DEPARTMENT OF HEALTH						ICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: ZO5R		
	PART I -	TO BE COMPI	TELED BA I	HE STA	TE SURVEY AGENCY	Facility ID: 00361		
1. MEDICARE/MEDICAID PROVIDE	R NO.	3. NAME AND AI (L3) TRUMAN S				4. TYPE OF ACTION: $\underline{7}$ (L8)		
(L1) 245346	0	(L4) 400 NORTH				1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 733402000	0.			L LASI	(L6) 56088	3. Termination 4. CHOW		
		(L5) TRUMAN, N	VIIN			5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF C	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey After Complaint		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Fun Survey Arter Compraint		
	/2017 ^(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11. LTC PERIOD OF CERTIFICATION	ſ	10.THE FACILITY	V IS CERTIFIED	۵S.				
From (a):		X A. In Complia			And/Or Approved Waivers Of	The Following Requirements:		
To (b):		· ·	equirements		2. Technical Personnel	6. Scope of Services Limit		
			e Based On:		3. 24 Hour RN	7. Medical Director		
		1. A	cceptable POC		4. 7-Day RN (Rural SN			
12.Total Facility Beds	50 (L18)				5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	50 (L17)		liance with Progra		-			
		Requirements	and/or Applied V	Vaivers:	* Code: A*	(L12)		
14. LTC CERTIFIED BED BREAKDO					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
50								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
17. SORVETOR SIGNATORE		Date .			10. DIME SORVET ROLLET	ATROVIL Duc.		
Kathryn Serie, Unit Supe	rvisor	1	0/06/2017		Kamala Fiske-Downing, E	inforcement Specialist 10/06/2017		
				(L19)		(L20)		
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILI	TY		IPLIANCE WITH	I CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
 Facility is Eligible to Particular 	articipate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible					5. Bour of the Above .			
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	JENT 2	4. LTC AGREEN	TENT	26. TERMINATION ACTION:	(1.20)		
						(L30)		
OF PARTICIPATION	BEGINNING	I DATE	ENDING DAT	ΓE	<u>VOLUNTARY</u> <u>00</u>			
10/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)			5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)			(L44)			00-Active		
()	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
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	(120)			(201)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	Posted 11/01/2017 Co.			
	(7.00)							
	(L32)			(L33)	DETERMINATION APPE	ROVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245346

October 9, 2017

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 August 29, 2017 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

An equal opportunity employer.

DEPARTMENT OF HEALTH

Electronically delivered October 9, 2017

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

RE: Project Number S5346028

Dear Ms. Craig-Paulson:

On August 2, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 30, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2017, effective August 29, 2017 and therefore remedies outlined in our letter to you dated August 2, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AN	D HUMA	N SERVICES		CENTERS FOR MEDICARE & MEDICAID SERVICES				
					AND TRANSMITTAL	ID: ZO5R		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00361	_	
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245346		3. NAME AND AL (L3) TRUMAN S				4. TYPE OF ACTION: <u>2(</u> L8)		
(L1) 245540 2.STATE VENDOR OR MEDICAID NO.		(L4) 400 NORTH				1. Initial 2. Recertification 2. Turning time 4. CHOW		
(L2) 733402000		(L5) TRUMAN, N			(L6) 56088	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other		
 5. EFFECTIVE DATE CHANGE OF OWNE (L9) 	ERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 07/20/20	17 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			_	
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of T	he Following Requirements:		
To (b):		Ũ	equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit		
		*			3. 24 Hour RN	7. Medical Director		
12. Total Facility Beds 5	60 (L18)	l. A	cceptable POC		4. 7-Day RN (Rural SNI	· <u> </u>		
13.Total Certified Beds 5	50 (L17)	X B. Not in Con	npliance with Prop	gram	5. Life Safety Code	9. Beds/Room		
		Requirements	and/or Applied V	Waivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
50								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	(IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
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17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Holly Kranz, HFE NE II		0	8/14/2017	(L19)	Kamala Fiske-Downing, E	nforcement Specialist 09/13/2017 (L20	0)	
PART II	- TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE ST			
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH	H CIVIL	21. 1. Statement of Finan			
1. Facility is Eligible to Participation	ate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible						· · · · · · · · · · · · · · · · · · · ·		
	(L21)							
22. ORIGINAL DATE 23. 1	LTC AGREE!	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY		
10/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburser			
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	1 <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	D. D 10		(L44)			00-Active		
()	B. Rescind Si	spension Date:	(1.45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	(L45)		30. REMARKS		_	
	27							
71	28)	03001		(L31)				
(L	.28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	Posted 09/15/2017 Co.			
(L	.32)			(L33)	DETERMINATION APPR	OVAL	-	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 2, 2017

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

RE: Project Numbers S5346028, H5346031 & H5346033

Dear Ms. Craig-Paulson:

On July 20, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the July 20, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5346031 and H5346033 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Mankato Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 201 Marshall, Minnesota 56258-2504 Email: kathryn.serie@state.mn.us Phone: (507) 476-4233 Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 29, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 29, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2018 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumalu Piske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	ES OMB NO. 0938-					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED	
		245346	B. WING			07/	20/2017	
	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH 4TH AVENUE EAST RUMAN, MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000			FO	000				
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.						
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with						
	complaint investiga the time of the stan	-						
		complaint H5346031 was mplaint was not substantiated.						
F 167 SS=C	completed. The co 483.10(g)(10)(i)(11)	complaint H5346033 was mplaint was not substantiated.) RIGHT TO SURVEY LY ACCESSIBLE	F 1	67			8/29/17	
	(g)(10) The residen	t has the right to-						
	of the facility condu	sults of the most recent survey cted by Federal or State plan of correction in effect with ty; and						
	(g)(11) The facility r	nust						
		eadily accessible to residents, s and legal representatives of						
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 08/11/2017	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 08/12/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/201 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		(X3) DATE	E SURVEY PLETED	
		245346	B. WING	i	07/2	20/2017	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	_	
TOUMAN	SENIOR LIVING			400	0 NORTH 4TH AVENUE EAST		
INUMAN	SENIOR LIVING			TR	RUMAN, MN 56088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
F 167	the facility. (ii) Have reports wit certifications, and or respecting the facil years, and any plar respect to the facilit to review upon requ (iii) Post notice of the areas of the facility accessible to the put (iv) The facility shall information about of This REQUIREMEN by: Based on observat review, the facility favailability of the la survey results. This 41 current residents wished to review th Findings include: During initial tour of a.m. a cabinet was entrance of the faci The most recent su review in the above drawer was a red b	ts of the most recent survey of th respect to any surveys, complaint investigations made ity during the 3 preceding of correction in effect with ty, available for any individual uest; and ne availability of such reports in that are prominent and ublic. If not make available identifying complainants or residents. NT is not met as evidenced tion, interview, and document ailed to post notice of st three years of State Agency a had the potential to affect all s, visitors, and staff who is information. If the facility on 7/17/17, at 8:35 observed inside the front lity with signage that indicated: invey findings are available for e drawer. Inside the cabinet inder containing the survey	F	167		with the the most cted by d any o the and and ont cate the request.	
	from the previous year dated 7/6/16. However, there were no additional surveys identified in the binder nor was there anything notifying residents, family and staff that three years of results were available upon request.				continue to be available in the cab drawer in a red binder. By 8/29/2017 all residents, family members and legal representative	inet	

Facility ID: 00361

If continuation sheet Page 2 of 52

PRINTED: 08/12/2017 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245346 B. WING 07/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN SENIOR LIVING **TRUMAN, MN 56088** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 167 Continued From page 2 F 167 When interviewed on 7/17/17, at 8:55 a.m. the notified of the posting and availability of human resources staff member (HR)-A previous 3 years of surveys. confirmed only the most current state survey results were readily available for residents, visitors By 8/29/2017 all staff will be educated and staff. HR-A further confirmed signage regarding the requirements of posting the identifying location of results and binder 3 preceding year s survey results. containing results did not identify 3 years of results were available upon request. Administrator or designee will monitor placement of survey results. Administrator or designee will audit weekly during walk through of facility to assure survey information remains in place. Audit outcomes will be presented to the QAA Committee for review &/or recommendations. 483.10(a)(1) DIGNITY AND RESPECT OF F 241 8/29/17 F 241 INDIVIDUALITY SS=D (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document It is the Facilities intent to comply with the review, the facility failed to provide toileting in a regulation to treat and care for each dignified manner for 1 of 3 residents (R3) resident in a manner and in an reviewed for dignity and to promote environment, that promotes maintenance independence for 1 of 1 resident (R59) reviewed or enhancement of his or her quality of life with restriction to remain in room while on contact recognizing each resident s individuality. precautions and to wear a wanderguard on the It is the Facilities intent to protect and leg without risk of elopement. promote the rights of the resident. Findings include: R3 s B&B Assessment Completed. Facility has purchased a Bariatric When interviewed about dignified care on Commode for R3 s room.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: ZO5R11

Facility ID: 00361

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PRINTED: 08/12/2017

		AND HUMAN SERVICES			PRINTED: 08/12/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245346	B. WING		07/20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 400 NORTH 4TH AVENUE EAST)DE
TRUMAN	SENIOR LIVING			TRUMAN, MN 56088	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 241	7/17/17, at 11:28 a. undignified when he movement (BM) an "diaper". R3's quarterly Minir assessment dated Interview for Menta indicating moderate MDS further identifi upon staff for trans always incontinent care plan last revise incontinent of bladd mobility and impaire When interviewed of nursing assistant (N incontinent of urine need to have a BM considered a check able to let staff kno product was wet. N toileted when need utilized a Hoyer lift. bathroom was not b the lift into the bath resident safely onto directed to have a B "He hates it". NA-E communicate to sta BM and indicated s her when finished s away. Initially, NA- available commode accommodate R3 a	m. R3 stated feeling it was e needed to have a bowel d was to just go in his mum Data Set (MDS) 5/16/17 included a Brief I Status (BIMS) score of 11 e cognitive impairment. The ied R3 was totally dependent fers and toilet use and was of bladder and bowel. The ed 7/10/17, indicated R3 was ler and bowel related to ed cognitive function. on 7/20/17, at 11:14 a.m. NA)-B stated R3 was always although could identify the . NA-B stated R3 was a and change and was also w when his incontinence NA-B stated R3 was not ing to have a BM because he NA-B also explained R3's big enough to accommodate room and to transfer the o the toilet; therefore R3 was BM in the brief. NA-B stated, B confirmed R3 was able aff when he needed to have a he had directed R3 to inform so staff could change him right B denied there was an	F 2	 41 R59 s Elopement Assessme completed. R3 & R59 have h plans reviewed, revised & up needed. By 8/29/2017 audits on resid for incontinence will be revier assessments will be updated care plans will be reviewed, n updated as needed. Audits of risk of elopement will be revi assessments will be updated care plans will be reviewed, n updated as needed. Policy & will be reviewed, revised & u needed. Policy & Procedure Services has been develope By 8/29/2017 all staff who ut care plans will be educated of follow interventions as outline of care and should entries/in be noted to be no longer relea report those changes immed DON or designee who will up of care at that time. Policy & on Elopement & Dignified Se review with all staff. DON or Clinical Team design conduct weekly audits of assessments/care plans to a are accurate, updated and of Thereafter, audits will continut Facilities Quality Assurance to determines substantial comp applicable regulations and Fa has been achieved. 	ad their care odated as lents at risk wed and d. Individual revised & on residents at ewed and d. Individual revised & a Procedures pdated as for Dignified d. ilizes resident on the need to ed in the plan terventions evant, to liately to the odate the plan Procedures ervices will be nees will assure they urrent. ue until the team oliance with

