating "Please Keep Closed".	d on	

Event ID: EJK521

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N		1 ` ′	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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K 029 K 154 SS=D	discovery. NFPA 101 LIFE SA Where a required a out of service for m period, the authorit and the building is watch system is prounprotected by the	age 3 AFETY CODE STANDARD automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1	K 029			7/7/15
	Based on observa faility failed to propautomatic sprinkler more than 4 hours authority having jurbuilding is evacuate system is provided by the shutdown urbeen returned to se	s not met as evidenced by: tion and record review, the erty document when the system is out of service for in a 24-hour period, the isdiction is notified, and the ed or an approved fire watch for all parties left unprotected itil the sprinkler system has ervice in accordance with LSC deficient practice could affect		It is the intent to comply with the L Safety Code standards. Policy and Procedure for System of Service specific to Fire Sprinkler Shas been developed and put in pla Attachment A).	out of ystem	
	on 07/02/2015, obs	veen 09:00 AM and 12:30 PM servation and documentation that there was not a single service plan for the fire				
	This deficient pract	ice was confirmed by the				

PRINTED: 07/24/2015 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION 1 - MAIN BUILDING 01) DATE SURVEY COMPLETED	
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K 154 K 155 SS=D	Facility Maintenand discovery. NFPA 101 LIFE SA Where a required f service for more the authority having building is evacuate provided for all par	ce Director (CS) at the time of AFETY CODE STANDARD ire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been	K 1				7/7/15	
	Based on observate faility failed to propalarm system is out hours in a 24-hour jurisdiction is notific evacuated or an approperation of the fire alarm service in accordance.	is not met as evidenced by: tion and record review, the erty document when the fire t of service for more than 4 period, the authority having ed, and the building is oproved fire watch is provided approtected by the shutdown system has been returned to noe with LSC (00) 9.6.1.8. This could affect the residents.			It is the intent to comply with the L Safety Code standards. Policy and Procedure for System of Service specific to Fire Alarm System been developed and put in place (Statachment B).	ut of em has		
	on 07/02/2015, observiewed revealed plan for the out of system.	ween 09:00 AM and 12:30 PM servation and documentation that there was not a single service plan for the fire alarm tice was confirmed by the se Director (CS) at the time of						

Facility ID: 00361

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATI COM	E SURVEY PLETED
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ATTACHMENT A

SYSTEM OUT OF SERVICE/FIRE SPRINKLER SYSTEM

Truman Senior Living, Inc.

POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE APPROVED BY: Lorna Craig-Paulson, Campus Administrator Effective Date: 7/7/2015 Revised Date: ______

I. POLICY

It is the policy of Truman Senior Living, Inc. to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system and/or fire sprinkler system is out of service.

II. PURPOSE

To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire sprinkler system at Truman Senior Living, Inc. is out of service.

III. RESPONSIBILITY

Responsibility for development and implementation of this policy rests with the facility safety officer.

IV. PROCEDURE

A. Notifications

- 1. Upon finding that a required fire protection system is out of service:
 - a. The following persons will be notified immediately:
 - i. Facility Administrator: Lorna Craig-Paulson (763) 219-0302
 - ii. Head of Maintenance: Curt Sager (507) 236-0532
 - iii. Local fire chief or fire marshal David Bentz (507)236-2749
 - iv. The facility's insurance carrier Guide One Ins. (515)267-5000
 - v. The facility's monitoring company 1st Choice Security (507)380-1864
 - b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building's fire alarm system is out of service, directing them to:
 - i. Close all smoke and fire doors in the area(s) affected by the impairment; and
 - ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times.
- If the building fire alarm and/or fire sprinkler system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone or e-mail at: (651)769-7779 or larry.gannon@state.mn.us

SYSTEM OUT OF SERVICE/FIRE SPRINKLER SYSTEM

POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE

Page 2 of 3

APPROVED BY: Lorna Craig-Paulson, Campus Administrator

Effective Date: 7/7/2015

Revised Date: _____

B. Preplanned impairments

For preplanned impairments (e.g. scheduled work or testing), all the parties identified above will be notified, in advance, of the extent and expected duration of the impairment. In addition, the person performing the work will be expected to place tags (as appropriate) at each fire department connection, sprinkler system control valve, fire alarm control unit and/or fire alarm annunciator indicating that the system, or part thereof, has been removed from service.

C. Alternate fire alarm signal

Upon notification that the building fire alarm system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment:

- a. The staff person discovering the fire must shout the code phrase **RED LANTERN** and go the aid of any person(s) in immediate danger.
- b. Personnel hearing the code phrase announced will immediately use the **whistles** provided at each nurse station to alert all other building occupants and then proceed to execute their duties as assigned in the fire safety plan.

D. Fire watch

At the direction of the fire chief, facility administrator or facility safety officer, a fire watch will be implemented.

- 1. Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee's personnel file.
- 2. Fire watch personnel will:
 - a. Have no other duties assigned to them while the affected fire protection system is out of service.
 - b. Carry a cell phone with them to use for notification of the fire department.
 - c. Perform continuous tours such that each portion of the building affected by the impairment is checked at not less than 30-minute intervals. In addition to watching for and promptly reporting any incidents of fire, visible smoke or strong smell of smoke or other unwanted odors, the fire watch will also ensure while on tour that:
 - Portable fire extinguishers are in place, unobstructed and in proper operating condition;
 - Corridors and exits are free and clear of storage and all other obstructions;
 - Exit and stairwell doors are clear and fully operational;
 - EXIT signs are visible and properly illuminated;
 - Fire doors, smoke barrier doors and hazardous area doors are kept closed and latched (i.e. not tied, wedged or blocked open in any fashion);
 - Oxygen cylinders/containers not in use are properly stored;
 - Electrical hazards are promptly reported and remedied;

SYSTEM OUT OF SERVICE/FIRE SPRINKLER SYSTEM

POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE

Page 3 of 3

APPROVED BY: Lorna Craig-Paulson, Campus Administrator

песиve	Date:	11112015
Revised	Date:	

 No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the

remainder of the facility); and

 Trash and other unnecessary accumulations of combustibles are promptly removed from the building.

- d. Document their tours in a log. Any problems found during the fire watch will also be documented and reported to the head of maintenance for immediate correction.
- 3. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer.

E. Evacuation

The nature and extent of the impairment, coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacuations will be performed in accordance with the fire safety plan and take place only at the direction of the fire chief, facility administrator or facility safety officer.

