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

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

ID: NQHK
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 **8/2/2016** (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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 8/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/01/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245346

August 16, 2016

Ms. Lorna Craig-Paulson, Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 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 June 6, 2016 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

August 17, 2016

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

RE: Project Number S5346027

Dear Ms. Craig-Paulson:

On June 29, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 7, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on April 28, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On July 6, 2016, the Minnesota Department of Health and on May 31, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 6, 2016. Based on our visit, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our standard survey, completed on April 28, 2016, effective July 6, 2016. The most serious deficiency in your facility was found to be widespread deficiencies that constitute noactual harm with potential for no more than minimal harm (Level C), whereby corrections were required

On August 2, 2016, the Minnesota Department of Health completed a second PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our second PCR, completed on August 8, 2016, as of July 22, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 22, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 29, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 28, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 28, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 28, 2016, is to be rescinded.

In our letter of June 29, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 28, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 22, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245346 Y1	A. Building B. Wing Y2	8/2/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 07/22/2016	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 8/17/2016	SIGNATURE OF SURVEYOR 03048	DATE 7/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NQHK
Facility ID: 00361

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

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

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

* Code: **A,1** (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 6/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/01/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 15, 2016

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

RE: Project Number S5346027
Dear Ms. Craig-Paulson:

On May 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 28, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 6, 2016, the Minnesota Department of Health and on May 31, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 6, 2016. Based on our visit, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our standard survey, completed on April 28, 2016, effective July 6, 2016. The deficiency not corrected is as follows:

F0356 -- S/S: C -- 483.30(e) -- Posted Nurse Staffing Information

The most serious deficiency in your facility was found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the electrically delivered attached CMS-2567.

Since this deficiency is considered to be in substantial compliance, remedies outlined in our letter to you dated May 10, 2016 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.

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
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's

informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

Electronically delivered
June 29, 2016

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

RE: Project Number S5346027

Dear Ms. Craig-Paulson:

On May 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 28, 2016. 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 May 31, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 6, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the standard survey. However, compliance with the health deficiencies issued pursuant to the April 28, 2016 standard survey has not yet been verified. This Department is imposing the following Category 1 remedy:

- State Monitoring effective July 7, 2016. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 28, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 28, 2016. They will also notify the State Medicaid Agency that they must

also deny payment for new Medicaid admissions effective July 28, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Truman Senior Living is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 28, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 October 28, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING ______ B. WING ______	R 07/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 7/6/16 to determine compliance with Federal deficiencies issued during a recertification survey exited on 4/28/16. As a result the following deficiency was determined to be not corrected- F356. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	{F 000}		
{F 356} SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	{F 356}		7/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 07/22/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING ______ B. WING ______	R 07/06/2016

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 356}	Continued From page 1 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the number of licensed and unlicensed nursing staff for each shift and the census were displayed in a location that could be visualized by the public. In addition, the nursing posting hours were not accurate for hours worked on the daily nursing hour posting. This had the potential to affect all 42 residents residing in the facility and their visitors. Findings include: During the initial tour on 7/6/16, at 8:30 a.m. it was observed that the daily posting of the nursing hours and census had not been posted and available for review. Interview with the director of nursing (DON) at this time, confirmed these findings. Review of the posted nursing hours and the actual hours worked for 7/4/16, 7/5/16 and 7/6/16 were then reviewed and found to be inaccurate for both licensed and unlicensed nursing staff hours and shifts. Inaccurate posting of the nursing hours worked were as noted: (1) Nursing hours posted vs. (versus) actual	{F 356}	It is the Facilities intent that nurses staffing data is posted in a prominent place readily accessible to residents and visitors. Nursing Hours have been posted in the commons area adjacent to the Nurses Station. (See Attachment A) All appropriate staff will be educated on the importance of posting Nursing Hours. (See Attachment B) Administrator or designee will conduct random audits for posting of Nursing Hours four times a week times 3 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. (See Attachment C) All audits will be reviewed at quarterly Quality Assurance team meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING ______ B. WING ______	R 07/06/2016