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
		245346	B. WING			07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				100 NORTH 4TH AVENUE EAST IRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	When interviewed of confirmed he would BM than in his brief able to tell staff whe unable to control un When interviewed of licensed practical in bathroom would no for toileting. LPN-E would need an extr unavailable to R3 a resident. LPN-B st could be toileted for clean him up. When interviewed of director of nursing of why a commode co toileting. DON stat further to understar report the results to When interviewed of stated R3 used to u a standing lift for tra the resident started no longer toileted a bathroom well enou- toilet. NA-E stated capable of sitting of large enough. NA- had one extra large another resident wa was not available fo utilized the Hoyer lift When interviewed of a standard of the top of the resident started capable of sitting of large enough. NA- had one extra large another resident wa was not available fo	on 7/20/17, at 11:24 a.m. R3 d rather sit on the toilet for a f. R3 further confirmed he was en needing to have a BM but rination since it just comes. on 7/20/17, at 11:32 a.m. nurse (LPN)-B confirmed R3's at accommodate the Hoyer lift a large commode which was is it was being used by another ated it would be better if R3 r BM's rather than having to on 7/20/17, at 12:58 p.m. the (DON) stated being unaware buldn't be used for R3 for BM ed she would investigate and the rationale and would	F	241			

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	bath bay across the confirmed the bath accommodate the b the toilet. R59's undated face of urinary tract infect R59's admission M identified a BIMS so with no behaviors a further identified R5 incontinent of bladd assistance for toilet During interview on signage was noted stating: Please che entering. NA-B sta room due to an infe and gloves were ne cares. During observation was sitting in a whe R59's right leg was ankle and a wander ankle. At this time banana's" and wou room but was not a go outside. R59 in he had a wandergu Review of the nursi 7/14/17, R59 was io (vancomycin-resista with bacteria resista vancomycin) in the	 a hall from his room. The DON bay would be able to Hoyer lift for safe transfer onto a sheet, identified a diagnosis ction. DS assessment dated 7/11/17, core of 13 (cognitively intact) and/or wandering. The MDS 59 as being occasionally der and needing extensive ting and transfers. 7/17/17, at 2:01 p.m. a on R59's private room door eck with nursing staff before ted R59 was confined to his ection in the urine and gown eeded by staff assisting with on 7/17/17, at 2:05 p.m.R59 eelchair (w/c) in his room. in a cast from upper thigh to rguard was noted on the left R59 stated he is "going Id prefer to go outside of his illowed to leave his room nor dicated he was also upset that tard attached to his left leg. and progress notes dated dentified with VRE ant enterococci, an infection 	F 2	241			

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED	
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From pa	ige 6	F 2	241			
	member (F)-A state urine but wore an ir urine. F-A further in been noted on R59 However, F-A state leave his room due F-A indicated this u meals in the dining the building. F-A fu sure why R59 had a knew that was also On 7/18/17, at 4:59 his friends at the din could join them for wasn't sure why he indicating he was u door leading outside During interview on who was sitting in h use of a disposable "just like being in a During a subsequen 11:50 a.m. R59 exp restriction to remain	p.m. R59 indicated he missed ning room table, wishing he meals. R59 also stated he had to wear a wanderguard, nable to propel himself to the e. 7/18/17, at 5:58 p.m. R59, his room eating his meal with a plate and utensils stated, it is					
	stated R59 can't lea him nuts". NA-C ir reason R59 wore a When interviewed o	7/19/17, at 12:02 p.m. NA-C ave his room and that "drives ndicated being unsure of the					

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	elopement risk and wanderguard. At 1. was indeed wearing ankle. Neither the the wanderguard at R59 should not hav immediately remove the wanderguard. On 7/20/17, at 9:45 not incontinent on h R59 wore contained On 7/20/17, at 1:33 precautions implem (Centers for Diseas guidelines for VRE, and the other reside was incontinent she tablecloths and/or of which could spread reiterated that keep was appropriate. A facility policy titled revised 8/16/12, in has the potential fo have a code alert tr ankle, wrist, or whe A facility policy titled Transmission-Base identified the facility the least restrictive individuals with pote infections.	did not require a 2:09 p.m. SS-A confirmed R59 g a wanderguard on the left SS-A nor RN-A were aware of ttached to R59 and confirmed ve this applied. RN-A ed the device after learning of a.m. NA-B stated R59 was his clothes indicating the pads d the urine. b p.m. the DON stated the hented were based on CDC se Control and Prevention) and what was best for R59 ents. DON stated since R59 e didn't want R59 touching other objects in the facility the infection. The DON bing R59 isolated in his room d Elopement/Wandering Policy dicated only a resident who r elopement/wandering will ransponder placed on their elchair. d Isolation-Categories of ed Precautions revised 1/2012, y shall make every effort to use approach to managing entially communicable	F2	241			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPLE NAME OF PROVIDER OR SUPPLIER 245346 B. WING 07/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST	1/2017
400 NORTH 4TH AVENUE EAST	<i>J/2011</i>
400 NORTH 4TH AVENUE EAST	
TRUMAN SENIOR LIVING TRUMAN, MN 56088	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 483.10(f)(1)-(3) SELF-DETERMINATION - F 242 8/ SS=D RIGHT TO MAKE CHOICES	8/29/17
 (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by; Based on observation, interview, and document review the facility failed to ensure bedtime preferences were honored for 1 of 3 residents (R3) reviewed for choices. Findings include: When interviewed on 7/17/17, at 10:50 a.m. R3 stated he liked to get to bed around 8:30 p.m. or later and one night as late as 9:00 p.m. R3 stated he like to get to bed around 8:30 p.m. or later and one night as late as 9:00 p.m. R3 stated it doesn't do any good to ask staff to got to be dearlier. R3 pointed to the wall and stated, "Like me talking to that wall; you get the same response." The quarterly Minimum Data Set (MDS) assessment dated 5/16/17, included a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The 	

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TATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	× ,	PLETED
		245346	B. WING			20/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
TRUMAN	I SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 242		ted R3 required total	F 24	By 8/29/2017 all staff wi		
dependence with transfers and	dependence with transfers and toilet use, and extensive assistance with bed mobility, personal			Resident Rights and Ind		
	lated 8/18/16, indicated it was esident to choose own 7/18/17, at 5:43 p.m. licensed N)-A set up and administered during the supper meal. The istered to R3 included: esterol lowering medication)		weekly that resident righ honored. Audits will con Facility s Quality Assur- determines substantial of applicable regulations a has been achieved.	its are being tinue until the ance team compliance with		
	When questioned to the bedtime medica responded that R3 right after supper a about that. Therefore administered with the	he rationale for R3 receiving ation at this time, LPN-A always wanted to go to bed nd is very vocal and adamant ore, the atorvastatin was he 5:00 p.m. medications.				
	following was obser - 6:51 p.m R3 was his room down the - 6:57 p.m R3's ca - 6:59 p.mnursing R3's room and info	rved: s observed propelling self into Bluebell hall. all light activated. assistant (NA)- A entered				
	 7:11 p.mR3's cal staff had returned. 7:19 p.mR3 seat room, call light rem R3 confirmed he wa - 7:21 p.mR3 prop this time. R3 gestur seated at the end or 	ted in wheelchair (w/c) in ained on; no staff returned. as waiting to get ready for bed. belled self out of room in w/c at red to surveyor who was if the hallway and requested				

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	E) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	N SENIOR LIVING				00 NORTH 4TH AVENUE EAST FRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	explaining to R3 the to facility staff, R3 s nursing desk and re slowly propelled sel hallway; the call ligh -7:27 p.mNA-F wa Bluebell hall distribu resident rooms. R3 the nurses desk. N continued to pass to located on the Blue and propelled self to entered R3's room, out of the room and distribution down th on. When finished w put the cart away at attempted to talk to about her tasks and - 7:32 p.mR3 cont w/c towards room; (35 minutes). - 7:33 p.mR3 prop his room. - 7:44 p.mR3 whe hallway and looked nurses station. R3 to down the hall; call life - 7:48 p.mNA-A at and engaged in cor approached NA-A at surveyor seated at R3's room. NA-A th turned off the call life assistance from NA cares; (50 minutes activated).	e request needed to be made stated he would go to the equest the medication. R3 If with one foot down the nt remained activated. as working at the end of the uting towels from a cart to 3 continued to make his way to IA-F walked past R3 and owels to resident rooms abell hall. R3 turned around oward his room in w/c. NA-F distributed the linens, walked d continued with linen he hall; R3's call light remained with linen distribution, NA-F nd walked past R3. R3 NA-F, who continued to go d ignored R3. tinued to slowly propel self in call light remained activated belled self in w/c and entered the down the hall towards the then propelled himself in w/c	F 2	242			

