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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EJK5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00361

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245346**
2.STATE VENDOR OR MEDICAID NO.
(L2) **733402000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/19/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 09/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245346	A. Building B. Wing	8/19/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **07/31/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **08/10/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/04/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/kfd	09/02/2015	03048	08/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/1/2015			

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

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245346	01 - MAIN BUILDING 01	7/30/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **07/02/2015**	ID Prefix Reg. # **NFPA 101** LSC K0154	Correction Completed **07/02/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	Correction Completed **07/02/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	09/02/2015	35482	07/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/2/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EJK5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00361

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(L1) **245346**
2.STATE VENDOR OR MEDICAID NO.
(L2) **733402000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 07/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/30/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/03/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an individualized activities program was implemented to meet the psychosocial needs of 2 of 4 residents (R2 & R37) reviewed for activities. Findings include: R37 R37's face sheet dated 6/30/15, identified current diagnoses of Alzheimer's disease and uncomplicated end-stage dementia.	F 248	It is the Facility's intent to ensure an individualized activities program is developed and implemented to meet our resident's psychosocial needs. 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).	7/31/15

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

Electronically Signed | 07/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	07/01/2015

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

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F 248	Continued From page 1 R37's admission Minimum Data Set (MDS) dated 5/11/15, revealed a self-assessment for activities of interest was not able to be completed with R37. The MDS identified that R37 enjoyed animals and snacks in the evening, was severely cognitively impaired and a Brief Interview for Mental Status (BIMS) was unable to be completed. R37's Care Area Assessment (CAA) for activities dated 6/29/15, directed the location of the information was in a 5/20/15 social services note. Review of the social services note did not address R37's activity needs nor preferences. R37's care plan dated 6/5/15, revealed R37 was to be engaged in activities to discourage behaviors such as wandering and taking other people's belongings. The care plan did not identify R37's activity interests. R37's activities assessment dated 5/4/15, identified R37 enjoyed sewing, being read to from Chicken Noodle Soup for the Soul books and liked to keep her hands busy. The assessment further identified manicures and hand massages were of interest as 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	F 248	Individualized 1:1 plan developed and implemented for R2. Participation is being monitored on Activity Participation Record (See Attachment B). All appropriate staff has been educated on the importance of individualized activity programs. Monthly audits will be completed to ensure ongoing programs of activities to meet the interests and the physical, mental, and psychosocial well-being of each resident. The Activity Director or designee will conduct audits of five random resident records per month for three months. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings.	

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F 248	Continued From page 2	F 248		

interest in the doll.

During further observation on 6/29/15, at 5:09 p.m. R37 was observed in the dining room with the doll on her lap.

During observation on 6/29/15, at 6:42 p.m. R37 was observed in the activities area of the main nursing station and had wheeled up to a table and was eating another resident's food. R37 was moved out of the area by registered nurse (RN)-A and escorted closer to the nurses station and left there. R37 proceeded to wheel about the lobby and at one point began pulling on another dependent resident's wheelchair. No 1:1 activities nor attempts to engage R37 in meaningful stimulation were observed throughout the afternoon shift on 6/29/15.

During observation on 6/30/15, at 9:46 a.m. R37 was observed in the lobby, looking out a window. No staff were in the immediate area. At 10:00, a dice shaking activity began in the activity room, however R37 did not attend. At 10:56 a.m., R37 was wheeling about the commons area with a hymnal in her lap and had taken some butter off the dining room table.

During interview on 6/30/15, at 9:57 a.m. activities staff (AS)-A indicated she and only one other person worked in her department. There had been a third staff member that retired recently and management had indicated there were no funds to hire a replacement. AS-A indicated it was difficult to get activities done and there was no one to fill in for vacations.

During interview on 6/30/15, at 10:14 a.m. RN-A indicated R37 didn't participate in activities much

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F 248	Continued From page 3 other than looking at a book and received no 1:1 activities she was aware of. During interview on 6/30/15, at 11:04 a.m. nursing assistant (NA)-D stated R37 generally was kept in the lobby when not lying down, and did not receive any 1:1 activities. NA-D further stated she did not feel the facility was meeting R37's needs as she needed a lot of attention and seemed to like tactile stimulation and to touch things with her hands. During interview on 6/30/15, at 12:52 p.m. the activities director (AS)-B indicated that R37 had identified interests of scrapbooking and liked being read to from Chicken Soup books; however, this was done in the afternoons while R37 was in bed. Massage was not available for as part of the standard activity services. AS-B further indicated no sensory activities were being provided for R37 other than she liked to look at old magazines and would rip them up. AS-B further indicated their staffing budget had recently been cut and it was "Tricky," to get 1:1 activities in. When interviewed on 7/1/15, at 12:45 p.m. the administrator indicated she felt there needed to be more activities for cognitively impaired residents and verified an activities staff member had retired recently and had not been replaced. R2 R2's significant change in condition Minimum Data Set (MDS), dated 5/6/15 revealed a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment). The MDS identified R2 exhibited vocally disruptive symptoms and indicated an interview for activities	F 248		

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F 248	Continued From page 4	F 248		

preferences was unable to be completed with R2. The staff assessment for activities interests identified R2 enjoyed pets, religious activities and that attending favorite activities were of importance to her.

R2's activities care plan dated 5/20/15, indicated R2 was independent in activities of choice with a goal of maintaining independent activity choices. The care plan indicated R2 would be given a copy of the calendar and encouraged to participate in social activities daily.

R2's behavioral care plan dated 5/20/15, indicated R2 would make noises, especially during the evening and listed interventions of diverting R2's behavior by having her participate in activities when able and to provide comfort measures for basic needs.

During observation on 6/29/15, at 5:47 p.m. R2 was noted to be sitting at the dining room table and had a calm facial affect. R2 was noted to be actively watching two other female residents and had her daughter with her visiting.

During continued observation on 6/29/15, at 6:27 p.m. a staff member (unidentified) came to take R2 out of the dining room and brought her back to her room. At 6:30 p.m., R2 began chanting unintelligible wounds and crying out.

At 6:41 p.m. another resident (unidentified) went into R2's room and attempted to console her, and R2 immediately stopped calling out. After the resident left R2 immediately began crying out again, and at 6:49 p.m. NA-E and NA-A entered her room to put her to bed. No calling out was observed when staff were present in R2's room to

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F 248	Continued From page 5 complete evening cares. Targeted observations of R2 throughout the survey from 6/29/15 through 7/1/15 revealed R2 did not participate in any individualized activities and called out when left alone in her room. During interview on 6/29/15, at 7:24 p.m. NA-E stated R2 called out often when in her room alone. During interview on 6/29/15, at 7:26 p.m. NA-A reported R2 did not like to be alone and generally did most of her calling out in her room. During interview on 6/30/15, at 10:27 a.m. RN-A stated R2 chanted and called out and stated R2 did not receive and individualized activities she was aware of. During interview on 6/30/15, at 1:38 p.m. AS-B stated R2 was only allotted one hour out of bed at a time and generally just went to meals and slept in between. AS-B stated R2 was not very cognitive, could carry on brief conversations and attended church on Sundays and occasionally on Fridays. AS-B stated no 1:1 activities were currently being provided for R2. During further interview on 7/1/15, at 8:58 a.m. AS-B stated R2's care plan had not been updated and did not accurately reflect her current activities status nor ability to independently direct her own self-leisure pursuits, "That's my fault on that one." AS-B stated R2 was a casual observer in the group activities offered such as news and trivia but was unable to answer any of the questions asked or participate meaningfully. AS-B stated R2 frequently called out and chanted and	F 248		

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F 248	Continued From page 6	F 248		

benefited from 1:1 attention; however, there were currently no 1:1 activities scheduled for R2. AS-B stated there was a doll in R2's room that could be given to her for the chanting behaviors and thought R2 enjoyed music, however was not sure if she had a music player in her room.

During interview on 6/30/15, at 1:59 p.m. NA-B stated R2 chanted repeatedly and was sometimes redirectable if staff went into her room to reassure her. NA-B stated R2 did not attend devotions and trivia consistently due to only being able to be up for limited amounts of time due to concerns with skin breakdown on her bottom.

During interview on 7/1/15, at 7:23 a.m. NA-C stated R2 was only up for meals and then laid back down due to skin concerns. NA-C confirmed R2 called out repeatedly and was redirectable with reassurance. NA-C stated R2 enjoyed music, however received music activities only once per week when in church. NA-C indicated the weekly church visit was the only structured activity she was aware of, and R2 received no 1:1 visits.

The facility's undated Activity Programs For Residents With Cognitive Impairments policy directed the facility to offer meaningful activity programs to residents who display disorientation to time, place, and/or person. Provide activity programs to reflect each resident's individual needs, to enhance and promote each resident's physical and mental status, and to promote cognitive health. To Include residents who have experienced recent events which may have escalated/compounded disorientation into reality awareness programs.