F. System(s) restored to service

When the impaired system has been restored to normal working order:

- a. The following persons will be notified immediately:
 - i. Facility Administrator Lorna Craig-Paulson (763)219-0302
 - ii. Head of Maintenance Curt Sager (507)236-0532
 - iii. Local fire chief or fire marshal David Bentz (507)236-2749
 - iv. The facility's insurance carrier Guide One Ins. (515)267-5000
 - v. The facility's monitoring company 1st Choice Security (507)380-1864
- b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine.
- c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: (651)769-7779
- d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed.

ATTACHMENT B SYSTEM OUT OF SERVICE/FIRE ALARM SYSTEM

Truman Senior Living, Inc.

POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE	Page 1 of 3
APPROVED BY: Lorna Craig-Paulson, Campus Administrator	Effective Date: 7/7/2015
	Revised Date:

I. POLICY

It is the policy of Truman Senior Living, Inc. to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system and/or fire sprinkler system is out of service.

II. PURPOSE

To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire alarm system at Truman Senior Living, Inc. is out of service.

III. RESPONSIBILITY

Responsibility for development and implementation of this policy rests with the facility safety officer.

IV. PROCEDURE

A. Notifications

- 1. Upon finding that a required fire protection system is out of service:
 - a. The following persons will be notified immediately:
 - i. Facility Administrator: Lorna Craig-Paulson (763) 219-0302
 - ii. Head of Maintenance: Curt Sager (507) 236-0532
 - iii. Local fire chief or fire marshal David Bentz (507)236-2749
 - iv. The facility's insurance carrier Guide One Ins. (515)267-5000
 - v. The facility's monitoring company 1st Choice Security (507)380-1864
 - b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building's fire alarm system is out of service, directing them to:
 - i. Close all smoke and fire doors in the area(s) affected by the impairment; and
 - ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times.
- 2. If the building fire alarm and/or fire sprinkler system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone or e-mail at: (651)769-7779 or larry.gannon@state.mn.us

SYSTEM OUT OF SERVICE/FIRE ALARM SYSTEM

POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE

Page 2 of 3

APPROVED BY: Lorna Craig-Paulson, Campus Administrator

Effective Date: 7/7/2015

Revised Date: _____

B. Preplanned impairments

For preplanned impairments (e.g. scheduled work or testing), all the parties identified above will be notified, in advance, of the extent and expected duration of the impairment. In addition, the person performing the work will be expected to place tags (as appropriate) at each fire department connection, sprinkler system control valve, fire alarm control unit and/or fire alarm annunciator indicating that the system, or part thereof, has been removed from service.

C. Alternate fire alarm signal

Upon notification that the building fire alarm system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment:

- a. The staff person discovering the fire must shout the code phrase **RED LANTERN** and go the aid of any person(s) in immediate danger.
- b. Personnel hearing the code phrase announced will immediately use the **whistles** provided at each nurse station to alert all other building occupants and then proceed to execute their duties as assigned in the fire safety plan.

D. Fire watch

At the direction of the fire chief, facility administrator or facility safety officer, a fire watch will be implemented.

- Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee's personnel file.
- 2. Fire watch personnel will:
 - a. Have no other duties assigned to them while the affected fire protection system is out of service.
 - b. Carry a cell phone with them to use for notification of the fire department.
 - c. Perform continuous tours such that each portion of the building affected by the impairment is checked at not less than 30-minute intervals. In addition to watching for and promptly reporting any incidents of fire, visible smoke or strong smell of smoke or other unwanted odors, the fire watch will also ensure while on tour that:
 - Portable fire extinguishers are in place, unobstructed and in proper operating condition;
 - Corridors and exits are free and clear of storage and all other obstructions;
 - Exit and stairwell doors are clear and fully operational;
 - EXIT signs are visible and properly illuminated;
 - Fire doors, smoke barrier doors and hazardous area doors are kept closed and latched (i.e. not tied, wedged or blocked open in any fashion);
 - Oxygen cylinders/containers not in use are properly stored;
 - Electrical hazards are promptly reported and remedied;

SYSTEM OUT OF SERVICE/FIRE ALARM SYSTEM

POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE

Page 3 of 3

APPROVED BY: Lorna Craig-Paulson, Campus Administrator

Effective Date: 7/7/2015

Revised Date:

- No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the remainder of the facility); and
- Trash and other unnecessary accumulations of combustibles are promptly removed from the building.
- d. Document their tours in a log. Any problems found during the fire watch will also be documented and reported to the head of maintenance for immediate correction.
- 3. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer.

E. Evacuation

The nature and extent of the impairment, coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacuations will be performed in accordance with the fire safety plan and take place only at the direction of the fire chief, facility administrator or facility safety officer.

F. System(s) restored to service

When the impaired system has been restored to normal working order:

- a. The following persons will be notified immediately:
 - i. Facility Administrator Lorna Craig-Paulson (763)219-0302
 - ii. Head of Maintenance Curt Sager (507)236-0532
 - iii. Local fire chief or fire marshal David Bentz (507)236-2749
 - iv. The facility's insurance carrier Guide One Ins. (515)267-5000
 - v. The facility's monitoring company 1st Choice Security (507)380-1864
- b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine.
- c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: (651)769-7779
- d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted July 14, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5346026

Dear Ms. Craig-Paulson:

The above facility was surveyed on June 28, 2015 through July 1, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Truman Senior Living July 14, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 476-4233.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 07/27/2015

DEFICIENCY)

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00361 07/01/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 NORTH 4TH AVENUE EAST** TRUMAN SENIOR LIVING **TRUMAN, MN 56088** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG

2 000

2 000 Initial Comments

NH LICENSING CORRECTION ORDER

*****ATTENTION*****

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/24/15

TITLE

Electronically Signed

(X6) DATE

PRINTED: 07/27/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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Minnesota Department of Health

STATE FORM 6899 EJK511 If continuation sheet 2 of 37

Minnesota Department of Health

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_ 00_	or related disorder: ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144 (a) If a nursing facil Alzheimer's disease or related of segregated or generated staff	train EASE OR RELATED ING:	2 002			0/-1/10
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Minnesota Department of Health STATE FORM