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245346 B. WING 07/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN SENIOR LIVING **TRUMAN, MN 56088** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 242 Continued From page 11 F 242 stated he preferred to get to bed between 7:00 p.m. and 7:30 p.m. R3 indicated that last night (7/19/17) staff assisted him to bed around 8:00 p.m. R3 stated, "They're set in their ways". R3 further stated it's sometimes 9:00 p.m. before he's assisted to bed. When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) confirmed it is a resident's right to go to bed per their choice. The DON stated the expectation was if a resident wanted to go to bed early it should be accommodated. The Care Providers of Minnesota Combined Federal and Minnesota State Bill of Rights dated 11/28/16, includes: The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. F 246 483.10(e)(3) REASONABLE ACCOMMODATION F 246 8/29/17 SS=D OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced bv: Based on interview and document review the It is the Facilities intent to comply with the facility failed to ensure the appropriate equipment regulation to treat each resident with was available for toileting needs for 1 of 3 dignity and respect. It is the Facilities residents (R3) reviewed for incontinence. intent to assure the residents right to reside and receive services in the facility

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245346	B. WING _		07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
RUMAN	SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 246	Continued From pa	ige 12	F 24	6		
	Findings include:			with reasonable accommod resident needs and preferer		
	stated feeling it was needed to have a b in his "diaper". R3's quarterly Minir assessment dated Interview for Menta indicating moderate MDS further identifi upon staff for trans always incontinent care plan last revise incontinent of bladd mobility and impair When interviewed of nursing assistant (N the need to have a stated R3 was not to required a Hoyer liff big enough to acco	on 7/17/17, at 11:28 a.m. R3 s undignified that when he sowel movement was to just go mum Data Set (MDS) 5/16/17 included a Brief I Status (BIMS) score of 11 e cognitive impairment. The ied R3 was totally dependent fers and toilet use and was of bladder and bowel. The ed 7/10/17, indicated R3 was der and bowel related to ed cognitive function. on 7/20/17, at 11:14 a.m. NA)-B stated R3 could identify bowel movement (BM). NA-B toileted for a BM because he t and R3's bathroom was not mmodate the lift and safe ilet; therefore, R3 was directed		 R3 s B&B Assessment Con Facility has purchased a Ba Commode for R3 s room. R3 s care plan has been re- revised & updated as needed By 8/29/2017 audits on resid for incontinence will be revise assessments will be update care plans will be revised, updated as needed. Policy & will be reviewed, revised & u needed. Policy & Procedure Services has been developed By 8/29/2017 all staff who u care plans will be educated follow interventions as outlir of care and should entries/ir be noted to be no longer rel report those changes imme DON or designee who will u 	riatric eviewed, ed. dents at risk ewed and d. Individual revised & & Procedures updated as for Dignified ed. tilizes resident on the need to need in the plan neterventions evant, to diately to the	
	to have a BM in the it". NA-B confirmed for a bowel movem there was an availa accommodate R3 a commode was availanother resident. When interviewed of confirmed he would BM than in his brief able to tell staff who	brief. NA-B stated, "He hates d R3 communicated the need ent. Initially, NA-B denied able commode large enough to and then remembered a larger ilable but currently utilized by on 7/20/17, at 11:24 a.m. R3 d rather sit on the toilet for a f. R3 further confirmed he was en needing to have a BM.		of care at that time. Policy & Dignified Services will be re staff. DON or Clinical Team desig all resident care plans initial appropriate interactions. Th plans shall be reviewed as r resident changes but at leas with all MDS . Audit outcom reported to the QAA Commi &/or comment.	A Procedure on view with all nees will audit ly for ereafter, care needed with st quarterly nes will be	

Facility ID: 00361

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246 F 278 SS=D	bathroom would no for toileting. LPN-B extra large common R3 as was being ut LPN-B stated it would toileted for BM's rate up. When interviewed of director of nursing (why a commode con- toileting. When interviewed of stated R3 used to be able to use the star confirmed once the Hoyer lift he was no not fit in R3's bathroot transfer onto the too would be capable of had one large enou- facility did have one since another resid available to R3. NA the Hoyer lift for at 1 When interviewed of BM's in the bath ba room. DON confirm able to accommoda transfer onto the toi 483.20(g)-(j) ASSE ACCURACY/COOF	urse (LPN)-B confirmed R3's t accommodate the Hoyer lift of urther stated R3 required and de which was unavailable to ilized by another resident. Juld be better if R3 could be ther than having to clean him on 7/20/17, at 12:58 p.m. the DON) stated being unaware outdn't be used for R3 for BM on 7/20/17, at 1:26 p.m. NA-E be toileted on the toilet when hading lift for transfers. NA-E resident started utilizing the olonger toileted as the lift did bom well enough to safely let. NA-E stated feeling R3 f sitting on a commode if they gh. NA-E further stated the e extra large commode but ent was utilizing was not A-E confirmed R3 had utilized least 2 years. on 7/20/17, at 2:25 p.m. the lid be able to be toileted for y across the hall from his ned the bath bay would be ate the Hoyer lift for safe liet. SSMENT RDINATION/CERTIFIED	F 2				8/29/17
	DON stated R3 wor BM's in the bath ba room. DON confirm able to accommoda transfer onto the toi 483.20(g)-(j) ASSE ACCURACY/COOF	uld be able to be toileted for y across the hall from his ned the bath bay would be ate the Hoyer lift for safe let. SSMENT	F 2	78			8/29/17

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	must accurately ref (h) Coordination A registered nurse i each assessment v participation of hea (i) Certification (1) A registered nur the assessment is of (2) Each individual assessment must s that portion of the a (j) Penalty for Falsif (1) Under Medicare who willfully and kn (i) Certifies a mater resident assessment penalty of not more assessment; or (ii) Causes another and false statemen subject to a civil mo \$5,000 for each ass (2) Clinical disagree material and false s This REQUIREMEN by: Based on observat review, the facility f Minimum Data Set residents (R24) rev	lect the resident's status. must conduct or coordinate with the appropriate Ith professionals. rse must sign and certify that completed. who completes a portion of the sign and certify the accuracy of assessment. fication and Medicaid, an individual owingly- rial and false statement in a nt is subject to a civil money a than \$1,000 for each individual to certify a material t in a resident assessment is oney penalty or not more than sessment. ement does not constitute a	F 2	278	It is the Facilities intent to comply v regulation to assure the accuracy o assessments that reflect the reside status.	f	

Facility ID: 00361

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	-	AND HUMAN SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245346	B. WING _		07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
TRUMAN	SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 278	reviewed with a col (R8) reviewed with venous stasis ulcer (R27) reviewed for Findings include: During observation R24 watching TV ir assistance (NA)-F R24 was noted to r attached to a drain colostomy bag. Interview with NA-F confirmed R24 had as a colostomy in p years. Review of the curre Set (MDS) assess R24 as requiring 1 and R24 had no bo program. R24's bla coded due to the us output for 7 days. F not coded due to the us output for 7 days. F not coded due to the Diagnosis included history of colon car Review of the curre as having a suprap neurogenic bladder Interventions included	ostomy, for 1 of 1 resident pressure ulcers who had rations and for 1 of 2 residents oral and dental services. on 7/19/17, at 11:03 a.m., his room when nursing re-positioned R24 in his chair. have a suprapubic catheter age bag as well as a F on 7/19/17, at 11:22 a.m. I a supra pubic catheter as well blace for at least a couple of ent quarterly Minimum Data ment dated 7/11/17, identified staff assistance with toileting bwel or bladder toileting dder continence was not se of a catheter and no urine R24's bowel continence was ne use of an ostomy and did novement for 7 days. The MDS 24 did not utilize any powel or the bladder. : neurogenic bladder and	F 27	 R24 s MDS has been modifies submitted. R8 s has had a net completed and submitted. R27 an Oral Assessment complete MDS has been reviewed, reviss submitted to CMS. By 8/29/2017, all appropriate s re-educated on completion of comprehensive assessments. audits will be completed on all ensure that a comprehensive as was completed accurately. The Director of Nursing or des conduct audits for accuracy of five random resident records p for three months. Thereafter, a continue until Facilities Quality Team determines substantial owith applicable regulations and policies has been achieved. 	ew MDS 7 has had d. R27 s sed and staff will be Bi-monthly MDSs to assessment ignee will MDS on ber month audits will Assurance compliance	

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST FRUMAN, MN 56088		
				-			() (=)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 16	F2	278			
	· · ·	dered, irrigate daily, provide		-			
		shift and cover collection bag.					
		identified R24 as having a					
		o a history of rectal cancer.					
		led: provide ostomy care after					
	wafer weekly and a	nent and change colostomy s needed.					
	Intonviow with the M	linimum Data Sat (MDS)					
		/linimum Data Set (MDS) //17, at 8:25 a.m. confirmed					
		y MDS dated 7/11/17, had not					
		tely to reflect R24's supra					
		ostomy use. The MDS					
		indicated she was unsure of					
	how long the reside	ent had these appliances but					
	did confirm it had b	een at least a year.					
	R8's face sheet, un	dated indicated current					
		venous insufficiency of the					
	right lower leg and	diabetes mellitus, type 2.					
		inge in status Minimum Data					
		nent dated 4/27/17, identified					
		aled pressure ulcers at section					
		lentified in section M0300 of					
		two stage two pressure ulcers					
		S assessment as a partial					
		ermis presenting as a shallow					
		ed or pink wound bed, without three pressure ulcers (defined					
	as a full thickness t						
		slough may be present) and					
		ined as full thickness tissue					
		pone, tendon or muscle,					
		ay be present) at the time of					
		nge in status assessment. In					
		ndicated two pressure ulcers					
	were present which	were unstageable due to					
	coverage of the wo	und bed by slough and/or					

		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245346	B. WING			07/	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	N SENIOR LIVING				400 NORTH 4TH AVENUE EAST FRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	eschar. Additionally M1030 as having nuclerations present R8's care area asse dated 4/27/17 ident present, proceed to pressure off ulcer a breaking down furth information was list diagnoses listing, p orders and care pla R8's care plan for p last revised on 3/23 pressure ulcers, rel perfusion related to and venous leg ulce problem, dated 6/18 identified R8 as hav related to periphera approach was listed stockings to help w wound issues on th A physician progress identified R8 as hav venous insufficience progress note furthe chronic nonhealing progressive and ch The note did not ide During interview on MDS coordinator st wounds "were press they were on the out that were pressure	y, R8 was identified at section ine venous and arterial essment for pressure ulcers, ified pressure ulcers were o care plan, attempt to keep treas and keep him from her. Location and date of the red as the progress notes, rimary care provider reviews, an. oressure ulcers, dated 8/10/15, 8/17 identified a problem of lated to ineffective tissue o peripheral vascular disease er. A secondary care plan 5/15, last revised on 3/23/17 ving impaired skin integrity al vascular disease. An d as R8 wearing compression ith venous stasis and multiple	F2	278			