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F 274	Continued From page 7	F 274		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This 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. 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	F 274	It is the Facility's intent that the Interdisciplinary team conducts a comprehensive assessment of each resident¿s needs. The staff will continue to complete comprehensive assessments for all residents per the RAI manual. Registered Dietitian will review R25 for Pressure Ulcers and recommendations will be implemented. Registered Dietitian will review all residents with Pressure Ulcers and recommendations will be implemented. Prior to Registered Dietitians monthly visit	8/10/15

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F 274	Continued From page 8 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 reassessment, especially since the development of further pressure ulcers located on the heel and coccyx. RN-D confirmed a comprehensive reassessment had not been completed at the time of the significant change in resident condition. During a subsequent interview with RN-D on 7/01/15, at 12:13 p.m. she also confirmed that R25 had not received dietary supplements since admission. During interview on 6/30/15, at 3:19 p.m. the consultant registered dietician (RD) indicated that no one had been completing dietary assessments at the facility for about a year. Documentation obtained from the wound nurse assessments dated 6/24/15 the following: Wound #1-full thickness-Stage III pressure ulcer; 0.60 centimeters (cm) x 3.00 cm; Depth-0.2 cm; drainage consistency-serosangunious; Acquisition-facility acquired; Wound #2- right heel; injury due to trauma-full thickness-dry; 2.00 cm x 2.00 cm. Wound #3- plantar, foot Stage III; 4.50 cm x 4.00 cm; depth 0.2 cm; and moderate drainage. The most recent significant change Minimum Data Set (MDS) dated 4/15/15, indicated a Brief Interview of Mental Status (BIMS) as 15/15 which indicated intact cognition. The Activities of Daily	F 274	Certified Dietary Manager will complete a Referrals form (See Attachment J) with those who need to be seen. Copy of completed form along with any progress notes will be provided to Administrator for review. All appropriate staff will be reeducated on completion of Comprehensive assessments. Monthly audits will be completed to ensure ongoing wound care is comprehensively assessed to minimize further skin breakdown. All appropriate staff will be reeducated on completion of Care Area Assessments (CAA) for all areas that trigger on MDS. The Director of Nursing or designee will conduct chart audits for Care Area Assessments of five random resident records per month for three months. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings. The Director of Nursing or designee will conduct chart audits for wound care assessments of five random resident records per month for three months. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be	

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F 274	Continued From page 9 Living (ADLs)-required extensive assistance with bed mobility, dressing, and personal hygiene, with limited staff assistance with toileting and supervision with eating. Nutrition and Pressure Ulcer care areas were both triggered on the MDS dated 4/15/15, yet no Care Area Assessment (CAA) was completed on either area. Documentation of the CAA was not available for review.	F 274	reviewed at quarterly Quality Assurance team meetings.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		7/31/15

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F 278	Continued From page 10 material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 1 of 3 residents (R60) reviewed for nutrition and 1 of 2 residents (R20) reviewed for dressing. Findings include: R60's quarterly MDS dated 1/28/15, identified R60 as receiving a mechanical altered diet with no swallowing problems. The MDS further indicated the residents weight was 112 pounds (lb). Review of the quarterly MDS dated 4/15/15, identified R60 as receiving a mechanical altered diet with no swallowing problems. The MDS further indicated the residents weight was 97 lb and required extensive assistance with eating. The quarterly MDS dated 4/15/15, was coded as the resident not having a 5% weight loss in the past 3 months although R60 had a 15 lb weight loss between the quarterly assessment period. On 6/30/15, at 10:00 a.m. registered nurse (RN)-A reviewed the above MDS data and confirmed the quarterly MDS dated 4/15/15 had been coded inaccurately. RN-A further indicated the MDS should have been coded as a greater than 5% weight loss to reflect the residents decline in weight. R60 should have been further assessed. R20's 30-day MDS dated 1/28/15, indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) with dressing.	F 278	It is the Facility's intent to comply with Medicare and Medicaid requirements and ensure that assessments accurately reflect the resident's status. R 60 quarterly MDS dated 4/15/2015 has been resubmitted with corrections. R 20 MDS dated 1/28/2015 has been resubmitted with corrections. RN responsible for inaccurate coding of MDS no longer is employed at the facility. All appropriate staff will be reeducated on completion of MDS and appropriate coding. Director of Nursing or designated staff will conduct audits on all MDS's to ensure that a comprehensive assessment was completed and that the CAA's were completed accurately (See Attachment C). Care plans will be updated as necessary. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings.	

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F 278	Continued From page 11 R20's occupational therapy (OT) progress and discharge summary dated 1/28/15, indicated the resident had met the goal of dressing lower body from stand by assist (supervision) to independent. When interviewed on 7/01/15, at 9:30 a.m. licensed practical nurse (LPN)-A stated when completing an MDS she would review the 7-day look back period data (data obtained the 7 days prior to the completion of the MDS) related to assistance required with dressing, and also review the nursing progress notes. LPN-A reviewed R20's data related to dressing during the 7-day look-back period prior to the 1/28/15 MDS. LPN-A stated the data collected indicated R20 should have been coded as "supervision" related to functional ability with dressing. LPN-A also reviewed the nursing progress notes during the 7-day look back period and could not find documentation to support the coding of extensive assistance with dressing for R20. LPN-A confirmed R20's MDS was coded inaccurately related to dressing.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		7/31/15

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F 280	Continued From page 12 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on document review, observation and staff interview the facility failed to revise the care plan to include the updated activity interventions provided for 1 of 3 residents (R2) reviewed for activities. Findings include: R2's significant change in condition Minimum Data Set (MDS) dated 5/6/15 revealed a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment). The MDS identified R2 exhibited vocally disruptive symptoms and indicated an interview for activities preferences was unable to be completed with R2. The staff assessment for activities interests identified R2 enjoyed pets, religious activities and that attending favorite activities were of importance to her. The activities care plan dated 5/20/15, indicated R2 was independent in activities of choice with a goal of maintaining independent activity choices. The care plan indicated R2 would be given a copy of the calendar and encouraged to participate in social activities daily.	F 280	It is the Facility's intent to comply with the regulation to develop comprehensive care plans for our resident's including individualized interventions. The staff will continue to complete comprehensive care plans for all residents per the RAI manual. Care plan for R2 has been updated to reflect individual interests. Individualized 1:1 plan developed and implemented for R2 (See Attachment A). Appropriate staffs have been educated to the importance of the development of comprehensive care plans including individualized interventions and accurate documentation of effectiveness of interventions. Monthly audits will be completed to ensure comprehensive care plans are accurate and being updated as needed to meet the interests and the physical, mental, and psychosocial well-being of each resident.	

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F 280	Continued From page 13 R2's behavioral care plan dated 5/20/15, indicated R2 would make noises, especially during the evening and listed interventions of diverting R2's behavior by having her participate in activities when able and to provide comfort measures for basic needs. During observation on 6/29/15, at 5:47 p.m. R2 was noted to be sitting at the dining room table and had a calm facial affect. R2 was noted to be actively watching two other female residents and had her daughter with her visiting. Targeted observations of R2 throughout the survey from 6/29/15 through 7/1/15 revealed R2 did not participate in any individualized activities and called out when left alone in her room and was unable to self-direct her own activities. During interview on 6/30/15, at 1:38 p.m. activities staff (AS)-B, who was the activities director stated R2 was only allotted one hour out of bed at a time and generally just went to meals and slept in between. AS-B stated R2 was not very cognitive, could carry on brief conversations and attended church on Sundays and occasionally on Fridays. AS-B stated no 1:1 activities were currently being provided for R2. During further interview on 7/1/15, at 8:58 a.m. AS-B stated R2's care plan had not been updated and did not accurately reflect her current activities status or ability to independently direct her own self-leisure pursuits, "That's my fault on that one." AS-B stated R2 was a casual observer in the group activities offered such as news and trivia but was unable to answer any of the questions asked or participate meaningfully.	F 280	The Activity Director or designee will conduct audits of five random resident records per month for three months. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings.	