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 356}	Continued From page 2 hours worked: 48 hrs vs. 38 hrs for 7/4/16; and 48 hrs vs. 46 hrs for both 7/5/16 and 7/6/16. (2) Hours of shift posted vs. actual hours of work: On 7/4/16, NA (nursing assistant) hours (6:00 a.m.-2:30 p.m.) vs. (6:30 a.m. -12:30 p.m.) minus a (6:30 a.m.- 2:30 p.m.) shift; and On 7/5/16 and 7/6/16, NA shift hours posted (6:00 a.m.- 2:30 p.m.) vs. (6:30 a.m.- 12:30 p.m.). Further interview with the DON on 7/6/16, at 1:00 p.m. confirmed the nursing hours posting should have been current and accessible to all residents and visitors.	{F 356}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245346		7/6/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 05/23/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 06/06/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 06/06/2016
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 06/06/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 07/06/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 06/06/2016
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 (INITIALS) KS/kfd	DATE 7/15/2016	SIGNATURE OF SURVEYOR 37038	DATE 7/6/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245346 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/31/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0021	Correction Completed 05/20/2016	ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 04/27/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 6/29/2016	SIGNATURE OF SURVEYOR 35482	DATE 5/31/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/27/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NQHK
Facility ID: 00361

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 05/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/01/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/01/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 10, 2016

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

RE: Project Number S5346027

Dear Ms. Craig-Paulson:

On April 28, 2016, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: 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 June 7, 2016, 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 July 28, 2016 (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 October 28, 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, 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

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 ______	04/28/2016

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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		5/20/16

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

Electronically Signed — 05/23/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING ____ B. WING ____	04/28/2016

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 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide a timely Medicare liability and appeal rights notice of Medicare non-coverage when skilled nursing services were terminated for 1 of 3 residents (R1) reviewed for liability notice and beneficiary appeal rights. Findings include: Review of R1's Notice of Medicare Non-Coverage for Medicare and Medicaid Services (CMS) Form-10123 indicated skilled nursing services ended on 1/8/16. R1 was notified of the discontinuation of skilled nursing services on 1/7/16. Notification of discontinuation was not given at least 48 hours prior to skilled nursing services ending.	F 156	It is the Facilities intent to comply with the regulation to provide a timely Medicare liability and appeal rights notice of Medicare Non-Coverage when skilled nursing services are terminated. R1 has been discharged. All residents with Medicare eligibility have been audited & are in compliance at this time. The Administrator has educated the Medicare Clinical Team regarding protocols for non-coverage letters, reviewed Policy & Procedure with IDT (See Attachment A) on May 4, 2016.	

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F 156	Continued From page 3 Review of the progress notes dated 1/6/16, at 10:39 a.m. indicate a facsimiles was received from the physician to "OK" resident to discharge to home. Progress notes dated 1/4/16, at 2:00 p.m. noted a conference between R1, the occupational therapist and the social worker and indicated R1 was anticipating discharge on 1/9/16. During interview on 4/28/16, at 1:00 p.m. the administrator indicated she was aware the notification should have been received at least 48 hours prior to skilled nursing services ending. The "Medicare Grand Rounds/Denial Letters" policy, dated 6/3/13 indicated when a potential resident is being discharged from therapy they will be reviewed to determine date Notice of Medicare Provider Non-Coverage needs to be given.	F 156	Administrator or designee reviews all projected non-coverage cases prior to the issuance of the notices. Outcome of on-going audits shall be done weekly following Medicare meetings. Audit outcomes will be presented to the QAA Committee for review &/or recommendations.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		6/6/16