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245346	B. WING	i		07/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				100 NORTH 4TH AVENUE EAST IRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	on the toes were pr some also. During interview on medical doctor (MD were vascular in na Skin assessments f period were reques The Resident Asses manual, Version 1.7 the instructions for purposes of coding being assessed is p and that other cond pressure is not the here." Additionally, indicate "Residents can have a pressur neuropathic ulcer. T considered when co an ulcer that is caus factors." R27's annual Minim 11/23/16 did not ide teeth, no care area R27's care plan, da 5/31/17, identified p oral assessments. mouth pain. Offer co only has a few brok her bottom teeth co worn down to the g During observation	Tobably circulatory and coded 7/25/17, at 12:35 p.m., D)-A confirmed R8's wounds ature and not due to pressure. for the previous six month ated, none were provided. ssment Instrument (RAI) 14, dated 10/16 indicates at section M0300A: "For the , determine that the lesion primarily related to pressure litions have been ruled out. If primary cause, do not code the RAI coding tips at M0210 with diabetes mellitus (DM) re, venous, arterial, or diabetic The primary etiology should be oding whether the diabetic has sed by pressure or other hum Data Set (MDS), dated entify any broken or damaged assessment was triggered assessment was triggered assessment was triggered assessment of no tooth or dental appt quarterly, FYI: ten teeth on her top half and onsist of teeth that have been	F	278			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	denied having any of dental issues. During interview on MDS Coordinator si broken teeth at the 11/16; however, have were already on the problem. Oral assessments ff 11/23/16 MDS were provided. The facility policy, ef 6/3/13 indicated a p assessments that a regulations to reflect residents including evaluation of their fit sources. The RAI Manual, Ve indicated "Check LC tooth fragment(s) (effective of the section to the section of the section of the section to the section of the section of the section of the section the section of the section of the section of the section the section of the section o	ont portion of her mouth. R27 concerns with mouth pain or 7/19/17, at 1:51 p.m. the tated she was aware R27 had time of the assessment in id not coded them as they e care plan and not a new for the lookback period of the e requested, none were initiled MDS Accuracy, dated purpose of having accurate re completed as mandated by et the acuity level of our diagnosis, treatments and an unctional status using facility ersion 1.14, dated 10/16 0200B, no natural teeth or edentulous): if the resident is all natural teeth or parts of	F 2				
F 279 SS=D	COMPRÉHENSIVE 483.20 (d) Use. A facility m assessments comp months in the residu results of the asses		F 2	19			8/29/17

Facility ID: 00361

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ige 20	F 2	279			
	comprehensive per- each resident, consistent resident, consistent of the second prehensive assistent of the second prehensive assistence and psychosocial metal or maintain the resident of the second physical, mental, arrequired under §483.24, §48 provided due to the under §483.10, incluse the teatment under §483.10, incluse the second of the part o	At develop and implement a rson-centered care plan for sistent with the resident rights O(c)(2) and §483.10(c)(3), that le objectives and timeframes is medical, nursing, and mental needs that are identified in the sessment. The comprehensive for the following - at are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not a resident's exercise of rights huding the right to refuse .83.10(c)(6). I services or specialized ces the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its ident's medical record. with the resident and the					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 08/12/2017 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245346	B. WING			07/20/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From pa	ge 21	F 2	279		
	future discharge. Fa whether the resider community was assilocal contact agence entities, for this purp (C) Discharge plans plan, as appropriate requirements set fo section. This REQUIREMEN by: Based on observat review, the facility fa was developed relat medications (antide 2 of 5 residents (R3 unnecessary medice Findings include: R32's face sheet, d diagnoses of demendisturbance and Ma R32's quarterly Min assessment dated a Interview for Mental indicative of severe mood section identiti depressed 7-11 day Personal Health Qu 2, indicative of mini	s in the comprehensive care e, in accordance with the rth in paragraph (c) of this NT is not met as evidenced ion, interview and document ailed to ensure the care plan ted to the use of psychoactive pressants and anxiolytics) for 32, R33) reviewed for ations. ated 7/19/17 included ntia without behavioral ajor depression. imum Data Set (MDS) 5/16/17, identified a Brief I Status (BIMS) score of 4/15, cognitive impairment. R32's fied feeling down or <i>vs</i> during the lookback, and a pestionnaire (PHQ-9) score of mal depression. The MDS			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. R32 & R33 s has had their care plans reviewed, revised & updated as needed By 8/29/2017 all residents on psychoactive medications will have their care plans reviewed, revised and updat as needed. By 8/29/2017 all staff who utilizes resided care plans will be educated on the needed as needed. By 8/29/2017 all staff who utilizes resided care plans will be educated on the needed of the ne	s o r ed ent to an
	1-3 days during the	al behaviors towards others lookback and no psychosis. ssessment (CAA) for			report those changes immediately to the DON or designee who will update the plot of care at that time.	

Facility ID: 00361

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМ	PLETED
		245346	B. WING			07/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 279	F 279 Continued From page 22 psychoactive medication use dated 2/22/17, indicated to proceed to care plan to monitor for effectiveness of meds and non-pharmacological interventions.		F 2	79	DON or Clinical Team designees s	hall	
					audit all resident care plans initially appropriate interactions. Thereafte plans shall be reviewed as needed resident changes but at least quar	/ for er, care I with	
	sexually inappropri re-approach, and u	at revised 7/18/17, identified ate behavior towards others, to use two staff if necessary. The ddress the anti-depressant se.			with all MDS . Audits will continue Facilities Quality Assurance Team determines substantial compliance applicable regulations and Facility has been achieved.	e until e with	
	received the medic	tion sheets indicated R32 dications: buspirone (anxiolytic), talopram (antidepressants) on a					
		on 7/18/17, R32 was in his <i>i</i> sitors and had a smiling facial					
	During observation was lying in bed, sl	on 7/19/17, at 7:40 a.m., R32 eeping.					
	stated he "does no depressed, engage	on 7/19/17, at 9:12 a.m. R32 t know," whether he is ed in conversation and smiled ersed with surveyor.					
	practical nurse (LP friendly with the sta R32 grabs at staff the table and will le	n 7/19/17, at 8:06 a.m. licensed N)-B stated R32 "gets a little aff." LPN-B stated sometimes breasts and sometimes sits at et out a "yell" for no apparent made inappropriate sexual					
	MDS coordinator s	on 7/19/17, at 8:22 a.m. the tated she usually identified cations on the care plan but					

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	E SURVEY PLETED
		245346	B. WING	i		07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				100 NORTH 4TH AVENUE EAST IRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	see any of those ma During interview on director of nursing (drugs should be a p plan. R33's face sheet id phobic anxiety diso depressive disorder psychotic symptom R33's quarterly MD identify a BIMS sco for depression. The 3/24/17, identified a intact) and a PHQ-S depression). The N cares and verbal be 1-3 days and no de occurred. R33's physician ord an orders for the ar Amitriptyline 10 mg everyday and Wellt R33's care plan dat use of the 3 antidep During interview on director of nursing (antidepressant med on the care plan an include these as pa The facility policy, e	r R32, stating "Nope, I don't eds on there." 7/19/17, at 1:21 p.m. the (DON) stated psychoactive part of the comprehensive care entified diagnoses including rder, insomnia and major r recurrent, severe with s-mild, recurrent. S dated 5/30/17, did not re nor a PHQ-9 assessment e 30 day medicare MDS dated a BIMS score of 13 (cognitively 9 score of 6 (minimal MDS also identified rejection of ehavioral symptoms occurred elusions or hallucinations ders dated 7/2017, identified ntidepressant medication every bedtime, Zoloft 200 mg putrin 450 mg everyday ted 3/7/27, did not identify the pressant medications. 7/20/17, at 2:22 p.m. the (DON) verified the dications were not addressed ad the expectation was to art of the care plans -	F	279			
		ated 9/10 indicated it is the					

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CENTERS FOR MEDICARE & MEDICAID SERVICES			(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		245346	B. WING			/20/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	DE			
TRUMAN	SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 279	Continued From pa	age 24	F 27	9				
F 280 SS=D	comprehensive car identifies the higher resident may be ex further stated the c designed to incorpor 483.10(c)(2)(i-ii,iv,v	evelop and maintain a re plan for each resident that st level of functioning the pected to attain. The policy omprehensive care plan is prate identified problem areas. r)(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 28	0		8/29/17		
	and implementation	participate in the development n of his or her person-centered ing but not limited to:						
	including the right t be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to and the right to request son-centered plan of care.						
	expected goals and amount, frequency	icipate in establishing the d outcomes of care, the type, , and duration of care, and any d to the effectiveness of the						
	(iv) The right to rec included in the plar	eive the services and/or items a of care.						
	.,	the care plan, including the gnificant changes to the plan						
	right to participate i	nall inform the resident of the n his or her treatment and sident in this right. The nust						

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DEPART CENTER	RINTED: 08/12/2017 FORM APPROVED MB NO. 0938-0391									
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	IULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
		245346	B. WING			07/20/2017				
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE					
TRUMAN SENIOR LIVING				400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 280	SENIOR LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident and or resident representative. (ii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident representative is determined not practicable for the development of the resident's care plan.		F 2	280						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	· · ·	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	COM	PLETED
		245346	B. WING		07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
TRUMAN	SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 280	disciplines as deter or as requested by (iii) Reviewed and r team after each ass comprehensive and assessments. This REQUIREMEN by: Based on observat review the facility fa include the use of a resident (R33) revie (ROM) Findings include: R33's face sheet id hemiplegia and her non-dominant side. R33's quarterly Min 5/30/17, did not ide Mental Status (BIM	 te staff or professionals in mined by the resident's needs the resident. revised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced tion, interview and document ailed to revise the care plan to a resting hand splint for 1 of 3 ewed for range of motion entified diagnoses including niparesis on the left 	F 2	 It is the Facilities intent to a regulation to develop a com care plan for each resident measurable objectives and meet a resident s needs th identified in the comprehen assessment and periodical revise the care plan as the changes in care occur. R33 s Care plan and care been reviewed, revised & u needed. Splint has been loo being applied per therapy recommendations. 	hprehensive that includes timetables to hat are sive ly review and residents sheets have updated as	
	score of 13 (cognitively intact). The 5/30/17 MDS also identified a functional limitation impairment of upper and lower extremities on one side as well as extensive assistance needed with dressing and grooming. R33's progress note from 6/8/17 identified R33 had ROM issues on the left side related to hemiparesis from an old CVA (cerebral vascular			By 8/29/2017 all residents v adaptive equipment will be monitoring protocols and th updated as needed. Care p will be completed as chang least quarterly with MDS . By 8/29/2017 all staff will be regarding specialized adap protocol.	reviewed for leir care plans blan updates les occur but at e educated	