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure causal risk factors related to falls and that interventions were implemented to minimize the risk of future falls for 1 of 3 residents (R60) reviewed with a history of falls. Findings include: R60 was admitted to the facility on 11/6/14. Review of the residents Diagnosis Report located in the medical record indicated R 60 had diagnoses including hip fracture and replacement, dementia, anxiety disorder and a history of urinary infections. Review of the quarterly minimum data set (MDS) dated 4/15/15, identified R60 as requiring extensive assistance of one staff for bed mobility and transfers. R60 was identified as non-ambulatory and having a brief interview of mental status (BIMS) of 3/10. The MDS further identified R60 as requiring a wheelchair for mobility and also identified as experiencing falls since admission.	F 323	It is the facility's intent to provide an environment free of accident hazards and to provide supervision to residents to promote a resident safety and well-being. R 60's plan of care was reviewed and revised. Falls will be reviewed each weekday morning by Interdisciplinary Team to determine causal factors and implement interventions to assist with the prevention of further falls from occurring. Therapy will be notified of all falls by next business day for potential recommendations. The facility's Fall Prevention Protocol was reviewed and revised (See Attachment D). The facility's Resident Event Report Policy was reviewed and revised (See Attachment E). The Facility will provide education for responsible staff on the Falls Prevention Protocol along with the Resident Event Report Policy. The Director of Nursing or designee will	8/10/15

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F 323	Continued From page 15 Review the current care plan dated 2/9/15, identified R60 as requiring extensive assistance with bed mobility. R60 utilizes a mechanical stand lift to transfer into bed. The care plan further included R60 as being at risk for falling related to dementia, weakness and poor impulse control. Interventions listed included: (1) assure resident is wearing eyeglasses, (2) assure floor is free of glare and clutter, (3) bed and chair alarm, (4) verbal reminders not to self transfer/ambulate, (5) keep personal items within reach, (6) provide toileting assistance and (6) observe frequently. Review of the fall assessment dated 4/15/15, identified R60 as being disoriented, having poor vision, poor balance, impaired mobility and receives antipsychotic medication. The assessment further indicated the resident was at high risk for falls and has a history of 1-2 falls in the past 3 months. During observations on 6/30/15, at 1:40 p.m. of R60's room environment, the bed was noted to have a alarm placed on it while the resident was in bed sleeping. R60's eyeglasses and call light were in reach as well as an alarm placed on her chair. When observed on 6/30/15, at 3:00 p.m. R60 was transferred with an EZ stand and 2 assistance from staff. R60 was noted to bear only a little weight and was unsteady during the transfer observation. R60's documented falls in the past year were reviewed: (1) Fall on 11/16/14, at 10:34 a.m. R60 was found on the floor next to her bed with the bed alarm sounding. No injuries were noted. No causal factors identified nor were there any interventions implemented to prevent further falls.	F 323	audit incident reports and assessments related to falls to ensure thorough assessment for causative factors. The Director of Nursing or designee will conduct periodic audits to ensure ongoing compliance. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings.	

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(2) Fall on 11/19/14, at 8:00 p.m. R60 was found on the floor next to her wheelchair and bed. The report indicated the resident was attempting to transfer herself to bed and landed on her left shoulder. No injuries were noted. No causal factors identified nor were there any interventions implemented to prevent further falls.

(3) Fall on 12/12/14, at 6:15 p.m. R60 was found sitting on the floor with the her wheelchair alarm sounding. No injuries were noted. No causal factors identified nor were there any interventions implemented.

(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.

(5) Fall on 1/23/15, at 10:20 p.m. R60 was calling out for help when the resident was found sitting on the floor in her room barefoot with her wet brief off. R60 indicated she needed to go to the bathroom. No injuries. No causal factors identified. Peri care provided.

(6) Fall on 3/27/15, at 5:29 p.m. indicated R60 fell out of her wheelchair. No injuries were noted. No causal factors identified. No interventions.

(7) Fall on 4/17/15, at 5:10 p.m. indicated R60 was found on the floor after sliding out of her wheelchair. No injuries. No causal factors identified and no interventions implemented.

(8) Fall on 5/6/15, at 8:30 p.m. R60 was found on the floor in the hall. No injuries noted. No causal

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F 323	Continued From page 17 factors identified and no interventions. (9) Fall on 6/22/15, at 7:20 p.m. R60 was and found on the floor in the hallway. No injuries. No causal factors identified and no interventions listed. No further documentation in the medical record was found nor provided by staff related to the above documented falls. Documentation was lacking to indicate a comprehensive fall assessment had been conducted at the time of each incident related to the fall and therefore no interventions were identified to prevent and/or to minimize the future risk of fall and injury. Interventions were not evaluated to determine their effectiveness and/or the need for revision (alarms). Review of the physical/occupational therapy discharge note for R60 dated 1/2/15, indicated the resident was receiving therapy for strengthening upon admission after a recent hip fracture repair. The PT/OT note identified R60 as being limited with progression due to her cognition ability and therefore R60 was unable to meet her full goal potential. Interview with registered nurse (RN)-A on 6/30/15 at 10:14 a.m. indicated falls are discussed during their daily management meetings. RN-A further included there is no one person that is responsible for following up on falls nor investigating causal factors to implement interventions to prevent further falls from occurring. RN-A concurred there was no further information available for review to indicate a comprehensive assessment had been conducted at time of the falls reviewed.	F 323		

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F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure interventions were implemented to prevent significant weight loss for 3 of 4 residents (R31, R37 & R60) reviewed for nutritional status. Findings include: R31 R31's physician's order sheets, dated 7/1/15 revealed diagnoses of chronic kidney failure and alcoholic cirrhosis as well as an order for a regular diet. R31's significant change minimum data set (MDS) dated 2/16/15, revealed R31 was not on a planned weight loss program and required supervision and setup at meals. A care area assessment (CAA) for nutrition did not trigger and was not completed for R31. R31's care plan dated 5/2015, revealed R31 had	F 325	It is the Facility's intent to comply with the regulation to ensure that residents are able to maintain their nutritional status and body weight. R37 is no longer a resident. Registered Dietitian will review R31 & R60 for weight loss. Registered Dietitian will review potential residents at risk for weight loss. Recommendations will be implemented and responsible staff will be educated. Weights for at risk residents will be monitored weekly by Certified Dietary Manager and presented to Quality Improvement committee weekly at which time the committee will review recommendations to determine if they are appropriate or need to be adjusted.	8/10/15

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F 325	Continued From page 19 anticipated weight loss due to ascites (a collection of fluid in the abdomen associated with liver disease) and 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. R31's most current dietary progress note, completed by the dietician on 4/23/15 indicated: -Reviewed residents wts. as they are down about 10 more lbs from last month at this time and this comes up as a significant wt. change over 90 and 180 days. Please address this with resident and consider restarting NIP [an intervention involving fortifying foods to provide additional calories]. The progress notes lacked evidence the recommendation was addressed with the resident nor was implemented per recommendation. R37's medical record lacked evidence of any further dietary assessments related to nutritional status. Review of R31's dietary oral intakes for the previous four months revealed the intakes ranging from 25-50% of food and 0-100% of fluids at meals. During interview on 6/30/15, at 3:19 p.m. the consultant registered dietician (RD) indicated that no one had been completing dietary assessments at the facility for about a year. The dietician further stated she thought the administrator was completing them, and that a dietary manager from another facility was now scheduled to visit twice weekly to complete the dietary assessments. The RD indicated she was unable	F 325	Prior to Registered Dietitians monthly visit Certified Dietary Manager will complete a Referrals form (See Attachment J) with those who need to be seen. Copy of completed form along with any progress notes will be provided to Administrator for review. Administrator will review contract with Registered Dietitian and clarify facility's expectations at next visit on 7/30/15. Policy and Procedures related to weight loss and residents nutritionally at risk have been reviewed and revised (See Attachment F). The Certified Dietary Manager or designee will educate responsible staff on the policy changes as well as audit to ensure all current recommendations are being carried out within the dietary department. The Administrator or designee will conduct audits for compliance weekly. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings.	

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F 325	Continued From page 20 to complete the required work as she was only hired for one day per month for consultation. During interview on 6/30/15, at 3:17 p.m. cook-A indicated she had "No idea," what the NIP program was. When asked whether a list of residents on the NIP program was maintained, cook-A provided a resident list, last updated 6/4/14, but it did not have R31's name listed. During observation on 7/1/15, at 8:04 a.m. R31 was seated at the breakfast table eating rice krispies and wheat toast. A partially finished chocolate supplement shake was observed in front of her. At 8:15, R31 pushed herself away from the table, stating she was finished after eating 50% of her foods and drinking approximately 75% of her supplement. A nursing staff member (unidentified) was nearby and had encouraged R31 to finish the supplement. During interview on 7/1/15, at 8:22 a.m. R31 stated she had never been a "big eater". R31 indicated she was satisfied with what dietary was offering, the food was "good" but she didn't eat much. During interview on 7/1/15, at 10:51 a.m. registered nurse (RN)-D, who was R31's clinical manager indicated R31 liked to snack a long in her room and did not usually finish her supplements. RN-D stated she had received a list of dietary recommendations from the RD; however, she was told specifically by the administrator not to follow up on them as this was the dietician's job. R37 R37's admission Minimum Data Set (MDS) dated	F 325		

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5/11/15, revealed R37 required limited assistance of one staff member at meals and had no swallowing disorders. The MDS further identified R37 was severely cognitively impaired. A nutritional status care area assessment (CAA) was blank.

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.

Review of R37's meal intakes for 5/2015 revealed R37 generally ate 25-100% of lunch and 75-100% of supper and was taking in similar percentages for the fluid intake. Meal intakes for 6/15 revealed R37 was eating 50-100% for both dinner and supper and 25-100 % of her fluids.