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F 279	Continued From page 4 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care for 4 of 10 residents (R48, R21, R18, R14) reviewed for activities of daily living, dental care, non-pressure related skin conditions, unnecessary medications and/or foley catheter use. Findings include: R48 had active diagnosis including blindness with absence of left eye. R48 was observed on 4/25/16, at 5:10 p.m. and on 4/27/16, at 7:16 a.m. with long dark facial hairs extending across upper lip and approximately 1 centimeter (cm) long hairs on her chin. In addition R48 was observed to be missing all teeth except for 2 on her lower gum line. Review of the the Brief Interview for Mental Status (BIMS) documented on the annual Minimum Data Set (MDS) dated 1/20/16, indicated that R48 had moderate cognitive impairment with a score of 12/15. Vision was coded as severely impaired and the activities of daily living (ADL) section of the MDS indicated R48 required extensive assistance of 1 staff for personal hygiene. Review of R48's most recent care plan dated	F 279	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident s needs that are identified in the comprehensive assessment. R48, R21, & R14 have had their care plans reviewed, revised & updated as needed. R18 expired on 5/16/16. (See Attachments B, C, & G) All staff who utilize resident care plans have been educated on the need to follow interventions as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. (See Attachment D) DON or Clinical Team designees shall audit all resident care plans initially for appropriate interactions. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS . Audit outcomes will be reported to the QAA Committee for review &/or comment. (See Attachment K)	

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F 279	Continued From page 5 3/23/16, did not include any ADL or self care deficit problems, goals, or intervention related to the management of facial hair and/or dental care. When interviewed on 4/26/16, at 2:57 p.m. nursing assistant (NA)-E stated bedtime oral cares included setting up supplies and assisting R48 to rinse mouth with mouthwash. When the Resident Care Sheet was reviewed it identified R48 as completing her own oral care. NA-E confirmed this as inaccurate. On 4/27/16, at 8:57 a.m. R48 was interviewed regarding the presence of facial hair on her upper lip and chin area. R48 reached up and touched areas on her upper lip and chin and stated she does not like to have facial hair present and stated she would like to have this shaved. On 4/28/16, at 9:20 a.m. no facial hair was noted on R48's upper lip or chin area. R48 stated she had to request staff to shave her yesterday. On 4/28/16, at 12:44 p.m. NA-C stated residents are shaved every morning with cares, including females if facial hair is visible. Further stated nursing assistants follow a Resident Care Sheet for ADL's. Upon review of Resident Care Sheet shaving was not included for R48. On 4/28/16, at 12:53 p.m. the director of nursing (DON) stated residents are checked for facial hair and shaved when they receive their baths. On 4/28/16, at 1:41 p.m. DON verified R48's care plan and Resident Care Sheet was inaccurate and did not include interventions for personal grooming related to facial hair nor dental care and should have.	F 279		

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F 279	Continued From page 6 R48 also had diagnoses of diabetes mellitus, methicillin resistant staphylococcus aureus (MRSA) unspecified site, right foot open wound and cellulitis of right lower limb. On 4/28/16, at 9:23 a.m. LPN-C was observed completing a dressing change to the open wound located on R48's right lateral foot. LPN-C donned gown and gloves for procedure stating R48 had MRSA in the wound which required contact precautions. LPN-C explained that R48 was currently on an antibiotic for infection to open wound on the right foot. Documentation in R48's record confirmed the wound culture from right foot dated 3/4/16, was positive for MRSA. Interview with the DON on 4/28/16, at 1:41 p.m. confirmed R48's care plan did not include any problems, goals, or interventions related to the right lateral foot wound. The DON verified a plan of care should have been developed to include this identified problem. R21 had diagnosis of generalized edema and unspecified edema of left lower extremity (LLE). Review of the BIMS documented on the quarterly MDS dated 2/11/16, indicated R21 was cognitively intact with a score of 13/15. R21's physician's orders as of 4/27/16 included order for Lasix (diuretic) 20 mg daily. Review of R48's most recent care plan dated 3/23/16, did not include any medication problems, goals, or interventions related to the use of a diuretic.	F 279		

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F 279	Continued From page 7	F 279		

Interview with DON on 4/28/16, at 1:12 p.m. confirmed there is no treatments or other interventions in place to monitor or document on the effects of a diuretic for R21. On 4/28/16 at 1:41 p.m. DON verified high risk medications such as Lasix should be on the care plan and monitored.