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

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2 302	facility failed to ensinformation on a de training program, the trained, the frequent topics covered at the potential to affect all consumers who was Findings include: During interview on 11:00 a.m. the social information was given training program for Alzheimer's training. During interview on administrator confined ucation about the SUGGESTED MET administrator or desimaterials given to reinclude information for staff. The adminential currents afformation current staff. Alzheimer's training current staff.	and document review, the ure that consumers received scription of the Alzheimer's received scription of the Alzheimer's recategories of employees recy of training, and the basic refacility. This had the ll 50 residents and any residents and any received to review the information. 7/1/15, at approximately all worker (SW) stated no render to consumers about the restaff related to rethe frequency. 7/1/15, at 1:03 p.m. the med the lack of consumer retraining. CHOD OF CORRECTION: The signee could review and revise residents and families to related to Alzheimer's training restrator or designee could rent residents and/or their are educated about the flave received related to	2 302	Corrected		
2 545	(21) days.	Subp. 3 A-C Comprehensive	2 545			8/14/15
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Minnesota Department of Health

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 545 Continued From page 4 assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on document review and staff interview the facility failed to conduct a comprehensive reassessment at the time of a significant change in resident condition for 1 of 1 (R25) resident reviewed who had pressure ulcers and was nutritionally at risk. Findings include: R25's most recent admission was 1/27/15, with diagnoses which included: Diabetes type II; congestive heart failure (CHF), anxiety disorder, pressure ulcers (3), pneumonia and hypertension.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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R25 experienced a significant change in condition related to further development of pressure ulcers (heel and coccyx). The significant change Minimum Data Set (MDS) was completed on 4/28/15. This MDS triggered care areas related to pressure ulcer and nutritional status; however, documentation was lacking to indicate a Care Area Assessment (CAA) had been completed for either triggered area. When interviewed on 7/01/15, at 11:46 a.m. registered nurse/clinical manager (RN)-D verified the registered dietician (RD) had not completed a comprehensive dietary reassessment since the initial assessment dated 1/29/15. RN-D confirmed that R25 required a nutritional	2 545	assessments must A. within 14 day B. within 14 day the resident's physic C. at least once This MN Requirements by: Based on documer facility failed to con reassessment at the in resident condition reviewed who had previewed which in congestive heart fare pressure ulcers (3) R25 experienced a related to further deceived and coccyx). Minimum Data Set 4/28/15. This MDS to pressure ulcer and documentation was Area Assessment (either triggered are When interviewed or registered nurse/clither egistered dietic comprehensive die initial assessment of the comprehensive die	be conducted: as after the date of admission; as after a significant change in cal or mental condition; and a every 12 months. ent is not met as evidenced at review and staff interview the duct a comprehensive e time of a significant change in for 1 of 1 (R25) resident bressure ulcers and was admission was 1/27/15, with cluded: Diabetes type II; illure (CHF), anxiety disorder, pneumonia and hypertension. significant change in condition evelopment of pressure ulcers The significant change (MDS) was completed on a triggered care areas related and nutritional status; however, as lacking to indicate a Care CAA) had been completed for a. a. a. a. a. a. a. a. b. a. a. a. b. a. a. b. b. a. b. b. a. b. a. b. a. b. a. b. b. a. b. b. a. b. b. b. c. b. b. c. d.	2 545			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
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2 545	coccyx. RN-D confreassessment had time of the significal condition. During a subsequer 7/01/15, at 12:13 p. R25 had not receive admission. During interview on consultant registere no one had been coat the facility for about assessments dated Wound #1-full thick 0.60 centimeters (compared to the compared to the compar	irmed a comprehensive not been completed at the nt change in resident at interview with RN-D on m. she also confirmed that ed dietary supplements since 6/30/15, at 3:19 p.m. the ed dietician (RD) indicated that ompleting dietary assessments out a year. ained from the wound nurse 16/24/15 the following: ness-Stage III pressure ulcer; m) x 3.00 cm; Depth-0.2 cm; cy-serosangunious; acquired; Wound #2- right rauma-full thickness-dry; 2.00 and #3- plantar, foot Stage III; depth 0.2 cm; and moderate gnificant change Minimum ted 4/15/15, indicated a Brief Status (BIMS) as 15/15 which nition. The Activities of Daily red extensive assistance with ng, and personal hygiene, with nce with toileting and ting. ure Ulcer care areas were the MDS dated 4/15/15, yet no nent (CAA) was completed on the care areas were the manual content of the CAA was not server to the care areas were the manual content of the CAA was not server.				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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2 545 2 570	in condition occurs. educate the staff re related to compreh director of nursing or resident records to assessments are of significant change. the quarterly quality TIME PERIOD FOR (21) days.	Ints when a significant change. The director of nursing could lated to the requirements densive reassessments. The could develop a tool to audit densure the appropriate completed at the time of these could be reviewed at a assurance meetings. R CORRECTION: Twenty-one	2 545 2 570			7/31/15
25/0	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requirements on the disciplines as deter and to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.	2 5 7 0	Corrected		7/31/15
		ted activity interventions cresidents (R2) reviewed for				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		H 4TH AVEN MN 56088	IUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 7	2 570			
	Data Set (MDS) da Interview for Menta (severe cognitive in identified R2 exhibit symptoms and indic preferences was ur. The staff assessme identified R2 enjoyed that attending favor importance to her. The activities care proposed in the interview of the interv	inge in condition Minimum ted 5/6/15 revealed a Brief I Status (BIMS) score of 1 inpairment). The MDS ted vocally disruptive cated an interview for activities hable to be completed with R2. Bent for activities interests and pets, religious activities and ite activities were of colan dated 5/20/15, indicated in activities of choice with a independent activity choices. Bated R2 would be given a copy encouraged to participate in y.				
	indicated R2 would during the evening diverting R2's beha in activities when al measures for basic					
	was noted to be sitt and had a calm fac	on 6/29/15, at 5:47 p.m. R2 ing at the dining room table ial affect. R2 was noted to be to other female residents and ith her visiting.				
	survey from 6/29/15 did not participate in and called out when	ons of R2 throughout the 5 through 7/1/15 revealed R2 in any individualized activities in left alone in her room and direct her own activities.				
	During interview on	6/30/15, at 1:38 p.m. activities				

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STATEMENT OF DEFICIENCIES (X1)