A dietician note, dated 5/19/15 indicated that R37 was supposed to be on the NIP program.

Review of R37's most current physician's orders, dated 6/30/15 revealed a general (regular) diet order.

Review of R37's weights since her admission in 5/15 revealed a decrease from 117 lbs on admission to 110.6 lbs on 6/15/15, with a significant weight loss occurring on 5/28/15 due to a 5% weight loss within 30 days.

During observation of supper on 6/29/15, at 5:09 p.m. R37 was noted to eat all of her meal of chow mien and drank all her fluids. R37 was able to feed herself independently with encouragement.

During observation of breakfast on 6/30/15, at

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F 325	Continued From page 22 8:18 a.m. R37 was observed to eat all of her breakfast and fluids with supervision of staff. During interview on 6/30/15, at 10:14 a.m. RN-A indicated R37 generally ate well at meals. During interview on 6/30/15, at 1:43 p.m. RN-D stated R37 would eat"Everything you put in front of her," and was unsure why there had not been a supplement ordered for R37 or the NIP program started. RN-D stated the dietician handled that, she came monthly and reviewed resident weights. During interview on 6/30/15, at 3:19 p.m. the dietician indicated R37 should have been started on the NIP program effective 5/19/15, and was not able to state whether this occurred. R60 R60's physician order sheet dated 7/1/15, revealed diagnoses including dysphasia and oropharyngeal phase as well as an order for a mechanical altered diet with thickened liquids. The quarterly minimum data set (MDS), dated 4/15/15 revealed R60 was not on a planned weight loss program and required extensive assistance with eating. The MDS further identified R60 experienced a weight loss of 15 pound (lb) from the previous quarterly assessment dated 1/28/15. Review of the care plan dated 5/2715, revealed R60 had a nutritional status of requiring a mechanically altered diet related to the diagnosis of dysphasia. Review of R60's log of weights revealed a 15 lb loss from 112 to 97 lbs. between 1/15 and 4/15.	F 325		

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F 325	Continued From page 23 R60's most current dietary progress note, completed by the dietician on 3/4/15 indicated: -Reviewed resident secondary to significant weight loss of -9.8% in the past 93 days. Resident will be added to NIP [an intervention involving fortifying foods to provide 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. Review of R60's dietary intakes for the previous 3 months revealed intakes ranging from 0-100% at meals. Average daily intake of food is 25-75%. During interview on 6/30/15, at 2:00 p.m. the RD indicated a dietary assessment had not been completed for R60. The RD also indicated she provides her recommendations with the facility staff, but is unsure if they are addressed. During observations on 6/29/15 at 5:30 p.m. during the supper meal, R60 ate all of her meal with no additional fortified foods served. Observations on 6/30/15 at 7:00 a.m. during breakfast the resident ate 75% of her food independently with no additional fortified foods served. Observation on 7/1/15 at 7:00 a.m. during breakfast the resident ate all of her meal with no additional fortified foods served. During interview on 6/30/15, at 2:30 p.m. Cook-A indicated she had "No idea," what the NIP program was. When asked if the facility maintained a list of residents on the NIP program, cook-A provided a list; last updated 6/4/14 which	F 325		

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F 325	Continued From page 24 included R60. Cook-A further confirmed R60 had not received additional fortified foods for breakfast nor with lunch. During interview on 7/1/15, at 9:00 a.m. the administrator indicated the current dietary 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. The facility policy, entitled Dietitian review of Acute At Risk Residents, dated 6/3/13, revealed the ultimate goal will be to ensure each resident receives the best nutritional care possible while in the facility. The policy further stated the dietitian expectations will need to be clearly stated so that the facility and the consultant dietitian know exactly what will be expected to be accomplished. Review of the Consultant Dietitian Services Agreement dated 5/15/13, revealed the dietitian was to complete nutritional assessments, progress notes and address residents at nutritional risk as needed.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		8/10/15

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	245346	A. BUILDING _____ B. WING _____	07/01/2015

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

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F 329	Continued From page 25 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R47 & R60) received side effect monitoring when receiving an antipsychotic medication. Findings include: R47's Diagnosis Report obtained in the medical record, indicated R47 had diagnosis that included: panic disorder, depressive disorder and dementia. Physician orders dated 6/15/15, indicated R47 was prescribed Risperdal 1.0 milligrams(mg) twice a day (antipsychotic). The current care plan indicated R47 was receiving an antipsychotic medication but did not include monitoring for the use of the Risperidal.	F 329	It is the Facility's intent that all resident's receiving antipsychotic medications will get side effect monitoring. R47 & R60 Abnormal Involuntary Movement Scale (AIMS) Assessments have been completed. Director of Nursing or designee will review Pharmacy Consultant monthly reports and all recommendations will be addressed according to facility policy and procedure. The facility's 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.	

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F 329	Continued From page 26 Review of the pharmacy consultant report dated 6/22/15, identified R47 as receiving Risperidal 1 mg twice a day with a start date of 6/15/15. The pharmacist recommendations included a Abnormal Involuntary Movement Scale (AIMS) assessment to be completed for the use of Risperidal. The pharmacist further indicated tardive dyskenesia (TD) symptoms should be monitored as a baseline with a start of an antipsychotic medication and every 6 months thereafter. Interview with the DON (director of nursing) on 7/1/15, at 9:20 a.m. confirmed that a baseline assessment for TD symptoms should have been completed since R47 is receiving Risperidal. R60's diagnosis report obtained in the medical record, indicated R60 had diagnosis that included: senile dementia with delirium, agitation, depression and anxiety. The physician orders dated 11/6/15, indicated R60 started receiving Seroquel (anti-psychotic) with a current order of 75 milligrams (mg) twice a day. The current care plan indicated R60 was receiving an antipsychotic medication but did not include monitoring for the use of the Seroquel. Review of the Pharmacy consultant report dated 6/22/15, identified R60 as currently receiving Seroquel 75 mg twice a day. The pharmacist recommendations included a AIMS assessment to be completed for the use of Seroquel. The pharmacist further indicated that TD symptoms should be monitored as a baseline with the start of an antipsychotic medication and every 6	F 329	Director of Nursing or designated staff will audit Consultant Pharmacists drug review monthly and implement recommendations. Director of Nursing or designated staff will conduct audits for compliance. Results of these audits will be reviewed at monthly Quality Improvement meeting to ensure substantial compliance with applicable regulations and Facility policy has been achieved. All audit results will be reviewed at quarterly Quality Assurance team meetings.	

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F 329	Continued From page 27 months thereafter. The pharmacist further indicated that the last AIMS assessment had been completed on 11/14 and should have been re-assessed on 5/15. Interview with the DON (director of nursing) on 7/1/15, at 9:30 a.m. confirmed that a AIMS assessment for tardive dyskenesia symptoms should have been completed after 6 months of use and had not been assessed since 11/14 The facility was unable to provide a policy for monitoring side effects for the use of antipsychotic medications.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		8/4/15

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F 431	Continued From page 28 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure only authorized personnel had access to the keys for 1 of 1 medication storage rooms located in the facility. This had the potential to affect any of the 50 residents who reside in the facility. Findings include: On 7/1/15, from 8:09 a.m. to 8:25 a.m. it was noted that medical records clerk (MRC)-A was in the medication room with the door propped open. MRC-A was working with medical records and an electronic machine located in the medication room. It was noted that multiple cartridges of prescription medications were on the counter across from where MRC-A was working including boxes of both narcotic and non-narcotic prescription drugs. No nursing staff were present while MRC-A was working in the medication room. MRC-A exited the medication room and shut the door. It was observed on 7/1/15, at 8:28 a.m. that	F 431	It is the Facility's intent that all drugs and biologicals are stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility's policy and procedure related to medication storage was developed (See Attachment I). The facility will provide education for responsible staff. All medications will be stored in lock cabinets in a centralized location to ensure safe secure placement. Training was completed with medical records clerk on 7/1/2015. The facility will provide education for responsible staff on 7/28/2015. New sign with regulation posted on medication door. The facility will provide education with all new hires and annually with all staff. Only licensed staff will have access to	

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F 431	Continued From page 29 MRC-A used a key to enter the medication room and propped open the medication room door. No nurse was present in 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 all have keys to the medication room. RN-B reported the medical records staff need the keys to the medication room to complete medical records job duties as the machine is located in the medication room to upload the documents into the electronic medical records system. RN-B confirmed there are prescription medications on the counter accessible to MRC-A, including narcotics such as Ultram and Ativan. RN-B stated that MRC-A does not bother the prescription medications; there is an invisible line there. During interview on 7/1/15, at 9:20 a.m. medical records clerk (MRC)-A stated she has always had a key to the medication room as the electronic machine located in this room is used to scan resident records and documents into the electronic medical record system. MRC-A confirmed she enters the medication room multiple times each day to complete her required job duties. MRC-A reported there are multiple cartridges of prescription medications placed on the counters and confirmed she is not a nurse and it is a level of trust. MRC-A confirmed when working in the medication room she will prop the medication room door open for two reasons:	F 431	keys for the locked medication cabinets. Only appropriate authorized staff will have access to medication room. The Director of Nursing or designee will ensure all staff is educated related to policy change.	