The Minimum Data Set (MDS) dated 4/7/16, identified R14 with active diagnoses including heart failure, diabetes, dementia, anxiety and depression. The MDS further identified R14 required extensive assistance with activities of daily living, transfers, mobility and requires the use of an indwelling foley catheter.

R14's care plan dated 4/7/16, did not address any interventions related to the care and treatment plan for the indwelling foley catheter. The indwelling foley catheter was initiated during a hospital stay on 3/6/16.

The MDS dated 4/6/16, for R18 identified active diagnoses including arteriosclerotic heart disease, polyarthritis, bacterial infection, muscle weakness, chronic kidney disease, long term use of anticoagulants, essential hypertension and Major depressive disorder. The MDS further identified R18 required assistance with transfers.

On 3/17/16, the admission skin assessment identified the following:
(1) 3 bruises on the forehead with swelling, measuring 5 cm (centimeters) x 3 cm bump with center scab 1 x 4 cm.;
(2) 2 bruises at eye level without any measurements;
(3) right antecubital area has a bruise

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F 279	Continued From page 8 documented 2 x 3 cm.; (4) 2 bruises on abdomen measuring 2 x 2 cm and 3 x 8 cm; (5) 2 bruises on left forearms measuring 2 x 2 cm and 1 x 1 cm. The 3/30/16, re-admission skin assessment documented further bruising on legs and left forearm measuring 3 x 1 cm and 2 x 1.5 cm.; 1 bruise on the lower left extremity measuring 2.3 x 1 cm and 14.5 cm x 2 cm. Review of the progress note dated 3/22/16, explained that R18 had fallen prior to admission at another facility. Review of the medication administration record indicated R18 receives Coumadin (anti-coagulant) daily. The care plan dated 4/7/16, did not reference/address the bruising nor the use of routine Coumadin. A care plan had not been developed to address the use and monitoring for risk of bleeding with daily Coumadin administration. When interviewed on 4/28/16, at 1:41 p.m. the DON verified the care plans should be more comprehensive and there is "a little more room for improvement."	F 279		
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	F 280		6/6/16

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F 280	Continued From page 9 comprehensive assessment; prepared 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, 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 observation, interview and document review the facility failed to revise the care plan related to the use of a window alarm for 1 of 3 residents (R30) reviewed for accidents with history of elopements. Findings include: R30's face sheet dated 4/28/16, identified current diagnoses of Parkinson's disease and delusional disorders. R30's significant change in status Minimum Data Set (MDS) dated 11/4/15, identified a risk of wandering to a dangerous place. R30's quarterly MDS assessment dated 2/4/16, identified no behaviors in last 7 days, and a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severely cognitively impaired. R30's Care Area Assessment (CAA) dated 11/6/15, identified a risk of wandering and mood	F 280	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident s needs that are identified in the comprehensive assessment and periodically review and revise the care plan as the residents changes in care occur. R30 s window alarm has been discontinued. Care plan has been updated. (See Attachment E) All residents with alarming devices have been reviewed for monitoring protocols and their care plans updated as needed. Care plan updates will be completed as changes occur but at least quarterly with MDS . All staff has been educated regarding alarm protocols on May 19, 2016. (See Attachment F)	

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F 280	Continued From page 10 and behavioral problems related to long-standing illness. R30's care plan dated 6/8/15, identified R30 was an elopement risk with a goal of no elopements from [nursing home] through the next evaluation. Approaches listed included: a window alarm and a wanderguard on the left leg. Fifteen minute safety checks were also to be completed. A social services progress note dated 11/24/15, indicated R30 had eloped from the facility through his window and had gotten three blocks from the facility. Fifteen minute safety checks were implemented for R30 and a magnetic window alarm was ordered. An elopement risk progress note dated 3/8/16, and completed by the licensed social worker (SW) indicated R30 continued to present as an elopement risk. Documentation indicated R30 repeatedly sets off alarms of secured doors, verbalizes wanting to leave and wanders. The progress note identified R30 had interventions including a wanderguard and window alarm. During interview on 4/27/16, at 7:23 a.m. R30 lifted up his pant leg to show surveyor staff a wanderguard bracelet on his left ankle but did not express any awareness of a magnetic alarm for his window. During observation of R30's room on 4/27/16, at 12:15 p.m. R30's window was observed and did not have a magnetic window alarm. The crank had been removed from the window so that it could not be opened. During interview on 4/27/16, at 12:26 p.m. the	F 280	DON or designee will initially audit all care plans and electronic medical record documentation of residents with alarming devices to assure compliance. Ongoing audits will be completed weekly X4 weeks or until 100% compliance is achieved. (See Attachment K) All audit outcomes will be reported to the QAA committee for review & comment.	