Facility ID: 00361

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	· · ·	E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _		COM	PLETED
		245346	B. WING			07/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 27	F 2	80			
	R33 had left hand to place resting hand to be worn all night R33's care plan dat an activity of daily lif functional/rehabilita mobility. The care the resting hand sp On 7/17/17, at 10:3 have left hand clen palm of hand. R33 and stated she was hand but it was lost On 7/20/17, at 7:26 her room with a res bedside table. R33 splint behind her ch R33 also stated, "I During interview on assistant (NA) E sta was previously loca	ted 3/7/27 indicated R33 had iving (ADL) ation limitation in physical plan did not identify the use of lint. 22 a.m. R33 was observed to ched and nails digging into the had a brace to the left foot s to have a splint on her left t. 6 a.m. R33 was observed in sting hand splint lying on the 8 stated staff had just found the hair this morning (7/20/17).			appropriate interactions. Thereafte plans shall be reviewed as needed resident changes but at least quar with all MDS . Audits will continue Facilities Quality Assurance Team determines substantial compliance applicable regulations and Facility has been achieved.	d with terly e until e with	
	During interview on 7/20/17, at 12:32 p.m. registered nurse (RN) A stated R33 had recently moved to a different room and the splint may have been lost during the move. When interviewed on 7/20/17, at 2:22 p.m. the director of nursing (DON) stated she would						

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED	
		245346	B. WING		07/	20/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
TRUMAN	I SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 282	Continued From pa	ige 28	F 28	2			
F 282		RVICES BY QUALIFIED	F 28			8/29/17	
		ive Care Plans ded or arranged by the facility, comprehensive care plan,					
	accordance with ea	qualified persons in ach resident's written plan of NT is not met as evidenced					
	review the facility facare related to more	tion, interview, and document ailed to implement the plan of aitoring bruising for 1 of 3 iewed for non-pressure skin		It is the Facilities intent to com regulation to develop a compre care plan for each resident that measurable objectives and time meet a resident s needs that a	hensive includes etables to are		
	Findings include:			identified in the comprehensive assessment and periodically re revise the care plan as the resid	view and		
	seated in wheelcha	p.m. R26 was observed ir in room. The resident had a		changes in care occur.			
	from the wrist to the bruise covering the interviewed at the t	of the right forearm extending e elbow. R26 also had a large top of the left hand. When ime, the resident could not		R26 s care plan has been revi revised & updated as needed. (sleeves have been put in place	Geri		
	identify how the bru	-		By 8/29/2017 all residents care be reviewed, revised & updated	las		
	history of bruising e medications such a atorvastatin being u	R26's care plan last reviewed 6/15/17, indicated a history of bruising easily related to antiplatelet medications such as aspirin, clopidigrel, and atorvastatin being used. Interventions included: analyze the resident's bruises to determine		needed. Policy & Procedure for Prevention and Treatment of SI Breakdown will be reviewed, re updated.	kin		
	pattern/trend, to dreshirts and pants an	ess resident in long sleeve d protect extremities, and to with care during direct care.		By 8/29/2017 all appropriate stare-educated on the importance following the Facilities Policy & for Prevention and Treatment of Breakdown and reporting all sk	of Procedure f Skin		

Facility ID: 00361

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From par nursing assistant (N that morning with A confirmed the resid the right forearm ar nursing was aware skin issue is identifi right away. NA-B s to get geri sleeves bruises so easily bu When interviewed of LPN-B who was wo being unaware of th and surveyor enteror resident's bruising. should have been r her knowledge this measured R26's br measured 14.5 cen The bruising was re edges and the top of black in color. The measured 4.2 cm x color. The progress note by LPN-B indicated that resident has br top of right fore arm measures 4.2 x 6.0 area on top of right cm dark purple in c	ge 29 NA)-B confirmed assisting R26 M cares. NA-B further ent had significant bruising to do top of left hand and stated of it. NA-B stated when a new ed it is reported to the nurse tated she had asked nursing for the resident because she ut this hadn't happened. on 7/20/17, at 11:48 a.m. orking on R26's wing, stated he resident's bruising. LPN-B ed R26's room to observe the LPN-B confirmed the bruising eported to the nurse and to did not occur. LPN-B uises. The right arm bruising timeters (cm) x (by) 8 cm. eddish purple around the of the arm was a brownish top of R26's left hand bruise 6 cm and was dark red in dated 7/20/17, at 11:54 a.m. : Notified by state inspector uising on top of left hand and h. Area on top of left hand and h. Area on top of left hand cm dark burgundy in color, forearm measures 14.5 x 8 olor around the edges with rea in the center. Majority of	F 2	282		ill audit r, care with erly until with	
	DON stated with ne bruising, would exp	on 7/20/17, at 12:43 p.m. the ew skin issues such as ect the nurse to make an entry ote and also on the daily					

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		AND HUMAN SERVICES			FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245346	B. WING	 	07/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING			00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	communication she interdisciplinary teal also be notified and would notify the phy significant and staff cause or if suspicio adult (VA) report an constraint. During s DON at approximat a VA incident report state agency related 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of life Quality of life is a ful applies to all care a residents. Each res facility must provide services to attain or practicable physical well-being, consiste comprehensive ass 483.25 Quality of care gasessment of a res that residents receive accordance with pro- practice, the compre- care plan, and the r but not limited to the (k) Pain Management The facility must en	eet to be investigated by the m. The resident's family would lif a significant new skin issue visician. Also, if bruising was were unable to identify the us, would file a vulnerable ind investigate within the time subsequent interview with tely 1:30 p.m., DON indicated thad been submitted to the d to R26's bruising.) PROVIDE CARE/SERVICES ELL BEING fe undamental principle that and services provided to facility sident must receive and the e the necessary care and fundamental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that tent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered residents' choices, including e following: ent. usure that pain management is	F 2			8/29/17
		ts who require such services,				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245346	B. WING			07/2	0/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING						
				-	RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	the comprehensive and the residents' g (I) Dialysis. The fac residents who requi services, consistent of practice, the com- care plan, and the r preferences. This REQUIREMEN by: Based on observat review the facility fa of 3 residents (R26) skin conditions. Findings include: On 7/18/17, at 1:36 seated in wheelcha large bruise on top from the wrist to the bruise covering the interviewed at the ti explain how the bru R26's quarterly Min assessment include status (BIMS) score cognitive impairment	essional standards of practice, person-centered care plan, joals and preferences. sility must ensure that ire dialysis receive such t with professional standards prehensive person-centered esidents' goals and NT is not met as evidenced ion, interview, and document iled to monitor bruising for 1) reviewed for non-pressure p.m. R26 was observed ir in room. The resident had a of the right forearm extending e elbow. R26 also had a large top of the left hand. When me, R26 was unable to	F3	309		ith the ive ides es to and s i, s will	
	transfers, toilet use the unit, and extens hygiene, dressing, a R26's care plan las history of bruising e	, and locomotion on and off ive assistance with personal			By 8/29/2017, all appropriate staff wire-educated on the importance of following the Facilities Policy & Procifor Prevention and Treatment of Skin Breakdown and reporting all skin iss Charge Nurse.	edure n	