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F 431	Continued From page 30 personal claustrophobia and visibility to others. During interview on 7/1/15, at 12:06 p.m. the director of nursing (DON) stated the nurses and herself were the only staff to have a medication room key. The DON stated she was not aware the MRC-A had possession of the medication room key. During interview on 7/1/15, at 12:17 p.m. the administrator confirmed the MRC-A has had possession of the medication room key from "day one", the DON and the two nurses are the only ones that have the key. A storage of medication policy was requested, but not made available for review.	F 431		

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	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/02/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 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:	K 000	EPOC	

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

Electronically Signed | 07/23/2015

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Truman Senior Living is a one-story building with no basement, and is fully sprinklered. The original 1970 building along with the 1975 and 1987 building additions were determined to be of Type II(000) construction. The 1996 building addition was determined to be of Type V(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by rated 2-hour fire wall assemblies, which include opening protectives consisting of factory labeled, self-closing, positive latching 90-minute fire door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 50 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 10 of 50 residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:30 PM on 07/02/2015, observation revealed the corridor door to the Laundry Room, B-50 was observed being held open by an un-approved device. This deficient practice was confirmed by the Facility Maintenance Director (CS) at the time of	K 029	It is our intent to comply with the Life Safety Code standards. Appropriate signage has been placed on the corridor door to the Laundry Room stating "Please Keep Door Closed".	7/10/15

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K 029	Continued From page 3 discovery.	K 029		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on observation and record review, the faility failed to property document when the automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service in accordance with LSC (00) 9.7.6.1. This deficient practice could affect all residents. Findings include: On facility tour between 09:00 AM and 12:30 PM on 07/02/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the	K 154	It is the intent to comply with the Life Safety Code standards. Policy and Procedure for System out of Service specific to Fire Sprinkler System has been developed and put in place (See Attachment A).	7/7/15

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K 154	Continued From page 4 Facility Maintenance Director (CS) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and record review, the faility failed to property document when the fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service in accordance with LSC (00) 9.6.1.8. This deficienct practice could affect the residents. Findings include: On facility tour between 09:00 AM and 12:30 PM on 07/02/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (CS) at the time of discovery.	K 155	It is the intent to comply with the Life Safety Code standards. Policy and Procedure for System out of Service specific to Fire Alarm System has been developed and put in place (See Attachment B).	7/7/15

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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.
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**

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;

- 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

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**

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.

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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.
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   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;
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      - 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;

- 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.

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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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00361	A. BUILDING: _____ B. WING _____	07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On June 28th, 29th, 30th and July 1st, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		8/4/15

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2 302	Continued From page 3 by: Based on interview and document review, the facility failed to ensure that consumers received information on a description of the Alzheimer's training program, the categories of employees trained, the frequency of training, and the basic topics covered at the facility. This had the potential to affect all 50 residents and any consumers who wanted to review the information. Findings include: During interview on 7/1/15, at approximately 11:00 a.m. the social worker (SW) stated no information was given to consumers about the training program for the staff related to Alzheimer's training or the frequency. During interview on 7/1/15, at 1:03 p.m. the administrator confirmed the lack of consumer education about the training. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise materials given to residents and families to include information related to Alzheimer's training for staff. The administrator or designee could ensure that all current residents and/or their responsible parties are educated about the training current staff have received related to Alzheimer's training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected	
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident	2 545		8/14/15

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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. 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 reassessment, especially since the development of further pressure ulcers located on the heel and	2 545	Corrected	

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2 545	Continued From page 5 coccyx. RN-D confirmed a comprehensive reassessment had not been completed at the time of the significant change in resident condition. During a subsequent interview with RN-D on 7/01/15, at 12:13 p.m. she also confirmed that R25 had not received dietary supplements since admission. During interview on 6/30/15, at 3:19 p.m. the consultant registered dietician (RD) indicated that no one had been completing dietary assessments at the facility for about a year. Documentation obtained from the wound nurse assessments dated 6/24/15 the following: Wound #1-full thickness-Stage III pressure ulcer; 0.60 centimeters (cm) x 3.00 cm; Depth-0.2 cm; drainage consistency-serosangunious; Acquisition-facility acquired; Wound #2- right heel; injury due to trauma-full thickness-dry; 2.00 cm x 2.00 cm. Wound #3- plantar, foot Stage III; 4.50 cm x 4.00 cm; depth 0.2 cm; and moderate drainage. The most recent significant change Minimum Data Set (MDS) dated 4/15/15, indicated a Brief Interview of Mental Status (BIMS) as 15/15 which indicated intact cognition. The Activities of Daily Living (ADLs)-required extensive assistance with bed mobility, dressing, and personal hygiene, with limited staff assistance with toileting and supervision with eating. Nutrition and Pressure Ulcer care areas were both triggered on the MDS dated 4/15/15, yet no Care Area Assessment (CAA) was completed on either area. Documentation of the CAA was not available for review. SUGGESTED METHOD OF CORRECTION: The administrator could insure the registered dietitian has time to conduct the comprehensive	2 545		

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2 545	Continued From page 6 resident assessments when a significant change in condition occurs. The director of nursing could educate the staff related to the requirements related to comprehensive reassessments. The director of nursing could develop a tool to audit resident records to ensure the appropriate assessments are completed at the time of significant change. These could be reviewed at the quarterly quality assurance meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on document review, observation and staff interview the facility failed to revise the care plan to include the updated activity interventions provided for 1 of 3 residents (R2) reviewed for activities. Findings include:	2 570	Corrected	7/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 7 R2's significant change in condition Minimum Data Set (MDS) dated 5/6/15 revealed a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment). The MDS identified R2 exhibited vocally disruptive symptoms and indicated an interview for activities preferences was unable to be completed with R2. The staff assessment for activities interests identified R2 enjoyed pets, religious activities and that attending favorite activities were of importance to her. The activities care plan dated 5/20/15, indicated R2 was independent in activities of choice with a goal of maintaining independent activity choices. The care plan indicated R2 would be given a copy of the calendar and encouraged to participate in social activities daily. R2's behavioral care plan dated 5/20/15, indicated R2 would make noises, especially during the evening and listed interventions of diverting R2's behavior by having her participate in activities when able and to provide comfort measures for basic needs. During observation on 6/29/15, at 5:47 p.m. R2 was noted to be sitting at the dining room table and had a calm facial affect. R2 was noted to be actively watching two other female residents and had her daughter with her visiting. Targeted observations of R2 throughout the survey from 6/29/15 through 7/1/15 revealed R2 did not participate in any individualized activities and called out when left alone in her room and was unable to self-direct her own activities. During interview on 6/30/15, at 1:38 p.m. activities	2 570		

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2 570	Continued From page 8 staff (AS)-B, who was the activities director stated R2 was only allotted one hour out of bed at a time and generally just went to meals and slept in between. AS-B stated R2 was not very cognitive, could carry on brief conversations and attended church on Sundays and occasionally on Fridays. AS-B stated no 1:1 activities were currently being provided for R2. During further interview on 7/1/15, at 8:58 a.m. AS-B stated R2's care plan had not been updated and did not accurately reflect her current activities status or ability to independently direct her own self-leisure pursuits, "That's my fault on that one." AS-B stated R2 was a casual observer in the group activities offered such as news and trivia but was unable to answer any of the questions asked or participate meaningfully. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		8/14/15

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2 830	Continued From page 9 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure causal risk factors related to falls and that interventions were implemented to minimize the risk of future falls for 1 of 3 residents (R60) reviewed with a history of falls. Findings include: R60 was admitted to the facility on 11/6/14. Review of the residents Diagnosis Report located in the medical record indicated R 60 had diagnoses including hip fracture and replacement, dementia, anxiety disorder and a history of urinary infections. Review of the quarterly minimum data set (MDS) dated 4/15/15, identified R60 as requiring extensive assistance of one staff for bed mobility and transfers. R60 was identified as non-ambulatory and having a brief interview of mental status (BIMS) of 3/10. The MDS further identified R60 as requiring a wheelchair for mobility and also identified as experiencing falls since admission. Review the current care plan dated 2/9/15,	2 830	Corrected	