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F 280	Continued From page 11 SW indicated R30 had eloped from the facility back in November 2015 and was found by the United Parcel Service (UPS) man 3 blocks from the facility. After completion of an investigation conducted, it revealed R30 had exited from the window in his room to avoid setting off the door alarm. Subsequently, a magnetic alarm was placed on R30's window and 15 minute safety checks were implemented. The alarm remained in place at this time. In addition, a wanderguard bracelet was applied to the left leg which R30 wore at all times. The SW visualized R30's window with the surveyor at this time and confirmed the window alarm was not present. The SW stated staff should have been verifying the window alarm was in place and thought she had seen it approximately two weeks prior. During interview on 4/27/16, at 12:48 p.m. nursing assistant (NA)-D stated she had worked at the facility since last fall and could not recall R30 having an alarm on his window. During interview on 4/27/16, at 12:51 p.m. licensed practical nurse (LPN)-C indicated she was aware R30 had a window alarm at one point but was unsure when it would have been removed. During interview on 4/27/16, at 12:52 p.m. LPN-A stated staff keep close vigilance over R30's whereabouts but did not recall R30 having a window alarm. During interview on 4/27/16, at 1:23 p.m. the maintenance assistant (MA) stated R30's alarm had been off since sometime last year, and the maintenance director had removed the crank from the window mechanism so R30 could not	F 280		

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F 280	Continued From page 12 exit from the window. During interview on 4/28/16, at 1:42 p.m. the DON stated the care plan should have been revised when the window alarm was discontinued and the crank was taken off. Policies regarding the use of window alarms and care planning were requested but not provided.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure facial hair was removed to maintain personal grooming for 2 of 3 residents (R48, R14) reviewed for activities of daily living (ADL). Findings include: R48 had active diagnosis of blindness with absence of left eye. R48 was observed on 4/25/16, at 5:10 p.m. and on 4/27/16, at 7:16 a.m. with long dark facial hairs extending across upper lip and approximately 1 centimeter (cm) long hairs on her chin. Review of the the Brief Interview for Mental Status (BIMS) documented on the annual	F 312	It is the Facilities intent that residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R14 & R48 have had their facial hair removed. R14 & R48 care plans have been updated. (See Attachments B & G) All female residents have been observed and routine shaving has been provided. Staff has been educated on the need to routinely monitor & shave female residents as needed when receiving personal cares.	6/6/16

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F 312	Continued From page 13 Minimum Data Set (MDS) dated 1/20/16, indicated that R48 had moderate cognitive impairment with a score of 12/15. Vision was coded as severely impaired and the activities of daily living (ADL) section of the MDS indicated R48 required extensive assistance of staff for personal hygiene. Review of R48's most recent care plan dated 3/23/16, did not include any ADL or self care deficit problems nor intervention related to the management of facial hair. When interviewed on 4/27/16, at 8:57 a.m. regarding the facial hair evident on her upper lip and chin area, R48 reached up and touched the areas on her upper lip and chin and stated she prefers to have no facial hair and would like to have staff shave these areas. On 4/28/16, at 9:20 a.m. no facial hair was noted on R48's upper lip or chin area. R48 reported that she requested staff shave her facial hair. When interviewed on 4/28/16, at 12:44 p.m. nursing assistant (NA)-C stated residents are routinely shaved every morning with cares, including females when facial hair is visible. NA-C further stated NA's follow the Resident Care Sheet for ADL's. Upon review of the Resident Care Sheet, it was noted that shaving for R48 was not included as part of routine cares. When interviewed on 4/28/16, at 12:53 p.m. the director of nursing (DON) stated residents are checked for facial hair and shaved when they receive their baths. On 4/28/16, at 1:41 p.m. DON verified R48's care	F 312	DON or designee will do weekly observational audits of all female residents to assure adequate personal cares have been provided. All outcome audits will be submitted to the QAA Committee for review &/or comment.	