Facility ID: 00361

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction		E SURVEY PLETED
		245346	B. WING			20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
TRUMAN	SENIOR LIVING					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 309	 Continued From page 32 atorvastatin being used. Interventions included were to analyze the resident's bruises to determine pattern/trend, to dress resident in long sleeve shirts and pants and protect extremities, and to handle the resident with care during direct care. When interviewed on 7/20/17, at 9:05 a.m. nursing assistant (NA)-B confirmed assisting R26 that morning with AM cares. NA-B further confirmed the resident had significant bruising to the right forearm and top of left hand and stated nursing was aware of it. NA-B stated when a new skin issue is identified it is reported to the nurse right away. NA-B stated she had asked nursing to get geri sleeves for the resident because she bruises so easily but this hadn't happened. When interviewed on 7/20/17, at 11:42 a.m. licensed practical nurse (LPN)-C stated when a new skin issue is identified such as a bruise, the bruise is measured, family and physician are notified, and an event is completed in the computer. In addition, an order will also be entered to monitor the bruise daily and measure of R26's bruising was not assigned to the resident's wing [location]. LPN-C checked R26's orders and verified there were no orders to monitor bruising. When interviewed on 7/20/17, at 11:48 a.m. LPN-B who was working on R26's wing, stated being unaware of the resident's bruising. LPN-B confirmed the bruising should have been reported to the nurse and to her knowledge this did not occur. LPN-B measured R26's bruising. LPN-B confirmed the bruising measured 14.5 centimeters (cm) x (by) 8 cm. 		F 3(09 DON or Clinical Team desinurse s notes regarding of condition for appropriatene effectiveness of intervention of proper protocol per Faci Audits will be conducted w Facility s Quality Assuran determines substantial cor applicable regulations and has been achieved.	hanges in skin ess and ons and for use lity policy. eekly until ce Team npliance with	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 08/12/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245346	B. WING		07/	20/2017
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	The bruising was reedges and the top of black in color. The measured 4.2 cm x color. LPN-B states physician and famil also notify the direct administrator due to The progress note of by LPN-B indicated that resident has br top of right fore arm measures 4.2 x 6.0 area on top of right cm dark purple in c some red colored a bruise is tannish in When interviewed of DON stated that ne bruising, she would entry into the progre communication she interdisciplinary tea also be notified and would notify the phy significant and staff cause or if suspicio adult (VA) report an constraint. During s DON at approximat a VA incident report state agency related On 7/20/17, at 12:5 had been informed observed seated in	addish purple around the of the arm was a brownish top of R26's left hand bruise 6 cm and was dark red in d she would notify R26's y of the bruising and would tor of nursing (DON) and the o the size of the bruising. dated 7/20/17, at 11:54 a.m. : Notified by state inspector uising on top of left hand and h. Area on top of left hand cm dark burgundy in color, forearm measures 14.5 x 8 olor around the edges with rea in the center. Majority of color. on 7/20/17, at 12:43 p.m. the w skin issues noted, such as expect the nurse to make an ess note and also on the daily bet to be investigated by the m. The resident's family would l if a significant new skin issue visician. Also, if bruising was f were unable to identify the us, would file a vulnerable of investigate within the time subsequent interview with ely 1:30 p.m., DON indicated t had been submitted to the	F 309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 315 SS=D	bilaterally that cover the resident's skin. The policy titled, Po Prevention and Trea dated 6/16/12 includ daily with cares by to skin concerns are no immediately to the of 483.25(e)(1)-(3) NC RESTORE BLADDI (e) Incontinence. (1) The facility must continent of bladder receives services and continence unless for becomes such that to maintain. (2)For a resident with on the resident's co facility must ensure (i) A resident who ear indwelling catheter resident's clinical co catheterization was (ii) A resident who ear indwelling catheter is assessed for rem as possible unless to demonstrates that of and	And procedure for the attent of Skin Breakdown ded: Skin will be observed the nursing assistant. If any noted, they are to be reported designated nurse. O CATHETER, PREVENT UTI, ER t ensure that resident who is r and bowel on admission and assistance to maintain his or her clinical condition is not continence is not possible th urinary incontinence, based omprehensive assessment, the that- nters the facility without an is not catheterized unless that necessary; enters the facility with an or subsequently receives one hoval of the catheter as soon the resident's clinical condition continence is not possible the that necessary is not catheterized unless the production demonstrates that necessary;	F 3				8/29/17
	and	is incontinent of bladder					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	SURVEY PLETED	
		245346	B. WING			07/2	0/2017	
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	SENIOR LIVING		400 NORTH 4TH AVENUE EAST					
	SENIOR EIVING			TI	RUMAN, MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 315	Continued From pa receives appropriate	ge 35 e treatment and services to	F3	815				
		t infections and to restore						
	on the resident's co facility must ensure incontinent of bowe treatment and servi bowel function as p This REQUIREMEN by: Based on observat review, the facility fa manner to restore a bladder function for	ith fecal incontinence, based mprehensive assessment, the that a resident who is I receives appropriate ces to restore as much normal ossible. NT is not met as evidenced ion, interview and document ailed to provide toileting in a is much normal bowel and 2 of 3 (R3, R33) residents nd urinary incontinence.			It is the Facilities intent to comply w regulation to treat each resident with dignity and respect. It is the Facilitie intent to assure the residents right to reside and receive services in the fa with reasonable accommodation of	า ร ว		
	Findings include:				resident needs and preferences.			
	stated when he nee movement (BM) he his "diaper".	on 7/17/17, at 11:28 a.m. eded to have a bowel was instructed to just go in num Data Set (MDS)			R3 & R33 s B&B Assessment Completed. Facility has purchased a Bariatric Commode for R3 s room. R3 & R33 s care plan has been reviewed, revised & updated as nee			
	assessment dated s Interview for Mental indicating moderate MDS further identifi upon staff for transf always incontinent or revised 7/10/17, ind	5/16/17 included a Brief Status (BIMS) score of 11 cognitive impairment. The ed R3 was totally dependent ers and toilet use and was of bowel. The care plan last licated R3 was incontinent of related to mobility and			By 8/29/2017 audits on residents at for incontinence will be reviewed and assessments will be updated. Individ care plans reviewed, revised & upda as needed. Policy & Procedures will reviewed, revised & updated as nee By 8/29/2017 all staff who utilizes re care plans will be educated on the n follow interventions as outlined in the	d dual ated be ded. sident eed to		
	nursing assistant (N	on 7/20/17, at 11:14 a.m. IA)-B stated R3 was always although could identify and			of care and should entries/interventi be noted to be no longer relevant, to report those changes immediately to	ons o		

		& MEDICAID SERVICES					0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245346	B. WING _			07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMA	N SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 315	communicate to sta bowel movement (I toileted when need utilized a Hoyer lift. bathroom was not I the lift into the bath the toilet, therefore in the brief. NA-B s confirmed she instr finished so staff co Initially, NA-B denie commode large en then remembered a available but curren resident. When interviewed of confirmed he would BM than in his brief able to tell staff who When interviewed of licensed practical m bathroom would no for toileting. LPN-E require an extra lar unavailable as it wa resident. LPN-B st could be toileted fo clean him up. When interviewed of director of nursing that a commode co toileting. When interviewed of stated R3 used to the	age 36 aff when he needed to have a BM). NA-B stated R3 was not ing to have a BM because he NA-B indicated R3's big enough to accommodate room and safely transfer onto R3 was directed to have a BM stated, "He hates it". NA-B ructed R3 to inform her when uld change him right away. ed there was an available ough to accommodate R3 and a larger commode was ntly utilized by another on 7/20/17, at 11:24 a.m. R3 d rather sit on the toilet for a f. R3 further confirmed he was en needing to have a BM. on 7/20/17, at 11:32 a.m. ourse (LPN)-B confirmed R3's of accommodate the Hoyer lift 8 further stated R3 would ge commode which was as being used for another ated it would be better if R3 r BM's rather than having to on 7/20/17, at 12:58 p.m. the (DON) stated being unaware buildn't be used for R3 for BM on 7/20/17, at 1:26 p.m. NA-E use the toilet when able to use ansfers. NA-E confirmed once	F 31	15	DON or designee who will update to of care at that time. DON or Clinical Team designees we all resident care plans initially for appropriate interactions. Thereafte plans shall be reviewed as needed resident changes but at least quart with all MDS . Audits will continue Facilities Quality Assurance Team determines substantial compliance applicable regulations and Facility has been achieved.	r, care with erly until with	

		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		245346	B. WING	i		07/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMA	N SENIOR LIVING				100 NORTH 4TH AVENUE EAST IRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	R3 started using the was toileted as the well enough to safe NA-E stated she the sitting on a commo- enough. NA-E furth extra large commo- resident was utilizin available for R3. N the Hoyer lift for at When interviewed of DON confirmed R3 for BM's in the bath from his room and toileting services to R33's face sheet ur including hemiplegi non-dominant side. R33's quarterly Min assessment dated Interview for Menta day medicare MDS BIMS score of 13 (0 5/30/17 MDS also it toileting program ar urine. R33's care plan las R33 as incontinent mobility impairment needing to void. Th regain the ability to voids per day by the included: total lift in on staff for toileting	e Hoyer lift he was no longer lift did not fit in R3's bathroom ely transfer him onto the toilet. ought R3 would be capable of de if they had one large her clarified the facility had one de available but since another ng this commode, it was not A-E confirmed R3 had utilized least 2 years. on 7/20/17, at 2:25 p.m. the would be able to be toileted abay located across the hall thus be provided appropriate maintain continence. ndated, identified diagnoses ia and hemiparesis on the left	F	315			

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT	E SURVEY IPLETED
		245346	B. WING	i		07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMA	N SENIOR LIVING				400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	R33's medical reco assessment of blac medical record. During interview on stated it takes so lo I am often times ind During interview on stated "I have a cor bathroom and she to lunch time so I had go to the bathroom said she had to go back". It was observed on had returned to ass resident room dowr this time, R33 turne p.m. licensed practi and asked R33 wha need to go to the ba needed to go get ac LPN-B and nursing onto the commode. R33 was continent incontinent of urine was soaked. During interview on R33 will tell staff wh movement (BM) bu urine. She stated s go (urine) but doesi	 And was reviewed. No dder function was noted in the A.7/17/17, at 10:26 a.m R33 ong for the staff to get here that continent. A.7/19/17, at 1:10 p.m. R33 mplaint! I asked to go to the told me no it was too close to to sit through lunch having to . I turned on my light and she get help and would be right A.1 turned on my light and she get help and would be right A.1 turned on my light and at 1:25 ical nurse (LPN)-B walked by at she needed. R33 replied, "I athroom". LPN-B stated she dditional help. At 1:27 p.m. assistant (NA)-F helped R33 . At 1:35 p.m. NA-F stated of bowel but was very and NA-F confirmed the brief A.7/19/17, at 7:42 NA-E stated hen she has to have a bowel it is always incontinent of she knows when she needs to 	F	315			

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		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245346	B. WING_			07/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				0 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315 F 329 SS=D	bedpan nor the com During interview on stated R33 is alway sometimes she will anyway. NA-F indic the bathroom when When interviewed of registered nurse (R assessment was no facility does not com When interviewed of director of nursing (assessments shoul continence status a interventions could toileting program. 483.45(d)(e)(1)-(2) FROM UNNECESS 483.45(d) Unnecess Each resident's dru unnecessary drugs drug when used (1) In excessive dos therapy); or (2) For excessive du (3) Without adequat (4) Without adequat	Annode at night. 7/20/17, at 8:35 a.m. NA-F vs incontinent of urine; ask but is usually incontinent ated R33 will request to go to needing to have a BM. on 7/20/17, at 12:20 p.m. N)-A stated that a bladder of available for review as the nduct them. on 7/20/17, at 2:20 p.m. the (DON) stated bladder d be conducted to determine and then individualized be implemented, such as a DRUG REGIMEN IS FREE SARY DRUGS sary Drugs-General. g regimen must be free from . An unnecessary drug is any se (including duplicate drug uration; or	F 3 ²		DEFICIENCY)		8/29/17
	which indicate the o	lose should be reduced or					