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2 830	Continued From page 10 identified R60 as requiring extensive assistance with bed mobility. R60 utilizes a mechanical stand lift to transfer into bed. The care plan further included R60 as being at risk for falling related to dementia, weakness and poor impulse control. Interventions listed included: (1) assure resident is wearing eyeglasses, (2) assure floor is free of glare and clutter, (3) bed and chair alarm, (4) verbal reminders not to self transfer/ambulate, (5) keep personal items within reach, (6) provide toileting assistance and (6) observe frequently. Review of the fall assessment dated 4/15/15, identified R60 as being disoriented, having poor vision, poor balance, impaired mobility and receives antipsychotic medication. The assessment further indicated the resident was at high risk for falls and has a history of 1-2 falls in the past 3 months. During observations on 6/30/15, at 1:40 p.m. of R60's room environment, the bed was noted to have a alarm placed on it while the resident was in bed sleeping. R60's eyeglasses and call light were in reach as well as an alarm placed on her chair. When observed on 6/30/15, at 3:00 p.m. R60 was transferred with an EZ stand and 2 assistance from staff. R60 was noted to bear only a little weight and was unsteady during the transfer observation. R60's documented falls in the past year were reviewed: (1) Fall on 11/16/14, at 10:34 a.m. R60 was found on the floor next to her bed with the bed alarm sounding. No injuries were noted. No causal factors identified nor were there any interventions implemented to prevent further falls. (2) Fall on 11/19/14, at 8:00 p.m. R60 was found	2 830		

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2 830	Continued From page 11 on the floor next to her wheelchair and bed. The report indicated the resident was attempting to transfer herself to bed and landed on her left shoulder. No injuries were noted. No causal factors identified nor were there any interventions implemented to prevent further falls. (3) Fall on 12/12/14, at 6:15 p.m. R60 was found sitting on the floor with the her wheelchair alarm sounding. No injuries were noted. No causal factors identified nor were there any interventions implemented. (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. (5) Fall on 1/23/15, at 10:20 p.m. R60 was calling out for help when the resident was found sitting on the floor in her room barefoot with her wet brief off. R60 indicated she needed to go to the bathroom. No injuries. No causal factors identified. Peri care provided. (6) Fall on 3/27/15, at 5:29 p.m. indicated R60 fell out of her wheelchair. No injuries were noted. No causal factors identified. No interventions. (7) Fall on 4/17/15, at 5:10 p.m. indicated R60 was found on the floor after sliding out of her wheelchair. No injuries. No causal factors identified and no interventions implemented. (8) Fall on 5/6/15, at 8:30 p.m. R60 was found on the floor in the hall. No injuries noted. No causal factors identified and no interventions. (9) Fall on 6/22/15, at 7:20 p.m. R60 was and	2 830		

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2 830	Continued From page 12 found on the floor in the hallway. No injuries. No causal factors identified and no interventions listed. No further documentation in the medical record was found nor provided by staff related to the above documented falls. Documentation was lacking to indicate a comprehensive fall assessment had been conducted at the time of each incident related to the fall and therefore no interventions were identified to prevent and/or to minimize the future risk of fall and injury. Interventions were not evaluated to determine their effectiveness and/or the need for revision (alarms). Review of the physical/occupational therapy discharge note for R60 dated 1/2/15, indicated the resident was receiving therapy for strengthening upon admission after a recent hip fracture repair. The PT/OT note identified R60 as being limited with progression due to her cognition ability and therefore R60 was unable to meet her full goal potential. Interview with registered nurse (RN)-A on 6/30/15 at 10:14 a.m. indicated falls are discussed during their daily management meetings. RN-A further included there is no one person that is responsible for following up on falls nor investigating causal factors to implement interventions to prevent further falls from occurring. RN-A concurred there was no further information available for review to indicate a comprehensive assessment had been conducted at time of the falls reviewed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies related to falls prevention and	2 830		

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2 830	Continued From page 13 provide education for responsible staff. The director of nursing or designee could audit incident reports and assessments related to falls to ensure thorough assessment for causative factors. The director of nursing or designee could conduct periodic audits to ensure ongoing compliance, and review results with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure interventions were implemented to prevent significant weight loss for 3 of 4 residents (R31, R37 & R60) reviewed for nutritional status. Findings include: R31 R31's physician's order sheets, dated 7/1/15 revealed diagnoses of chronic kidney failure and alcoholic cirrhosis as well as an order for a	2 965	Corrected	8/14/15

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2 965	Continued From page 14 regular diet. R31's significant change minimum data set (MDS) dated 2/16/15, revealed R31 was not on a planned weight loss program and required supervision and setup at meals. A care area assessment (CAA) for nutrition did not trigger and was not completed for R31. R31's care plan dated 5/2015, revealed R31 had anticipated weight loss due to ascites (a collection of fluid in the abdomen associated with liver disease) and 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. R31's most current dietary progress note, completed by the dietician on 4/23/15 indicated: -Reviewed residents wts. as they are down about 10 more lbs from last month at this time and this comes up as a significant wt. change over 90 and 180 days. Please address this with resident and consider restarting NIP [an intervention involving fortifying foods to provide additional calories]. The progress notes lacked evidence the recommendation was addressed with the resident nor was implemented per recommendation. R37's medical record lacked evidence of any further dietary assessments related to nutritional status. Review of R31's dietary oral intakes for the previous four months revealed the intakes ranging from 25-50% of food and 0-100% of fluids at meals.	2 965		

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2 965	Continued From page 15 During interview on 6/30/15, at 3:19 p.m. the consultant registered dietician (RD) indicated that no one had been completing dietary assessments at the facility for about a year. The dietician further stated she thought the administrator was completing them, and that a dietary manager from another facility was now scheduled to visit twice weekly to complete the dietary assessments. The RD indicated she was unable to complete the required work as she was only hired for one day per month for consultation. During interview on 6/30/15, at 3:17 p.m. cook-A indicated she had "No idea," what the NIP program was. When asked whether a list of residents on the NIP program was maintained, cook-A provided a resident list, last updated 6/4/14, but it did not have R31's name listed. During observation on 7/1/15, at 8:04 a.m. R31 was seated at the breakfast table eating rice krispies and wheat toast. A partially finished chocolate supplement shake was observed in front of her. At 8:15, R31 pushed herself away from the table, stating she was finished after eating 50% of her foods and drinking approximately 75% of her supplement. A nursing staff member (unidentified) was nearby and had encouraged R31 to finish the supplement. During interview on 7/1/15, at 8:22 a.m. R31 stated she had never been a "big eater". R31 indicated she was satisfied with what dietary was offering, the food was "good" but she didn't eat much. During interview on 7/1/15, at 10:51 a.m. registered nurse (RN)-D, who was R31's clinical manager indicated R31 liked to snack a long in her room and did not usually finish her	2 965		

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2 965	Continued From page 16	2 965		

supplements. RN-D stated she had received a list of dietary recommendations from the RD; however, she was told specifically by the administrator not to follow up on them as this was the dietician's job.

R37
R37's admission Minimum Data Set (MDS) dated 5/11/15, revealed R37 required limited assistance of one staff member at meals and had no swallowing disorders. The MDS further identified R37 was severely cognitively impaired. A nutritional status care area assessment (CAA) was blank.

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.

Review of R37's meal intakes for 5/2015 revealed R37 generally ate 25-100% of lunch and 75-100% of supper and was taking in similar percentages for the fluid intake. Meal intakes for 6/15 revealed R37 was eating 50-100% for both dinner and supper and 25-100 % of her fluids.

A dietician note, dated 5/19/15 indicated that R37 was supposed to be on the NIP program.

Review of R37's most current physician's orders, dated 6/30/15 revealed a general (regular) diet order.

Review of R37's weights since her admission in 5/15 revealed a decrease from 117 lbs on admission to 110.6 lbs on 6/15/15, with a significant weight loss occurring on 5/28/15 due to a 5% weight loss within 30 days.