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	245346	A. BUILDING ______ B. WING ______	04/28/2016

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 312	Continued From page 14 plan and Resident Care Sheet did not include interventions for personal grooming related to facial hair and should have. The Minimum Data Set (MDS) assessment dated 4/7/16, indicated R14 required extensive assistance of staff for personal hygiene. The Brief Interview for Mental Status (BIMS) score was 5/15, indicating cognitively impaired. R14's diagnoses listed on the MDS included: dementia, heart failure, diabetes, anxiety and depression. Review of care plan dated 4/7/16, indicated R14 has fluctuating in ADL status and personal hygiene is based on how R14 feeling. Staff were to check on R14 frequently to ensure that personal hygiene is performed. When interviewed on 4/27/16, at 7:05 a.m. nursing assistant (NA)-B revealed that R14 requires total assistance with her cares. R14 will lift her arm to enter a sleeve or open her mouth, but due to her change in cognition, she is unable to follow through on simple tasks and NA-B must complete it for her. Observations were made on 4/26/15 at 1:30 p.m., on 4/27/16, at 7:05 a.m. and 4/28/16, at 1:41 p.m. which revealed R14 had facial hair present, approximately 1/4-1/2 inch above the lip and on the chin. The director of nursing (DON) was interviewed on 4/28/16, at 1:41 p.m. and verified the care plan should be revised to include removal of facial hair.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		6/6/16

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	245346	A. BUILDING ______ B. WING ______	**04/28/2016**

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F 323	Continued From page 15 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 consistently monitor and implement the use of a window alarm device for 1 of 3 residents (R30) reviewed for accidents with history of elopements. Findings include: R30's face sheet dated 4/28/16, identified current diagnoses of Parkinson's disease and delusional disorders. R30's significant change in status Minimum Data Set (MDS) dated 11/4/15, identified a risk of wandering to a dangerous place. R30's quarterly MDS assessment dated 2/4/16, identified no behaviors in last 7 days, and a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severely cognitively impaired. R30's Care Area Assessment (CAA) dated 11/6/15, identified a risk of wandering and mood and behavioral problems related to long-standing illness. R30's care plan dated 6/8/15, identified R30 was an elopement risk with a goal of no elopements	F 323	It is the facilities intent to 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. R30 s window alarm has been discontinued. Care plan has been updated. (See Attachment E) All residents with alarming devices have been reviewed for monitoring protocols and their care plans updated as needed. Care plan updates will be completed as changes occur but at least quarterly with MDS . All staff has been educated regarding alarm protocols on May 19, 2016. (See Attachment F) DON or designee will initially audit all care plans and electronic medical record documentation of residents with alarming devices to assure compliance. Ongoing audits will be completed weekly X4 weeks or until 100% compliance is achieved. (See Attachment K)	