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORMA	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(3) DATE	SURVEY
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	 paragraphs (d)(1) the second second	has of the reasons stated in harough (5) of this section. Topic Drugs. Thensive assessment of a must ensure that have not used psychotropic these drugs unless the sary to treat a specific sed and documented in the use psychotropic drugs receive tions, and behavioral s clinically contraindicated, in nue these drugs; NT is not met as evidenced ion, interview and document ailed to ensure target behavior npleted for anti-psychotic f 5 residents (R51, R33) essary medications.	F 3	329	It is the Facility s intent for resident drug regimen to be free from unneced drugs. R51 & R33 s medication regime has been reviewed. Sleep study has beer implemented utilizing the Facility slee log.	ssary S	
	of unspecified demo disturbance and Pa R51's admission Mi assessment dated s behavioral concerns	ndated, indicated diagnoses entia with behavioral rkinson's disease. 5/30/17, indicated no mood or s, and identified a Personal re (PHQ-9) score was not			Monitoring of medications will be completed as detailed in the Pharmaceutical Services Policy and Procedures Manual. On a monthly ba nursing staff shall chart a summary o observed dose-responses of the administered medications. Audits will	of	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245346	B. WING _			07/2	20/2017
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN S	ENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
G Fpireona Fparsehtarb Tidud A5pAd F7sn	sychoactive medic ndicated R51 had b mergency room fo ontinued on Abilify nanagement of der and REM sleep disc R51's care plan, las sychotropic drug u intidepressant and elated to dementia leep disorder. A guy whibiting signs of d ypotension, or anti arget behavior liste pproaches of offer outine and allow him ehaviors were liste The current physicia dentified R51 was of inspecified dement listurbance. A pharmacy consult /24/17, with a return ractitioner of 5/30/ abilify was being ad ementia with psych R51's medication ar /17, lacked evident leep pattern and/on nonitoring related to	ssessment. sessment (CAA) for ations dated 5/30/17, been admitted from the llowing a fall at home, and (antipsychotic) daily for mentia-psychosis, depression, order. trevised 5/31/17, identified se - resident receives anti-psychotic medication without behaviors and REM oal was listed identified: not lrug related sedation, cholinergic symptoms. A ed for inability to sleep, with ing a snack, follow bedtime m to vent. No other target ed. an's orders dated 7/17, on Abilify 5 milligrams daily for ia without behavioral cant review, completed m fax date from the nurse 17, indicated the condition the lministered was Parkinson's nosis. md treatment sheets dated ce of any monitoring of R51's r other specific target behavior	F 32	29	completed on a monthly basis to er completion of necessary monitoring charting. Director of Nursing or designated s audit documentation to support the necessity of ongoing utilization of pharmacological sleep agents. Aud continue until the Facility s Quality Assurance Team determines subst compliance with applicable regulati and Facility policy has been achieve	g and taff will lits will antial ons	

		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TRUMAN	SENIOR LIVING				100 NORTH 4TH AVENUE EAST IRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	with transfers; howe any other behaviors wander guard alarm out the front doors, wife. During interview on social worker (SW) documenting on be look back period rel and could not identic charting being docu- record related to his During observation was wheeling back neat in appearance wheelchair. R51 was affect. During observation was seated in his w his side. R51 appe shaven. R51 was a anxiolytic for sleep sleep otherwise, thi for years"; however reason he took the was unsure the spe been for the prescri- and stated R51 was review with the neu During interview on director of nursing (on a consultant pha- with unnecessary m	N)-B stated R51 was impulsive ever, she had not observed s. LPN-B stated R51 wore a in to alert staff if attempts to go as often was looking for his 7/19/17, at 9:02 a.m. the stated they only were haviors for R51 during the lated to the MDS assessment ify any specific target behavior umented anywhere in the s anti-psychotic usage. on 7/19/17, at 9:10 a.m. R51 from breakfast, appeared , propelling himself in his as noted to have a flat facial on 7/19/17, at 10:56 a.m. R51 theelchair, with family (F)-B at ared neat in appearance and able to state he took an because "I would fall out of s has been under good control r, was unable to state the anti-psychotic. F-B stated she ecific behaviors would have ibed anti-psychotic medication, s scheduled for a medication	F	329			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245346	B. WING	;		07/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				400 NORTH 4TH AVENUE EAST IRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa monitored for anti-p	age 43 osychotic medications.	F:	329			
	phobic anxiety diso	lentified diagnoses including order, insomnia and major r recurrent, severe with is-mild, recurrent.					
	did not identify a Br (BIMS) score nor a depression. The 30 3/24/17, identified a intact) and a PHQ-9 depression). The M cares and verbal be	PS assessment dated 5/30/17, rief Interview for Mental Status PHQ-9 an assessment for day medicare MDS dated a BIMS score of 13 (cognitively 9 score of 6 (minimal MDS also identified rejection of ehavioral symptoms occurred elusions or hallucinations					
	7/24/17, identified a (anti-psychotic med	ders dated 6/24/17 through an order for Zyprexa dication used to treat ams (mg) every day.					
	7/20/17, indicated v	es from 3/22/17 through /erbally abusive behavior lo other behaviors were					
	received anti-psych Major depression w included: monitor re response to medica target behavior of a return later, allow to visits.	ted 3/7/17, indicated R33 notic medication related to vith psychosis. Approaches esidents behavior and ation monthly and identified a aggression: leave safe and o vent frustrations and 1:1					
	During interview on	7/20/17 at 2:22 p.m. the					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUR COMPLETE	URVEY ETED
	2047
245346 B. WING 07/20/20	2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TRUMAN SENIOR LIVING 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) OMPLETION DATE
F 329Continued From page 44 director of nursing (DON) stated staff need to document in the progress notes and comment on behaviors; in addition, the nursing assistants need to be documenting behaviors. The DON verified R33 did not have behavior monitoring related to the use of a psychotropic medication so effectiveness and response could be evaluated.F 329Policies related to anti-psychotic medication usage were requested, none were provided.F 329	29/17

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 08/12/2017 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245346	B. WING	i		07/20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
TRUMAN	I SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From pa	ge 45	F 4	431		
	labeled in accordan professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance w the facility must sto locked compartmer	als used in the facility must be ce with currently accepted les, and include the ory and cautionary e expiration date when s and Biologicals. <i>v</i> ith State and Federal laws, re all drugs and biologicals in nts under proper temperature				
	have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa ensure periodic rec schedule IV medicat diversion for 4 of 4 medications review. IV medications were the medication roor	t provide separately locked, l compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview and document ailed to develop a system to onciliation of overflow tions to prevent potential resident (R9, R13, R31, R51) ed whose overflow schedule e stored in a locked cabinet in			It is the Facilities intent to have system in place to ensure periodic reconciliation of overflow schedule IV medications to prevent potential diversion. Policy & Procedure to count/reconcile Schedule IV medications has been developed and implemented. R9, R13, R31 & R51 s schedule IV medications have been logged for future ability to reconcile.	1

Event ID: ZO5R11

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	was observed with I (LPN)-A. The right was noted to have 2 contained resident of stored in the medication blister-pack cards of medication on each medications observ as follows: (1) R9 - lorazepam (0.25 mg dose): (a) 1 card of #3 (b) 2 cards of # 10/10/16 (c) 1 card of #3 (d) 3 cards of # 12/5/16 (e) 3 cards of # 1/3/17 (f) 1 card of #30 (g) 2 cards of # 3/22/17 (h) 1 card of #30 (i) 1 card of #33 (i) 1 card of #33 (i) 1 card of #33 (i) 1 card of #33 (j) 2 cards of # 3/22/17 (c) 1 card of #3 (b) 2 cards of # 3/22/17 (c) 1 card of #3 (c) 1 card	icensed practical nurse side of the medication room 2 locked cabinets which overflow medications not ation carts. The medications resident into small crate-like is were packaged on ontaining up to #30 of the card . The schedule IV ed in the locked cabinets were 0.5 milligrams (mg) 1/2 tablets 0 1/2 tablets filled 9/12/16 30 1/2 tablets (#60 total) filled 0 1/2 tablets (#60 total) filled 0 1/2 tablets (#90 total) filled 30 1/2 tablets (#90 total) filled 30 1/2 tablets (#90 total) filled 0 1/2 tablets filled 2/27/17 30 1/2 tablets (#60 total) filled 0 1/2 tablets filled 5/16/17 0 1/2 tablets filled 5/16/17 30 tablets filled 1/3/17 30 tablets (#60 total) filled 0 tablets filled 5/16/17 tablets 4CL 50 mg 1/2 tablets (25 mg 30 tablets (#180 total) filled	F 4	.31	All residents with Scheduled IV medications have been logged for f ability to reconcile according the Facility s Policy & Procedure. By 8/29/2017 all licensed staff will b educated on the work flow process & Procedure will be reviewed. Director of Nursing or designated s audit the Schedule IV Classification monthly to ensure compliance with applicable regulations and Facility p Audit findings will be reported to Fa Quality Assurance Team.	be . Policy taff will h log policy.	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245346 B. WING 07/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN SENIOR LIVING **TRUMAN, MN 56088** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 47 F 431 (b) 1 card of #30 tablets filled 12/24/16 Total = 60 full tablets (5) R51-clonazepam 0.5 mg 1/2 tablets (0.25 mg dose) (a) 1 card of #14 tablets filled 4/10/17 (6) R51-clonazepam 0.5 mg (full tablets) (a) 1 card of #13 tablets filled 4/10/17 (b) 1 card of #2 tablets filled 5/17/17 (c) 1 card of #30 tablets filled 6/23/17 Total = 45 full tablets When interviewed on 7/19/17, at 1:58 p.m. LPN-A confirmed nursing staff did not count/reconcile the schedule IV overflow medications stored in the locked cabinets in the medication room. LPN-A stated when a card of medication is taken from the overflow cabinet and placed into the medication cart, that card of medications is counted and documented in the eMAR (electronic medication administration record). LPN-A confirmed there was no record-keeping system in place to track the count of overflow schedule IV medications and further confirmed if medication was missing they would have no knowledge. When interviewed on 7/20/17, at 11:36 a.m. the consulting pharmacist stated that there was no specific time frame for reconciliation of schedule IV medications though must conduct periodic reconciliation. The consulting pharmacist confirmed the facility should have some system in place to reconcile supply of controlled substances. When interviewed on 7/20/17, at 1:00 p.m. the director of nursing (DON) confirmed there should be a system in place to account for/reconcile schedule IV medications stored in the medication room to prevent diversion.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245346	B. WING			07/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				0 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From page	ge 48	F 4	31			
	physician orders da diagnoses including and anxiety disorde indicated R9 could r orally once daily at 8 and 1/2 tab (0.25 m needed for agitation R13's medical recon signed physician or diagnoses including	d was reviewed. R9's signed ted 6/23/17, identified Major depressive disorder r. The physician orders receive lorazepam 0.5 mg 8:00 a.m. for anxiety disorder g) up to three times a day as n/anxiety. rd was reviewed. R13's ders dated 7/7/17, identified scoliosis and osteoarthritis of sician orders indicated R13					
	could receive trama for chronic pain.	dol 25 mg orally every 6 hours rd was reviewed. R31's					
	diagnoses including and anxiety disorde indicated R31 could	ders dated 7/12/17, identified major depressive disorder r. The physician orders l receive lorazepam 0.5 mg dose) orally once daily for disorder.					
F 469 SS=F	signed physician or R51 could receive of bedtime for REM sl 483.90(i)(4) MAINT	rd was reviewed. R51's ders dated 7/7/17, indicated clonazepam 1 mg orally at eep behavior disorder. AINS EFFECTIVE PEST RAM	F 4	69			8/29/17
	so that the facility is This REQUIREMEN by:	fective pest control program free of pests and rodents. NT is not met as evidenced					
		ion, interview and document ailed to ensure adequate pest			It is the Facilities intent to provide a and safe environment for our reside		