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00361	B. WING		07/0	1/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		'H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
	R2 was only allotted and generally just w between. AS-B sta could carry on brief church on Sundays	as the activities director stated done hour out of bed at a time went to meals and slept in ted R2 was not very cognitive, conversations and attended and occasionally on Fridays. activities were currently being				
	AS-B stated R2's ca and did not accurat status or ability to in self-leisure pursuits AS-B stated R2 was group activities offe	view on 7/1/15, at 8:58 a.m. are plan had not been updated ely reflect her current activities adependently direct her own s, "That's my fault on that one." is a casual observer in the ared such as news and trivial answer any of the questions is meaningfully.				
	director of nursing (develop and implementated to care plandesignee, could prostaff related to the trevisions. The quali	THOD OF CORRECTION: The (DON) or designee, could nent policies and procedures revisions. The DON or ovide training for all nursing imeliness of care plan ty assessment and assurance erform random audits to				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			8/14/15
	receive nursing care custodial care, and	general. A resident must e and treatment, personal and supervision based on d preferences as identified in				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of the care as design of the comprehensive plan of the care as design of	resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			
	by: Based on observatireview the facility fafactors related to faimplemented to min	ent is not met as evidenced on, interview and document iled to ensure causal risk lls and that interventions were simize the risk of future falls (R60) reviewed with a history		Corrected		
	Findings include:					
	Review of the resident in the medical recording diagnoses including	o the facility on 11/6/14. ents Diagnosis Report located of indicated R 60 had hip fracture and replacement, isorder and a history of				
	dated 4/15/15, idemextensive assistance and transfers. R60 ambulatory and have status (BIMS) of 3/1 R60 as requiring a valso identified as exadmission.	erly minimum data set (MDS) tified R60 as requiring te of one staff for bed mobility was identified as non-ring a brief interview of mental 10. The MDS further identified wheelchair for mobility and experiencing falls since				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00361	B. WING		07/0	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAI	N SENIOR LIVING		'H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	identified R60 as rewith bed mobility. Relift to transfer into be included R60 as bed dementia, weakness Interventions listed is wearing eyeglass glare and clutter, (3 verbal reminders not keep personal item toileting assistance. Review of the fall a identified R60 as bevision, poor balance receives antipsyche assessment further high risk for falls and the past 3 months. During observations R60's room environ have a alarm place in bed sleeping. Rewere in reach as we chair. When observations R60 was transferred assistance from state a little weight and we transfer observation. R60's documented reviewed: (1) Fall on 11/16/14 on the floor next to sounding. No injurie factors identified no implemented to present the sounding of the present in the	equiring extensive assistance and utilizes a mechanical stand ed. The care plan further ing at risk for falling related to as and poor impulse control. included: (1) assure resident ses, (2) assure floor is free of to be and chair alarm, (4) but to self transfer/ambulate, (5) is within reach, (6) provide and (6) observe frequently. Seessment dated 4/15/15, sing disoriented, having poor end in the indicated the resident was at an indicated the resident was 60's eyeglasses and call light ell as an alarm placed on her ared on 6/30/15, at 3:00 p.m. and with an EZ stand and 2 and with an EZ stand and 2 and with an EZ stand and 2 and in the past year were and in the past year were and the se were noted. No causal or were there any interventions are resident was an interventions of the past year were there any interventions.	2 830			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		00361	B. WING		07/0	1/2015	
400 NORT			DDRESS, CITY, STATE, ZIP CODE				
IRUMAN	I SENIOR LIVING	TRUMAN,	MN 56088				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From page 11		2 830				
	report indicated the transfer herself to be shoulder. No injuries factors identified no implemented to pre (3) Fall on 12/12/14 sitting on the floor visounding. No injuries	her wheelchair and bed. The resident was attempting to bed and landed on her left as were noted. No causal or were there any interventions went further falls. 4, at 6:15 p.m. R60 was found with the her wheelchair alarm as were noted. No causal or were there any interventions					
	(4) Fall on 12/22/14, at 1:45 a.m. R60 was found sitting on the floor in her room with 1 shoe on when the staff were alerted to the residents bed alarm sounding. No injuries were noted. No causal factors identified. Ativan was given.						
	out for help when the on the floor in her rebrief off. R60 indicates	at 10:20 p.m. R60 was calling ne resident was found sitting com barefoot with her wet ated she needed to go to the es. No causal factors provided.					
	fell out of her whee	at 5:29 p.m. indicated R60 Ichair. No injuries were noted. dentified. No interventions.					
	was found on the flowheelchair. No injur	at 5:10 p.m. indicated R60 oor after sliding out of her ries. No causal factors terventions implemented.					
		at 8:30 p.m. R60 was found on No injuries noted. No causal ad no interventions.					
	(9) Fall on 6/22/15	at 7:20 p.m. R60 was and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY MPLETED	
		00361	B. WING		07/0	1/2015	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADD			STATE, ZIP CODE			
TRUMAN	SENIOR LIVING		TH 4TH AVEN , MN 56088	IUE EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From page 12		2 830				
	found on the floor in the hallway. No injuries. No causal factors identified and no interventions listed.						
	was found nor provabove documented lacking to indicate a assessment had be each incident relate interventions were minimize the future Interventions were	ntation in the medical record ided by staff related to the falls. Documentation was a comprehensive fall een conducted at the time of ed to the fall and therefore no dentified to prevent and/or to risk of fall and injury. not evaluated to determine and/or the need for revision					
	discharge note for I the resident was re strengthening upon fracture repair. The being limited with p	admission after a recent hip e PT/OT note identified R60 as rogression due to her I therefore R60 was unable to					
	at 10:14 a.m. indicatheir daily manager included there is no responsible for follor investigating causainterventions to preoccurring. RN-A coinformation availab	wing up on falls nor I factors to implement vent further falls from ncurred there was no further le for review to indicate a lessment had been conducted					
	The director of nurs	CHOD OF CORRECTION: sing or designee could review related to falls prevention and					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00361	B. WING		07/0	1/2015	
			DRESS, CITY, S	STATE, ZIP CODE			
TRUMAN	TRUMAN SENIOR LIVING 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
	director of nursing of incident reports and to ensure thorough factors. The director conduct periodic au compliance, and revassurance committed TIME PERIOD FOF (21) days.	or responsible staff. The or designee could audit assessments related to falls assessment for causative or of nursing or designee could dits to ensure ongoing view results with the quality	2 830			8/14/15	
	-Nutritional Status Subpart. 2. Nutrition must ensure that a which supplies the determined by the cassessment. Subst	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident citutes of similar nutritive value esidents who refuse food	2 903			6/14/15	
	by: Based on interview facility failed to ensu implemented to pre 3 of 4 residents (R3 nutritional status. Findings include: R31 R31's physician's or	and document review, the ure interventions were vent significant weight loss for 1, R37 & R60) reviewed for order sheets, dated 7/1/15 of chronic kidney failure and		Corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED		
00361		B. WING		07/01/2015				
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
TRUMAN	I SENIOR LIVING		'H 4TH AVEN MN 56088	IUE EAST				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
2 965	Continued From page 14		2 965					
	regular diet.							
	(MDS) dated 2/16/1 planned weight loss supervision and set	ange minimum data set 5, revealed R31 was not on a s program and required tup at meals. A care area for nutrition did not trigger and for R31.						
	anticipated weight I	ted 5/2015, revealed R31 had coss due to ascites (a the abdomen associated with edema.						
	Review of R31's weights (wts) revealed a 10 pound (lb) loss from 135 to 125 lbs. between 3/15 and 4/15, which was identified as a significant weight loss.							
	completed by the d -Reviewed resident 10 more lbs from la comes up as a sign 180 days. Please a consider restarting	dietary progress note, ietician on 4/23/15 indicated: s wts. as they are down about ast month at this time and this ificant wt. change over 90 and ddress this with resident and NIP [an intervention involving rovide additional calories].						
	recommendation w nor was implement R37's medical reco	s lacked evidence the as addressed with the resident ed per recommendation. rd lacked evidence of any ssments related to nutritional						
	previous four month	etary oral intakes for the ns revealed the intakes % of food and 0-100% of						