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F 323	Continued From page 16 from [nursing home] through the next evaluation. Approaches listed included: a window alarm and a wanderguard on the left leg. Fifteen minute safety checks were also to be completed. A social services progress note dated 11/24/15, indicated R30 had eloped from the facility through his window and had gotten three blocks from the facility. Fifteen minute safety checks were implemented for R30 and a magnetic window alarm was ordered. An elopement risk progress note dated 3/8/16 and completed by the licensed social worker (SW) indicated R30 continued to present as an elopement risk. Documentation indicated R30 repeatedly sets off alarms of secured doors, verbalizes wanting to leave and wanders. The progress note identified R30 had interventions including a wanderguard and window alarm. During observation on 4/26/16, at 3:15 p.m. R30 was observed ambulating near the central nursing station with a shuffling gait. During interview on 4/27/16, at 7:23 a.m. R30 lifted up his pant leg to show surveyor staff a wanderguard bracelet on his left ankle, stating "You should tell them to throw that in a lake." R30 further expressed a desire to go out to his church in the country as well as discussed wanting to get his driver's license back. R30 did not express any awareness of an alarm being on his window. During observation on 4/27/16, at 9:15 a.m. R30 was observed ambulating down the Evergreen hallway with a slow and shuffling gait without the use of any assistive devices.	F 323	All audit outcomes will be reported to the QAA committee for review & comment.	

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	245346	A. BUILDING ______ B. WING ______	04/28/2016

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F 323	Continued From page 17 During observation of R30's room on 4/27/16, at 12:15 p.m. R30's window was observed and did not have a window alarm on it. The crank had been removed from the window so that it could not be opened. During interview on 4/27/16, at 12:26 p.m. the director of nursing (DON) indicated she was unaware of whether or not R30 needed an alarm on his window and referred the surveyor to check with social services. During interview on 4/27/16, at 12:23 p.m. the maintenance director (MD) stated he thought R30 had removed the window alarm awhile ago, perhaps several months and it had been left off the window. The MD stated he did not think any alarms were on R30's window at this time. During interview on 4/27/16, at 12:26 p.m. the SW indicated R30 had eloped from the facility back in November 2015 and was found by the United Parcel Service (UPS) man 3 blocks from the facility. After completion of an investigation conducted, it revealed R30 had exited from the window in his room to avoid setting off the door alarm. Subsequently, a magnetic alarm was placed on R30's window and 15 minute safety checks were implemented. The alarm remained in place at this time. In addition, a wanderguard bracelet was applied to the left leg which R30 wore at all times. The SW visualized R30's window with the surveyor at this time and confirmed the window alarm was not present. The SW stated staff should have been verifying the window alarm was in place and thought she had seen it approximately two weeks prior. During interview on 4/27/16, at 12:48 p.m.	F 323		

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F 323	Continued From page 18	F 323		

nursing assistant (NA)-D stated she had worked at the facility since last fall and could not recall R30 having an alarm on his window. NA-D was aware of a wanderguard bracelet placed on R30's ankle and that staff frequently had to do safety checks.

During interview on 4/27/16, at 12:51 p.m. licensed practical nurse (LPN)-C indicated she was aware R30 had a window alarm at one point but was unsure when it would have been removed.

During interview on 4/27/16, at 12:52 p.m. LPN-A stated staff keep close vigilance over R30's whereabouts and that he wore an alarm on the left ankle, but did not recall R30 having a window alarm and/or ever exiting from the window.

During interview on 4/27/16, at 1:02 p.m. the DON stated she had checked with staff and R30 had a window alarm before and she was instructing maintenance staff to place it back on the window. The DON state she was assigning someone responsible for checking this alarm daily as there had not been a system in place prior; to verify whether it was on the window and functioning.

During interview on 4/27/16, at 1:23 p.m. the maintenance assistant (MA) stated R30's alarm had been removed sometime last year, and the maintenance director had removed the crank from the window mechanism so R30 could not exit from the window.

Policies regarding the use of window alarms and resident elopement were requested, but not provided.

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure that the number of licensed and unlicensed nursing staff for each shift was displayed in a location that	F 356	It is the Facilities intent that nurses staffing data is posted in a prominent place readily accessible to residents and visitors.	5/2/16