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2 965	Continued From page 17 During observation of supper on 6/29/15, at 5:09 p.m. R37 was noted to eat all of her meal of chow mien and drank all her fluids. R37 was able to feed herself independently with encouragement. During observation of breakfast on 6/30/15, at 8:18 a.m. R37 was observed to eat all of her breakfast and fluids with supervision of staff. During interview on 6/30/15, at 10:14 a.m. RN-A indicated R37 generally ate well at meals. During interview on 6/30/15, at 1:43 p.m. RN-D stated R37 would eat"Everything you put in front of her," and was unsure why there had not been a supplement ordered for R37 or the NIP program started. RN-D stated the dietician handled that, she came monthly and reviewed resident weights. During interview on 6/30/15, at 3:19 p.m. the dietician indicated R37 should have been started on the NIP program effective 5/19/15, and was not able to state whether this occurred. R60 R60's physician order sheet dated 7/1/15, revealed diagnoses including dysphasia and oropharyngeal phase as well as an order for a mechanical altered diet with thickened liquids. The quarterly minimum data set (MDS), dated 4/15/15 revealed R60 was not on a planned weight loss program and required extensive assistance with eating. The MDS further identified R60 experienced a weight loss of 15 pound (lb) from the previous quarterly assessment dated 1/28/15.	2 965		

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2 965	Continued From page 18 Review of the care plan dated 5/2715, revealed R60 had a nutritional status of requiring a mechanically altered diet related to the diagnosis of dysphasia. Review of R60's log of weights revealed a 15 lb loss from 112 to 97 lbs. between 1/15 and 4/15. R60's most current dietary progress note, completed by the dietician on 3/4/15 indicated: -Reviewed resident secondary to significant weight loss of -9.8% in the past 93 days. Resident will be added to NIP [an intervention involving fortifying foods to provide 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. Review of R60's dietary intakes for the previous 3 months revealed intakes ranging from 0-100% at meals. Average daily intake of food is 25-75%. During interview on 6/30/15, at 2:00 p.m. the RD indicated a dietary assessment had not been completed for R60. The RD also indicated she provides her recommendations with the facility staff, but is unsure if they are addressed. During observations on 6/29/15 at 5:30 p.m. during the supper meal, R60 ate all of her meal with no additional fortified foods served. Observations on 6/30/15 at 7:00 a.m. during breakfast the resident ate 75% of her food independently with no additional fortified foods served. Observation on 7/1/15 at 7:00 a.m. during breakfast the resident ate all of her meal with no additional fortified foods served.	2 965		

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2 965	Continued From page 19 During interview on 6/30/15, at 2:30 p.m. Cook-A indicated she had "No idea," what the NIP program was. When asked if the facility maintained a list of residents on the NIP program, cook-A provided a list; last updated 6/4/14 which included R60. Cook-A further confirmed R60 had not received additional fortified foods for breakfast nor with lunch. During interview on 7/1/15, at 9:00 a.m. the administrator indicated the current dietary 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. The facility policy, entitled Dietitian review of Acute At Risk Residents, dated 6/3/13, revealed the ultimate goal will be to ensure each resident receives the best nutritional care possible while in the facility. The policy further stated the dietitian expectations will need to be clearly stated so that the facility and the consultant dietitian know exactly what will be expected to be accomplished. Review of the Consultant Dietitian Services Agreement dated 5/15/13, revealed the dietitian was to complete nutritional assessments, progress notes and address residents at nutritional risk as needed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise current policies and procedures related to weight loss and residents nutritionally at risk. The administrator or designee could educate responsible staff on the policy changes as well as audit to ensure all current recommendations are	2 965		

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2 965	Continued From page 20 being carried out within the dietary department. The administrator or designee could conduct audits for compliance and review with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to perform a tuberculin skin test	21426	Corrected	7/31/15

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21426	Continued From page 21 (TST) within the required timeframe per Center for Disease Control (CDC) recommendations and per facility policy for 2 of 5 residents (R12 and R14) and failed to perform the second TST for 1 of 5 employees (NA-G) reviewed for infection control compliance. 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. R14 was admitted to the facility on 11/02/14 and the electronic medical record did not contain evidence a TST had been completed in accordance to CDC and facility policy. Review of nursing assistant (NA)-G employee file indicated a hire date of 1/29/15. The first TST was documented as being administered on 1/29/15 at 11:20 a.m. and read on 1/31/15 with a negative 0 mm reading. No second step was administered according to the documentation provided. The director of nursing (DON) was interviewed on 7/1/15, at 12:30 p.m. and confirmed documentation was lacking related to TSTs being administered to R12 and R14 in accordance with the facility and CDC policy. The DON further confirmed the employee record for NA-G lacked evidence of completion of the second step TST in accordance with facility policy and procedure and further stated she thought it had been missed. The facility policy/procedure found in the Truman Senior Living Employee Handbook last revised	21426		

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21426	Continued From page 22 2/9/15, and under section Mantoux Test: The first step must be completed and read with negative results before being scheduled on the floor where you would have direct contact with residents. The second step must be administered and read 7 to 21 days after the first step was read or the entire process must be repeated. If you can provide documentation of a negative Mantoux given within the past 12 months, the first step Mantoux requirement is satisfied, and the second step may be administered one to three weeks after the start date. The Tuberculosis Screening Policy indicated: Tuberculosis (TB) screening is performed on all residents to detect reactivation and to identify new infections. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could reeducate nursing staff to their policies for resident and employee Tuberculosis screening, and could perform audits to ensure their policies were being followed. The results of the audits could be reviewed at the quarterly quality assurance meetings to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and	21435		7/31/15

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21435	Continued From page 23 comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an individualized activities program was implemented to meet the needs of 2 of 4 residents (R2 & R37) reviewed for activities. Findings include: R37 R37's face sheet dated 6/30/15, identified current diagnoses of Alzheimer's disease and uncomplicated end-stage dementia. R37's admission Minimum Data Set (MDS) dated 5/11/15, revealed a self-assessment for activities of interest was not able to be completed with R37. The MDS identified that R37 enjoyed animals and snacks in the evening, was severely cognitively impaired and a Brief Interview for Mental Status (BIMS) was unable to be completed. R37's Care Area Assessment (CAA) for activities dated 6/29/15, directed the location of the information was in a 5/20/15 social services note. Review of the social services note did not address R37's activity needs nor preferences. R37's care plan dated 6/5/15, revealed R37 was to be engaged in activities to discourage behaviors such as wandering and taking other	21435	Corrected	

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21435	Continued From page 24 people's belongings. The care plan did not identify R37's activity interests. R37's activities assessment dated 5/4/15, identified R37 enjoyed sewing, being read to from Chicken Noodle Soup for the Soul books and liked to keep her hands busy. The assessment further identified manicures and hand massages were of interest as 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. During further observation on 6/29/15, at 5:09 p.m. R37 was observed in the dining room with the doll on her lap. During observation on 6/29/15, at 6:42 p.m. R37 was observed in the activities area of the main nursing station and had wheeled up to a table and was eating another resident's food. R37 was moved out of the area by registered nurse (RN)-A and escorted closer to the nurses station and left there. R37 proceeded to wheel about the lobby and at one point began pulling on another dependent resident's wheelchair. No 1:1 activities nor attempts to engage R37 in meaningful stimulation were observed throughout the afternoon shift on 6/29/15. During observation on 6/30/15, at 9:46 a.m. R37	21435		

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was observed in the lobby, looking out a window. No staff were in the immediate area. At 10:00, a dice shaking activity began in the activity room, however R37 did not attend. At 10:56 a.m., R37 was wheeling about the commons area with a hymnal in her lap and had taken some butter off the dining room table.

During interview on 6/30/15, at 9:57 a.m. activities staff (AS)-A indicated she and only one other person worked in her department. There had been a third staff member that retired recently and management had indicated there were no funds to hire a replacement. AS-A indicated it was difficult to get activities done and there was no one to fill in for vacations.

During interview on 6/30/15, at 10:14 a.m. RN-A indicated R37 didn't participate in activities much other than looking at a book and received no 1:1 activities she was aware of.

During interview on 6/30/15, at 11:04 a.m. nursing assistant (NA)-D stated R37 generally was kept in the lobby when not lying down, and did not receive any 1:1 activities. NA-D further stated she did not feel the facility was meeting R37's needs as she needed a lot of attention and seemed to like tactile stimulation and to touch things with her hands.

During interview on 6/30/15, at 12:52 p.m. the activities director (AS)-B indicated that R37 had identified interests of scrapbooking and liked being read to from Chicken Soup books; however, this was done in the afternoons while R37 was in bed. Massage was not available for as part of the standard activity services. AS-B further indicated no sensory activities were being provided for R37 other than she liked to look at

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21435	Continued From page 26 old magazines and would rip them up. AS-B further indicated their staffing budget had recently been cut and it was "Tricky," to get 1:1 activities in. When interviewed on 7/1/15, at 12:45 p.m. the administrator indicated she felt there needed to be more activities for cognitively impaired residents and verified an activities staff member had retired recently and had not been replaced. R2 R2's significant change in condition Minimum Data Set (MDS), dated 5/6/15 revealed a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment). The MDS identified R2 exhibited vocally disruptive symptoms and indicated an interview for activities preferences was unable to be completed with R2. The staff assessment for activities interests identified R2 enjoyed pets, religious activities and that attending favorite activities were of importance to her. R2's activities care plan dated 5/20/15, indicated R2 was independent in activities of choice with a goal of maintaining independent activity choices. The care plan indicated R2 would be given a copy of the calendar and encouraged to participate in social activities daily. R2's behavioral care plan dated 5/20/15, indicated R2 would make noises, especially during the evening and listed interventions of diverting R2's behavior by having her participate in activities when able and to provide comfort measures for basic needs. During observation on 6/29/15, at 5:47 p.m. R2	21435		

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was noted to be sitting at the dining room table and had a calm facial affect. R2 was noted to be actively watching two other female residents and had her daughter with her visiting.

During continued observation on 6/29/15, at 6:27 p.m. a staff member (unidentified) came to take R2 out of the dining room and brought her back to her room. At 6:30 p.m., R2 began chanting unintelligible wounds and crying out.