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRUMA	N SENIOR LIVING		H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	During interview on consultant registerer no one had been coat the facility for abordurther stated she the completing them, as from another facility twice weekly to comassessments. The to complete the required for one day possible the required fo	6/30/15, at 3:19 p.m. the ed dietician (RD) indicated that empleting dietary assessments out a year. The dietician mought the administrator was not that a dietary manager was now scheduled to visit aplete the dietary RD indicated she was unable uired work as she was only er month for consultation. 6/30/15, at 3:17 p.m. cook-A No idea," what the NIP en asked whether a list of P program was maintained, resident list, last updated thave R31's name listed. on 7/1/15, at 8:04 a.m. R31 breakfast table eating rice toast. A partially finished ent shake was observed in 5, R31 pushed herself awaying she was finished after boods and drinking of her supplement. A nursing entified) was nearby and had finish the supplement. 7/1/15, at 8:22 a.m. R31 er been a "big eater". R31 satisfied with what dietary was as "good" but she didn't eat	2 965			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	01/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN	SENIOR LIVING		ΓΗ 4TH AVEN , MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 16	2 965			
	list of dietary recom however, she was t	D stated she had received a mendations from the RD; old specifically by the follow up on them as this was				
	5/11/15, revealed R of one staff membe swallowing disorder R37 was severely c	inimum Data Set (MDS) dated 37 required limited assistance r at meals and had no rs. The MDS further identified ognitively impaired. A re area assessment (CAA)				
	R37's care plan, dated 5/24/15 indicated R37 required setup and cueing for eating with a goal of encouraging 75% or more of intakes. The care plan did not mention any use of supplements.					
	R37 generally ate 2 of supper and was for the fluid intake.	eal intakes for 5/2015 revealed 5-100% of lunch and 75-100% taking in similar percentages Meal intakes for 6/15 revealed -100% for both dinner and % of her fluids.				
		ted 5/19/15 indicated that R37 e on the NIP program.				
		ost current physician's orders, aled a general (regular) diet				
	5/15 revealed a dec admission to 110.6	eights since her admission in crease from 117 lbs on lbs on 6/15/15, with a ess occurring on 5/28/15 due within 30 days.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAN	SENIOR LIVING		'H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 17	2 965			
	p.m. R37 was noted mien and drank all I feed herself indeperself independent indeperself independent indeperself independent i	ler sheet dated 7/1/15, including dysphasia and se as well as an order for a diet with thickened liquids. num data set (MDS), dated 60 was not on a planned in and required extensive ing. The MDS further identified weight loss of 15 pound (lb)				
	The quarterly minim 4/15/15 revealed Reweight loss progran assistance with eatin R60 experienced a	num data set (MDS), dated 60 was not on a planned n and required extensive ng. The MDS further identified				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00361	B. WING		07/0	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN SENIOR LIVING			H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 18	2 965			
	R60 had a nutrition	plan dated 5/2715, revealed al status of requiring a d diet related to the diagnosis				
	Review of R60's log of weights revealed a 15 lb loss from 112 to 97 lbs. between 1/15 and 4/15.					
	completed by the di -Reviewed resident weight loss of -9.8% will be added to NIF	dietary progress note, ietician on 3/4/15 indicated: secondary to significant in the past 93 days. Resident [an intervention involving rovide additional calories].				
	The progress notes for R60 lacked evidence the RD's recommendation for the NIP program was addressed nor implemented. R60's medical record lacked evidence of any further dietary assessment related to nutritional status.					
	months revealed in	etary intakes for the previous 3 takes ranging from 0-100% at ly intake of food is 25-75%.				
	indicated a dietary a completed for R60. provides her recom	6/30/15, at 2:00 p.m. the RD assessment had not been The RD also indicated she mendations with the facility if they are addressed.				
	during the supper n with no additional for Observations on 6/5 breakfast the reside independently with served. Observation during breakfast the	s on 6/29/15 at 5:30 p.m. neal, R60 ate all of her meal ortified foods served. 30/15 at 7:00 a.m. during ent ate 75% of her food no additional fortified foods n on 7/1/15 at 7:00 a.m. e resident ate all of her meal ortified foods served.				

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			ATE SURVEY MPLETED	
		00361	B. WING		07/0	1/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0170	.,	
TRUMAN	I SENIOR LIVING		H 4TH AVEN	NUE EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 965	Continued From page 19		2 965				
	indicated she had "program was. Whe maintained a list of cook-A provided a lincluded R60. Cook not received addition breakfast nor with lincluded manager was not a	7/1/15, at 9:00 a.m. the teed the current dietary certified dietary manager					
	manager was not a certified dietary manager (CDM); however, the administrator was credentialed. The administrator further indicated the dietician was to expected to ensure that RD recommendations were implemented.						
	Acute At Risk Residence the ultimate goal will receive the best not the facility. The pole expectations will nee the facility and the content of the facility and the content of the facility and	entitled Dietitian review of dents, dated 6/3/13, revealed II be to ensure each resident utritional care possible while in icy further stated the dietitian ed to be clearly stated so that consultant dietitian know expected to be accomplished.					
	Agreement dated 5 was to complete nu	sultant Dietitian Services /15/13, revealed the dietitian tritional assessments, address residents at eeded.					
	The administrator of revise current policition weight loss and restadministrator or destresponsible staff or	THOD OF CORRECTION: or designee could review and less and procedures related to idents nutritionally at risk. The signee could educate a the policy changes as well as current recommendations are					