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F 356	Continued From page 20 could be visualized by the public. This had the potential to affect all 40 residents residing in the facility and their visitors. Findings include: During observations on 4/25/16, 4/26/16 and 4/27/16 the facility nursing hour posting was not displayed in a location that could be visualized by the public. There was a white board which listed only the licensed nurses on duty for each wing and the census, but did not contain any information related to nursing assistants. During an interview on 4/27/16, at 2:25 p.m. the director of nursing (DON) indicated the complete nursing staff posting was located behind the nursing station underneath the counter face down and contained the current census and nursing licensed/unlicensed hours. The DON verified the required information was not prominently displayed stating she would "find a better way of doing it".	F 356	Nursing Hours have been posted in the commons area adjacent to the Nurses Station. (See Attachment H) Administrator has educated staff on the posting requirement. Daily, Administrator or designee shall audit posting to assure accuracy and availability of information to the public. Audit outcomes shall be submitted to the QAA committee for review &/or comment.	
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain clean and orderly rooms for 2 of 11 rooms (R18, R40) and failed to repair and/or replace broken and cracked signage located	F 465	It is the Facilities intent to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	6/6/16

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F 465	Continued From page 21 outside resident rooms for 6 of 11 rooms (E5, E6, E10, E14, E17, E19) located on the Evergreen unit. Findings: During observations on 4/25/16, at 3:38 p.m. there were ants present on floor next to R18's recliner. The floor adjacent to the recliner was sticky to touch. The bedside table which had vases, figurines and personal items stored, had a thick layer of dirt and debris on the items and the table. The window sill which had plants on it, also had a thick layer of debris and dirt on the window sill. It was noted the bathroom wall had paint peeling from the wall, approximately 15 inches horizontally in length. The television cable wall access located in the room was cracked and the switch plate was broken, allowing visualization into the wall. During additional observations on 4/26/16, at 9:05 a.m. there were black marks located on the wall near the head of bed and the paint was scraped off the wall located near the foot of the bed (lower 1/3 of wall). Observation of R40's bathroom on 4/25/16 at 7:09 p.m. revealed the base of the faucet in the bathroom had slow leaking water which caused a build-up of black and green sediment. During observations of the Evergreen unit on 4/28/16, revealed the resident name plate holders with resident pictures and names were broken, cracked and/or had large pieces of missing plastic. These six (6) broken name holders were located outside of each resident room as noted: E5, E6, E10, E14, E17, E19).	F 465	All broken and cracked signage located outside of residents rooms will be replaced. R40 & R14 rooms have been cleaned. Director of Maintenance or designee will monitor weekly during preventative maintenance checks for broken or cracked equipment and report findings to Administrator. Weekly, Administrator will do an observational walk-through the building to assure compliance. Director of Maintenance or designee will do weekly audits for cleanliness of resident rooms and common areas. Audits will be forwarded to the Administrator for review. (See Attachment J) Walk-through findings and audits will be reported to the QAA Committee for review &/or comment.	

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

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F 465	Continued From page 22 When interviewed on 4/29/16, at 4:00 p.m. the maintenance director (MD) indicated he was aware of the broken and/or cracked name holders and verified they had not been replaced. He also indicated the second maintenance employee was helping with housekeeping tasks as they had been short of staff.	F 465		

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

F5346024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING 01 - MAIN BUILDING 01 B. WING _______	04/27/2016

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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 April 27, 2016. 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: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2016

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	K 000		

<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 40 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2	K 021	It is our intent to comply with the Life Safety Code standards. Spring hinge has been installed on door on Aster Oxygen room door and all other door hold devices have been removed.	5/20/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/27/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 3 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. FINDINGS INCLUDE: On 04/27/2016, between the hours of 11:00AM and 2:00PM, observation revealed, hold open devices on the following oxygen storage rooms: A-Wing storage room and B-Wing storage room. These hold open devices are not connected to the fire alarm system to release the door upon activation of the fire alarm. This finding was verified with the chief building engineer at the time of discovery.	K 021		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1. FINDINGS INCLUDE:	K 072	It is our intent to comply with the Life Safety Code standards. Therapy device was removed. Door now opens as an exit.	4/27/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _______	**04/27/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 4 On 04/27/2016, between the hours of 11:00AM and 2:00PM, observation revealed, the south exit door in the Physical Therapy Area was observed to have a therapy training device attached to the door and upon testing the door it was determined that it could not be opened. This finding was verified with the chief building engineer at the time of discovery.	K 072		