At 6:41 p.m. another resident (unidentified) went into R2's room and attempted to console her, and R2 immediately stopped calling out. After the resident left R2 immediately began crying out again, and at 6:49 p.m. NA-E and NA-A entered her room to put her to bed. No calling out was observed when staff were present in R2's room to complete evening cares.

Targeted observations of R2 throughout the survey from 6/29/15 through 7/1/15 revealed R2 did not participate in any individualized activities and called out when left alone in her room.

During interview on 6/29/15, at 7:24 p.m. NA-E stated R2 called out often when in her room alone.

During interview on 6/29/15, at 7:26 p.m. NA-A reported R2 did not like to be alone and generally did most of her calling out in her room.

During interview on 6/30/15, at 10:27 a.m. RN-A stated R2 chanted and called out and stated R2 did not receive and individualized activities she was aware of.

During interview on 6/30/15, at 1:38 p.m. AS-B stated R2 was only allotted one hour out of bed at

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a time and generally just went to meals and slept in between. AS-B stated R2 was not very cognitive, could carry on brief conversations and attended church on Sundays and occasionally on Fridays. AS-B stated no 1:1 activities were currently being provided for R2.

During further interview on 7/1/15, at 8:58 a.m. AS-B stated R2's care plan had not been updated and did not accurately reflect her current activities status nor ability to independently direct her own self-leisure pursuits, "That's my fault on that one." AS-B stated R2 was a casual observer in the group activities offered such as news and trivia but was unable to answer any of the questions asked or participate meaningfully. AS-B stated R2 frequently called out and chanted and benefited from 1:1 attention; however, there were currently no 1:1 activities scheduled for R2. AS-B stated there was a doll in R2's room that could be given to her for the chanting behaviors and thought R2 enjoyed music, however was not sure if she had a music player in her room.

During interview on 6/30/15, at 1:59 p.m. NA-B stated R2 chanted repeatedly and was sometimes redirectable if staff went into her room to reassure her. NA-B stated R2 did not attend devotions and trivia consistently due to only being able to be up for limited amounts of time due to concerns with skin breakdown on her bottom.

During interview on 7/1/15, at 7:23 a.m. NA-C stated R2 was only up for meals and then laid back down due to skin concerns. NA-C confirmed R2 called out repeatedly and was redirectable with reassurance. NA-C stated R2 enjoyed music, however received music activities only once per week when in church. NA-C indicated the weekly church visit was the only

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21435	Continued From page 29 structured activity she was aware of, and R2 received no 1:1 visits. The facility's undated Activity Programs For Residents With Cognitive Impairments policy directed the facility to offer meaningful activity programs to residents who display disorientation to time, place, and/or person. Provide activity programs to reflect each resident's individual needs, to enhance and promote each resident's physical and mental status, and to promote cognitive health. To Include residents who have experienced recent events which may have escalated/compounded disorientation into reality awareness programs. SUGGESTED METHOD OF CORRECTION: The activities director or designee could review and revise policies and programming related to the cognitively impaired. The activities director or designee could educate staff on individualized activities programming, and conduct audits to ensure activities being provided reflect resident interests and abilities. The audits could be referred to the quality assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration;	21535		8/10/15

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21535	Continued From page 30 C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R47 & R60) received side effect monitoring when receiving an antipsychotic medication. Findings include: R47's Diagnosis Report obtained in the medical record, indicated R47 had diagnosis that included: panic disorder, depressive disorder and dementia. Physician orders dated 6/15/15, indicated R47 was prescribed Risperdal 1.0 milligrams(mg) twice a day (antipsychotic). The current care plan indicated R47 was receiving an antipsychotic medication but did not include monitoring for the use of the Risperidal.	21535	Corrected	

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21535	Continued From page 31 Review of the pharmacy consultant report dated 6/22/15, identified R47 as receiving Risperidal 1 mg twice a day with a start date of 6/15/15. The pharmacist recommendations included a Abnormal Involuntary Movement Scale (AIMS) assessment to be completed for the use of Risperidal. The pharmacist further indicated tardive dyskenesia (TD) symptoms should be monitored as a baseline with a start of an antipsychotic medication and every 6 months thereafter. Interview with the DON (director of nursing) on 7/1/15, at 9:20 a.m. confirmed that a baseline assessment for TD symptoms should have been completed since R47 is receiving Risperidal. R60's diagnosis report obtained in the medical record, indicated R60 had diagnosis that included: senile dementia with delirium, agitation, depression and anxiety. The physician orders dated 11/6/15, indicated R60 started receiving Seroquel (anti-psychotic) with a current order of 75 milligrams (mg) twice a day. The current care plan indicated R60 was receiving an antipsychotic medication but did not include monitoring for the use of the Seroquel. Review of the Pharmacy consultant report dated 6/22/15, identified R60 as currently receiving Seroquel 75 mg twice a day. The pharmacist recommendations included a AIMS assessment to be completed for the use of Seroquel. The pharmacist further indicated that TD symptoms should be monitored as a baseline with the start of an antipsychotic medication and every 6	21535		

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21535	Continued From page 32 months thereafter. The pharmacist further indicated that the last AIMS assessment had been completed on 11/14 and should have been re-assessed on 5/15. Interview with the DON (director of nursing) on 7/1/15, at 9:30 a.m. confirmed that a AIMS assessment for tardive dyskenesia symptoms should have been completed after 6 months of use and had not been assessed since 11/14 The facility was unable to provide a policy for monitoring side effects for the use of antipsychotic medications. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/revise policies related to side effect monitoring of medications and ensure all responsible staff are educated. The director of nursing could conduct audits for side effect monitoring and refer results to the the quality assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by:	21610		8/4/15

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21610	Continued From page 33 Based on observation and interview, the facility failed to ensure only authorized personnel had access to the keys for 1 of 1 medication storage rooms located in the facility. This had the potential to affect any of the 50 residents who reside in the facility. Findings include: On 7/1/15, from 8:09 a.m. to 8:25 a.m. it was noted that medical records clerk (MRC)-A was in the medication room with the door propped open. MRC-A was working with medical records and an electronic machine located in the medication room. It was noted that multiple cartridges of prescription medications were on the counter across from where MRC-A was working. No nursing staff were present while MRC-A was working in the medication room. MRC-A exited the medication room and shut the door. It was observed on 7/1/15, at 8:28 a.m. that MRC-A used a key to enter the medication room and propped open the medication room door. No nurse was present in 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 all have keys to the medication room. RN-B reported the medical records staff need the keys to the medication room to complete medical records job duties as the machine is located in the medication room to upload the documents into the electronic medical records system.	21610	Corrected	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 34 RN-B confirmed there are prescription medications on the counter accessible to MRC-A, including narcotics such as Ultram and Ativan. RN-B stated that MRC-A does not bother the prescription medications; there is an invisible line there. During interview on 7/1/15, at 9:20 a.m. medical records clerk (MRC)-A stated she has always had a key to the medication room as the electronic machine located in this room is used to scan resident records and documents into the electronic medical record system. MRC-A confirmed she enters the medication room multiple times each day to complete her required job duties. MRC-A reported there are multiple cartridges of prescription medications placed on the counters and confirmed she is not a nurse and it is a level of trust. MRC-A confirmed when working in the medication room she will prop the medication room door open for two reasons: personal claustrophobia and visibility to others. During interview on 7/1/15, at 12:06 p.m. the director of nursing (DON) stated the nurses and herself were the only staff to have a medication room key. The DON stated she was not aware the MRC-A had possession of the medication room key. During interview on 7/1/15, at 12:17 p.m. the administrator confirmed the MRC-A has had possession of the medication room key from "day one", the DON and the two nurses are the only ones that have the key. A storage of medication policy was requested, but not made available for review. SUGGESTED METHOD OF CORRECTION:	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00361	A. BUILDING: _____ B. WING _____	07/01/2015

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21610	Continued From page 35 The director of nursing or designee could ensure facility policies and procedures allow access to the medication room for only appropriate authorized staff. The director of nursing or designee could ensure all staff are educated related to policy changes. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21943	MN St. Statues 144A.33 Subd. 1 Resident & Family Advisory Council Education Educational program. Each resident and family council authorized under section 144.651 , subdivision 27, shall be educated and informed about the following: (1) care in the nursing home or board and care home; (2) resident rights and responsibilities; (3) resident and family council organization and maintenance; (4) laws and rules that apply to homes and residents; (5) human relations; and (6) resident and family self-help methods to increase quality of care and quality of life in a nursing home or board and care home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to attempt to establish a family council during the past calendar year. Findings include: During an interview on 6/30/15, at 3:30 p.m. the facility social worker indicated there had been no active family council in the past year. The social worker also verified there had been no attempts by the facility to establish a family council during	21943	Corrected	7/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00361	A. BUILDING: _____ B. WING _____	07/01/2015

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21943	Continued From page 36 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		