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/0	1/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		TH 4TH AVEI MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	being carried out wi The administrator of audits for compliant assurance committee TIME PERIOD FOR (21) days.	Ithin the dietary department. It designee could conduct It and review with the quality It are and review with the quality It are and review with the quality It are a constant to the conduct of the cond	2 965			701/15
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implement (b) Written compliable maintained by the	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of eation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.	21426			7/31/15
	by: Based on interview	ent is not met as evidenced and document review the orm a tuberculin skin test		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00361	B. WING		07/0	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
TRUMAN	SENIOR LIVING		H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 21	21426			
	for Disease Control per facility policy for R14) and failed to p of 5 employees (NA control compliance.	quired timeframe per Center (CDC) recommendations and r 2 of 5 residents (R12 and perform the second TST for 1 A-G) reviewed for infection				
	Findings include:					
	R12 had an admission date of 5/30/13, and review of the electronic record did not contain evidence of a TST being completed following admission to the facility in accordance with CDC guidelines and facility policy.					
	the electronic media	o the facility on 11/02/14 and cal record did not contain d been completed in and facility policy.				
	indicated a hire date was documented as 1/29/15 at 11:20 a.r negative 0 mm read	assistant (NA)-G employee file e of 1/29/15. The first TST is being administered on in. and read on 1/31/15 with a ding. No second step was ding to the documentation				
	7/1/15, at 12:30 p.n documentation was administered to R1: the facility and CDC confirmed the empl evidence of comple accordance with fac further stated she the confirment of the facility policy/page 12:30 p.n. documentation was administered to R1: the facility policy/page 12:30 p.n. documentation was administered to R1: the facility policy/page 12:30 p.n. documentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: the facility and CDC confirmentation was administered to R1: th	sing (DON) was interviewed on an and confirmed lacking related to TSTs being 2 and R14 in accordance with 2 policy. The DON further oyee record for NA-G lacked stion of the second step TST in cility policy and procedure and hought it had been missed.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00361	B. WING		07/0	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
TRUMAN	I SENIOR LIVING		H 4TH AVEN MN 56088	IUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	step must be comp results before being you would have dire second step must be 21 days after the fir process must be redocumentation of a within the past 12 m requirement is satist be administered on date. The Tubercul indicated: Tubercul indicated: Tubercul performed on all regand to identify new SUGGESTED MET The director of nurs reeducate nursing serident and employand could perform a were being followed could be reviewed a assurance meeting:	ection Mantoux Test: The first leted and read with negative g scheduled on the floor where ect contact with residents. The pe administered and read 7 to st step was read or the entire peated. If you can provide negative Mantoux given nonths, the first step Mantoux efied, and the second step may e to three weeks after the start losis Screening Policy losis (TB) screening is sidents to detect reactivation	21426			
21435	MN Rule 4658.0900 Recreation Progran	Subp. 1 Activity and n; General	21435			7/31/15
	home must provide recreation program based on each indiv strengths, and need meet the physical, r well-being of each r	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 07/0	1/2015
_			TH 4TH AVEI			
TRUMAN	I SENIOR LIVING		, MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	comprehensive pla 4658.0400 and 465 provided opportunit planning and develor recreation program. This MN Requirements: Based on observation review the facility faindividualized activitimplemented to me residents (R2 & R3). Findings include: R37 R37's face sheet dadiagnoses of Alzhei uncomplicated end. R37's admission M 5/11/15, revealed a of interest was not R37. The MDS ide animals and snacks cognitively impaired Mental Status (BIM completed. R37's Care Area As dated 6/29/15, directinformation was in Review of the social	n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and . ent is not met as evidenced on, interview and document ailed to ensure an ties program was et the needs of 2 of 4 7) reviewed for activities.	21435	Corrected		
	to be engaged in ac	ted 6/5/15, revealed R37 was ctivities to discourage wandering and taking other				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER	<u>I</u>	DRESS CITY S	STATE, ZIP CODE	1 01/0	1/2013
	SENIOR LIVING	400 NOR	TH 4TH AVEN			
(V4) ID	SHIMMA DV STA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 24	21435			
	people's belongings identify R37's activi	s. The care plan did not ty interests.				
	identified R37 enjoy Chicken Noodle So liked to keep her ha	essment dated 5/4/15, yed sewing, being read to from oup for the Soul books and ands busy. The assessment anicures and hand massages well as pet therapy.				
	During observation on 6/28/15, at 1:04 p.m. R37 was noted to be lying in bed with a picture book of cows on her lap and was holding a baby doll. She did not appear to be interested in the objects and was unable to respond verbally to any questions but smiled when spoken to.					
	During observation on 6/29/15, at 3:07 p.m. R37 was again observed in bed with the doll. She was alert and did not appear to engage with or have interest in the doll.					
		ervation on 6/29/15, at 5:09 erved in the dining room with				
	was observed in the nursing station and was eating another moved out of the ar and escorted close there. R37 proceed and at one point be dependent resident activities nor attem meaningful stimular the afternoon shift of	on 6/29/15, at 6:42 p.m. R37 e activities area of the main had wheeled up to a table and resident's food. R37 was rea by registered nurse (RN)-Ar to the nurses station and left ded to wheel about the lobby gan pulling on another 's wheelchair. No 1:1 pts to engage R37 in tion were observed throughout on 6/29/15.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00361	B. WING		07/0	1/2015
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN SENIOR LIVING			MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	was observed in the No staff were in the dice shaking activity however R37 did now was wheeling about hymnal in her lap at the dining room tab. During interview on staff (AS)-A indicate person worked in his been a third staff mand management he funds to hire a replay was difficult to get a no one to fill in for wheeling interview on indicated R37 didn' other than looking a activities she was a difficult when now the lobby when	e lobby, looking out a window. Immediate area. At 10:00, a began in the activity room, of attend. At 10:56 a.m., R37 to the commons area with a nd had taken some butter off le. 6/30/15, at 9:57 a.m. activities and she and only one other er department. There had ember that retired recently had indicated there were no accement. AS-A indicated it activities done and there was racations. 6/30/15, at 10:14 a.m. RN-A to participate in activities much at a book and received no 1:1	21435			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			SURVEY LETED
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN	TRUMAN SENIOR LIVING 400 NOR TRUMAN			NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 26	21435			
	further indicated the	would rip them up. AS-B eir staffing budget had recently "Tricky," to get 1:1 activities				
	administrator indicate be more activities for residents and verifications.	on 7/1/15, at 12:45 p.m. the ated she felt there needed to or cognitively impaired ed an activities staff member and had not been replaced.				
	Data Set (MDS), da Interview for Menta (severe cognitive in identified R2 exhibit symptoms and indic preferences was un The staff assessme identified R2 enjoye	nge in condition Minimum ated 5/6/15 revealed a Brief I Status (BIMS) score of 1 apairment). The MDS ted vocally disruptive cated an interview for activities able to be completed with R2. Lent for activities interests and ite activities were of				
	R2 was independer goal of maintaining The care plan indic	plan dated 5/20/15, indicated at in activities of choice with a independent activity choices. ated R2 would be given a copy encouraged to participate in y.				
	indicated R2 would during the evening diverting R2's beha in activities when al measures for basic	e plan dated 5/20/15, make noises, especially and listed interventions of vior by having her participate ole and to provide comfort needs. on 6/29/15, at 5:47 p.m. R2				

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AND BLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	1/2015
	PROVIDER OR SUPPLIER	400 NOR	TH 4TH AVEN	STATE, ZIP CODE IUE EAST		
			MN 56088			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 27	21435			
	and had a calm fac	ing at the dining room table al affect. R2 was noted to be to other female residents and ith her visiting.				
	p.m. a staff membe R2 out of the dining	r (unidentified) came to take room and brought her back 0 p.m., R2 began chanting s and crying out.				
	into R2's room and R2 immediately sto resident left R2 imm again, and at 6:49 pher room to put her	er resident (unidentified) went attempted to console her, and pped calling out. After the nediately began crying out o.m. NA-E and NA-A entered to bed. No calling out was if were present in R2's room to ares.				
	survey from 6/29/15 did not participate in	ons of R2 throughout the 5 through 7/1/15 revealed R2 n any individualized activities n left alone in her room.				
		6/29/15, at 7:24 p.m. NA-E t often when in her room				
		6/29/15, at 7:26 p.m. NA-A like to be alone and generally ng out in her room.				
	stated R2 chanted	6/30/15, at 10:27 a.m. RN-A and called out and stated R2 individualized activities she				
		6/30/15, at 1:38 p.m. AS-B allotted one hour out of bed at				

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00361	B. WING		07/	01/2015	
NAME OF PROVIDER OR SUPPLIER TRUMAN SENIOR LIVING	400 NOR	DDRESS, CITY, ST TH 4TH AVENI I, MN 56088				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
in between. AS-B s cognitive, could carrattended church on Fridays. AS-B state currently being prov During further interv AS-B stated R2's ca and did not accurate status nor ability to i self-leisure pursuits. AS-B stated R2 was group activities offer but was unable to at asked or participate R2 frequently called benefited from 1:1 acurrently no 1:1 activistated there was a cogiven to her for the control throught R2 enjoyed if she had a music puring interview on stated R2 chanted resometimes redirectate to reassure her. NA devotions and trivial able to be up for lim concerns with skin but During interview on stated R2 was only back down due to sl confirmed R2 called redirectable with reaenjoyed music, how only once per week	y just went to meals and slept tated R2 was not very ry on brief conversations and Sundays and occasionally on ed no 1:1 activities were ided for R2. Yiew on 7/1/15, at 8:58 a.m. are plan had not been updated ely reflect her current activities independently direct her own, "That's my fault on that one." a casual observer in the red such as news and trivia nswer any of the questions meaningfully. AS-B stated out and chanted and attention; however, there were vities scheduled for R2. AS-B doll in R2's room that could be chanting behaviors and music, however was not sure					

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00361	B. WING		07/0	1/2015	
	PROVIDER OR SUPPLIER	400 NORT	ORESS, CITY, S TH 4TH AVEN MN 56088	STATE, ZIP CODE NUE EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21435	structured activity s received no 1:1 visis The facility's undate Residents With Cogdirected the facility programs to resident to time, place, and/oprograms to reflect needs, to enhance physical and mental cognitive health. To experienced recent escalated/compound awareness program SUGGESTED MET The activities direct and revise policies the cognitively impadesignee could edu activities programmensure activities be interests and abilitie referred to the qualiensure ongoing corrections.	he was aware of, and R2 ts. ed Activity Programs For gnitive Impairments policy to offer meaningful activity hts who display disorientation or person. Provide activity each resident's individual and promote each resident's I status, and to promote Include residents who have events which may have ided disorientation into reality is. CHOD OF CORRECTION: or or designee could review and programming related to aired. The activities director or icate staff on individualized ding, and conduct audits to ing provided reflect resident es. The audits could be ity assurance committee to	21435				
21535	Drug Usage; Gener Subpart 1. Genera must be free from u unnecessary drug is	al. A resident's drug regimen innecessary drugs. An s any drug when used: dose, including duplicate drug	21535			8/10/15	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		H 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	C. without adec D. in the preser which indicate the or discontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is incontavailable through the system and the State subject to frequent This MN Requirement by: Based on interview facility failed to ensure Reform an antipsy Findings include: R47's Diagnosis Referecord, indicated Refincluded: panic dischementia. Physician orders day was prescribed Rist twice a day (antipsy The current care plants).	quate indications for its use; or nee of adverse consequences lose should be reduced or rug regimen review required in a nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State Guidance to Surveyors for icilities, published by the lefth and Human Services, ing Administration, April 1992. orporated by reference. It is left Minitex interlibrary loan the Law Library. It is not change. The entry is not met as evidenced and document review the lare 2 of 5 residents (R47 & leftect monitoring when without medication. The export obtained in the medical large for the entry depressive disorder and large for the entry dependence of the entry	21535	Corrected		
	receiving an antipsy	ychotic medication but did not for the use of the Risperidal.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/0	1/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TRUMAN	N SENIOR LIVING		TH 4TH AVEN MN 56088	IUE EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21535	Continued From pa	ge 31	21535				
	6/22/15, identified F mg twice a day with pharmacist recomm Abnormal Involunta assessment to be or Risperidal. The phatardive dyskenesia monitored as a bas antipsychotic medicathereafter. Interview with the D 7/1/15, at 9:20 a.m. assessment for TD completed since R4 R60's diagnosis reprecord, indicated R6 included: senile de	macy consultant report dated R47 as receiving Risperidal 1 a start date of 6/15/15. The nendations included a ry Movement Scale (AIMS) completed for the use of armacist further indicated (TD) symptoms should be eline with a start of an eation and every 6 months around that a baseline symptoms should have been a receiving Risperidal.					
	R60 started receiving with a current order day. The current care play receiving an antipsy include monitoring of the Pharm 6/22/15, identified F Seroquel 75 mg twith recommendations in to be completed for pharmacist further in the start or the start of the pharmacist further in the start or the start o	rs dated 11/6/15, indicated and Seroquel (anti-psychotic) of 75 milligrams (mg) twice a an indicated R60 was an indicated R60 was acceptated and the use of the Seroquel. The macy consultant report dated R60 as currently receiving an indicated and AIMS assessment and the use of Seroquel. The indicated that TD symptoms das a baseline with the start					

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/0	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVEN , MN 56088	IUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	months thereafter. indicated that the labeen completed on re-assessed on 5/1 Interview with the D 7/1/15, at 9:30 a.m. assessment for tard should have been duse and had not be The facility was unamonitoring side effect antipsychotic medic SUGGESTED MET The director of nurs review/revise policiem monitoring of medic responsible staff an nursing could condimonitoring and refect assurance committic compliance.	The pharmacist further ast AIMS assessment had 11/14 and should have been 5. OON (director of nursing) on a confirmed that a AIMS dive dyskenesia symptoms completed after 6 months of en assessed since 11/14 able to provide a policy for ects for the use of	21535			
21610	MN Rule 4658.1340 and Preparation Are	O Subp. 1 Medicine Cabinet ea;Storage	21610			8/4/15
	must store all drugs under proper tempe	e of drugs. A nursing home is in locked compartments erature controls, and permit sing personnel to have				
	This MN Requirements	ent is not met as evidenced				

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
		00361	B. WING		07/0	1/2015
	PROVIDER OR SUPPLIER	400 NOR	DRESS, CITY, TH 4TH AVE , MN 56088	STATE, ZIP CODE NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21610			21610			
	failed to ensure only access to the keys rooms located in th	on and interview, the facility y authorized personnel had for 1 of 1 medication storage e facility. This had the ny of the 50 residents who		Corrected		
	noted that medical the medication roor MRC-A was working electronic machine room. It was noted prescription medical across from where nursing staff were working in the medication roor. It was observed on MRC-A used a key and propped open to the nurse was present the nurses station. passing medication and MRC-A was no At 8:41 a.m. MRC-A and pulled the door. During interview on registered nurse (R director of nursing all have keys to the reported the medication roor records job duties at the medication roor or medication roor records in the medication roor medication roor medication roor records in the medication roor records in the medication roor me	29 a.m. to 8:25 a.m. it was records clerk (MRC)-A was in m with the door propped open. g with medical records and an located in the medication that multiple cartridges of ations were on the counter MRC-A was working. No present while MRC-A was location room. MRC-A exited m and shut the door. 7/1/15, at 8:28 a.m. that to enter the medication room door. No in the medication room nor at Both nurses were observed s in the dining and the hallway t visible from the dining room. A exited the medical records staff medication room. RN-B all records staff need the keys from to complete medical as the machine is located in m to upload the documents medical records system.				

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		00361	B. WING		07/0	1/2015
	PROVIDER OR SUPPLIER	400 NOR	DRESS, CITY, S FH 4TH AVEN , MN 56088	STATE, ZIP CODE NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	including narcotics RN-B stated that M prescription medical there. During interview on records clerk (MRC a key to the medical machine located in resident records an electronic medical r confirmed she ente multiple times each job duties. MRC-A cartridges of prescribe counters and coand it is a level of tr working in the medimedication room dopersonal claustroph. During interview on director of nursing (herself were the on room key. The DO the MRC-A had postroom key. During interview on administrator confir possession of the none", the DON and ones that have the	ere are prescription counter accessible to MRC-A, such as Ultram and Ativan. RC-A does not bother the ations; there is an invisible line 7/1/15, at 9:20 a.m. medical characteristic and invisible line ation room as the electronic this room is used to scan documents into the record system. MRC-A resthe medication room day to complete her required reported there are multiple ription medications placed on confirmed she is not a nurse rust. MRC-A confirmed when reaction room she will prop the roor open for two reasons: robia and visibility to others. 7/1/15, at 12:06 p.m. the DON) stated the nurses and ly staff to have a medication N stated she was not aware resession of the medication 7/1/15, at 12:17 p.m. the med the MRC-A has had redication room key from "day the two nurses are the only key. ation policy was requested, but	21610			
	SUGGESTED MET	HOD OF CORRECTION:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/0	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		TH 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	The director of nurs facility policies and the medication roor authorized staff. The designee could ensurelated to policy chart TIME PERIOD FOR (21) days.	sing or designee could ensure procedures allow access to in for only appropriate ne director of nursing or ure all staff are educated anges. R CORRECTION: Twenty-one	21610			7/04/45
21943	Family Advisory Co Educational prograticouncil authorized to subdivision 27, shat about the following: or board and care in responsibilities; (3) organization and muthat apply to homes relations; and (6) remethods to increas life in a nursing home.	m. Each resident and family under section 144.651, II be educated and informed (1) care in the nursing home nome; (2) resident rights and resident and family council aintenance; (4) laws and rules and residents; (5) human esident and family self-help e quality of care and quality of ne or board and care home.	21943			7/31/15
	by: Based on interview facility failed to atte council during the principal failed to atte council during the principal failed: During an interview facility social worker active family counce worker also verified	and document review the mpt to establish a family hast calendar year. on 6/30/15, at 3:30 p.m. the r indicated there had been no attempts ablish a family council during		Corrected		

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NAME OF PROVIDER OR SUPPLIER TRUMAN SENIOR LIVING STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES DEFEN: (EACH DEFICIENCY MUST BE RECEDED BY FULL DEFICIENCY MUST BY RECEDED BY FUL	AND DUAN OF CODDECTION TO DENTIFICATION NUMBER.		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
TRUMAN SENIOR LIVING 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088 (X4) ID PROVIDER'S PLAN OF CORRECTION (00361	B. WING		07/0	1/2015
TRUMAN, MN 56088 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (NAME OF	OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	TRUMAI	IAN SENIOR LIVING			NUE EAST		
	PREFIX	X (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
this time. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21943	this time. SUGGESTED MET The administrator of individual to be respect to establish a family would need to docut council, and identify the calendar year. TIME PERIOD OF	THOD OF CORRECTION: or designee could delegate an consible for the annual attempt or council/group. That individual ament it's efforts at forming a or when the attempt occurred in				

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