Facility ID: 00361

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245346	B. WING		07/	20/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	P CODE	
RUMAN	I SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 469	Continued From pa	age 49	F 4	169		
	throughout the facil the potential to affe the facility. Findings include: During interview on resided down the A	ined to control crawling insects lity. This deficient practice had act all 41 residents residing in 7/17/17, at 10:58, R16 (who ster Wing of the facility) bugs in here, I killed two black aday."		The Facility will maintain a with a licensed pest contr carefully consider all avail techniques and subseque appropriate measures tha development of pest popu- keep pesticides and other levels that are economical reduce or minimize risks to and the environment.	ol contractor to able pest control ent integration of it discourage the ilations and interventions to Ily justified and	
	black/brown colored approximately one by the central nursi to hide underneath During observation another of these sa	During observation on 7/19/17, at 7:37 a.m. a lack/brown colored crawling insect, pproximately one inch long ran across the floor y the central nursing station, and was observed o hide underneath a garbage can. During observation on 7/20/17, at 8:37 a.m. nother of these same crawling insects, pproximately 3/4 inches long was noted crawlin		The Facility will make ever control pest populations in premises and understand eradication of all pests is assessment will include th characterization of biologi agents, health risks, envir and efficacy.	n and around the s that the impossible. Risk ne cal control	
	in the hallway in the Bluebell wing. When retrieved and shown to the environmental services director (ESD), he stated "they are harmless beetles, we have had numerous complaints, especially down the Aster Wing." The ESD stated Pest Pro, the facility's pest contractor had been to the facility on 6/26/17 and was due again at the end of 7/16 at the facility. The ESD further stated "They are usually dying after they get in, so we know the spray is killing them, there is not much I can do about it."			Monthly applications of per premises will conform to f and local regulations and Regular daily observation conducted by all staff and ESD and/or Administrator applications will be made and during the summer m populations peak due to s development cycles and of	ederal, state, be documented. will be reported to the . Additional when necessary onths when pecies climate changes.	
	maintenance assist was having more d and they had an ex month for routine p	7/20/17, at 9:05 a.m. tant (M)-A stated the facility ifficulty with bugs than usual, terminator come once a est control. M-A further stated st contractor] sprays, they		By 8/29/2017 all staff will Facility s Pest Control Po Procedure. The Environmental Servic designee will monitor faci ensure facility is free of po	blicy & ces Director or lity daily to	

Facility ID: 00361

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		. 0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	E SURVEY IPLETED
		245346	B. WING		07/	20/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DΕ	
TRUMAN	I SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 469	Continued From pa	age 50	F 46	9		
		nd all we can do is sweep ne up underneath the walls."		Audits will continue until Facili Assurance Team determines compliance with applicable re	substantial	
	dead beetles of the	on 7/20/17, at 11:40 a.m. two same black/brown variety floor on the Evergreen Wing.		and Facility policies has been		
	another dead beetl	on 7/20/17, at 11:42 a.m., e was noted outside the allway adjacent to the				
	During observation of the lunch meal on 7/20/17, at approximately 12:15 p.m. five dead and several crawling beetles were noted on the floor of the common dining area.					
	12:43 4 dead black wash sink and 3 black dry storage room.	and interview on 7/20/17, at k beetles on the floor under the ack beetles on the floor of the Cook (C)-A stated at this time em on the floor of the dry nes.				
	ESD stated he "I do contractor had see 6/26/17 and was av current concern. T Pest Pro had treated	n 7/20/17, at 12:26 p.m. the bubt it," if the pest control n the beetles during his ware of the extent of the 'he ESD stated on 6/26/17 ed the interior and exterior of earwigs, another type of				
	insect. The ESD fu when we can, I thin The ESD supplied indicated the contra 6/26/17, and had tr	arwigs, another type of urther stated "We all sweep up ik it has to do with moisture." a Pest Pro log report, which actor had been there on eated areas of interior to wling insects of earwigs. The				

If continuation sheet Page 51 of 52

		AND HUMAN SERVICES				FORM	08/12/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245346	B. WING			07/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	N SENIOR LIVING				100 NORTH 4TH AVENUE EAST FRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 469	pesticide solution w stated he had actua day after their last t had returned to rep find the paperwork Pro. A message wa time to return a call During interview on service representat manufacturer of De stated the facility ca days, and it would r application to contra infestation was occ would spray around of the facility and to bugs trying to enter On 7/24/17, at 3:58 Pest Pro returned a had completed the at the facility denied 6/27/17 to relay the noticed inside the fa not aware of the ex Friday," which was He denied seeing th and stated he only the and entries with spr known it was bad I outside with the ATV insecticide] around also stated "it is the repair their door gas badly in need of rep	vas used. The ESD further ally called Pest Pro back the reatment on 6/27/17, and he reat a treatment, but could not and would get this from Pest as left with Pest Pro at this 7/20/17, at 1:03 p.m. a tive from Syngenta, emand CS control chemical an re-treat the floor every 21 normally take more than one ol beetles. If a high level of urring, normally a contractor a the entire exterior perimeter o put up a barrier to prevent	F 4	469			

If continuation sheet Page 52 of 52

	and and the second s	AND HUMAN SERVICES		F5346025		: 08/14/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED
		245346	B. WING		07	/18/2017
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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ADAGA DESCRETACED TO THE ADDD/	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	ĸ	000		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Truman Senior Livi compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, ng was found not to be in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 re Occupancies.				
	Please return the p Safety Deficiencies Health Care Fire In State Fire Marshal 444 Cedar St., Suit St Paul, MN 55101 By email to: Marian.Whitney@s	spections Division e 145 -5145, or		EPOC		
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	nically Signed					08/11/2017
Annal - Calan	au statement ending with	an astariak (*) denotes a deficiency wh	ich the in	astitution may be excused from correcting provid	lina it is de	ermined that

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/14/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245346	B. WING			07/1	18/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Angela.Kappenmar <mailto:angela.kap THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for corre- prevent a reoccurrer Truman Senior Livin no basement, and i original 1970 buildin 1987 building additi Type II(000) constru- addition was detern construction. The nursing home in outpatient medical of facility by rated 2-ho include opening pro- labeled, self-closing fire door assemblie The facility has a fir detection in the corr- corridors which is re- department notifica</mailto:angela.kap 	itney@state.mn.us> and @state.mn.us openman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. mg is a one-story building with s fully sprinklered. The mg along with the 1975 and ons were determined to be of uction. The 1996 building mined to be of Type V(111) s separated from an clinic and an assisted living our fire wall assemblies, which otectives consisting of factory g, positive latching 90-minute	KO	000			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		DATE SURVEY	
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMPLETED 07/18/2017	
		245346	B. WING			
NAME OF I	PROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING			00 NORTH 4TH AVENUE EAST RUMAN, MN 56088	U	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 000	Continued From pa	age 2	K 000			
	The requirement a NOT MET as evide	t 42 CFR, Subpart 483.70(a) is				
K 291 SS=D	NFPA 101 Emerge	-	K 291		8/29/17	
	is provided automa 18.2.9.1, 19.2.9.1 This STANDARD Based on observa failed to maintain e accordance with 7 affect 41 out of 41 Emergency Lightin least 1-1/2 hour du in accordance with FINDINGS INCLUI	of at least 1-1/2-hour duration atically in accordance with 7.9. is not met as evidenced by: tion and interview, the Facility emergency lighting in 9. The deficient practice could residents. g Emergency lighting of at ration is provided automatically 7.9. 18.2.9.1, 19.2.9.1 DE: ween 8:30 AM and 12:30 PM		It is the Facilities intent to comply with Life Safety Code standards. When Maintenance Assistant returned, documentation was located. The Annu 90 minute test was conducted in September 2016. See Attachment K29 Annual test is scheduled for the month September 2017.	al 1	
	located to show the was conducted on Emergency Lights. This deficient prac Facility Maintenand discovery.	tice was confirmed by the ce Director at the time of	14 000		0/11/17	
K 300 SS=E	18.3 and 19.3 Prot not addressed by t deficient. This info applicable Life Saf	on - Other KS section any LSC Section ection requirements that are he provided K-tags, but are mation, along with the ety Code or NFPA standard included on Form CMS-2567.	K 300		8/11/17	

Facility ID: 00361

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					08/14/2017 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OME	B NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245346	B. WING			07/1	8/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	SENIOR LIVING				0 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ME	(X5) COMPLETION DATE
K 300	Continued From pa	ge 3	К 3	00			
	Based on document the Facility failed to documentation on the Inspection per NFP could affect 41 out Protection - Other List in the REMARH 18.3 and 19.3 Protection addressed by the deficient. This infort applicable Life Safectiation, should be	the Annual Fire/Smoke Door A 80. The deficient practice of 41 residents. AS section any LSC Section ection requirements that are he provided K-tags, but are mation, along with the ety Code or NFPA standard included on Form CMS-2567.			It is the Facilities intent to comply wit Life Safety Code standards. As of 8/11/2017, The Annual Inspection Fire Door Assemblies has been completed.		
	FINDINGS INCLUE	DE					
	on 07/18/2017, doc located to indicate	veen 08:30 AM and 12:30 PM cumentation could not be that the Annual Fire and ction had occurred per the					
K 324	Maintenance Direc		ĸ	324			8/29/17
SS=F	with NFPA 96, Star and Fire Protection Operations, unless * residential cookin	t is protected in accordance dard for Ventilation Control of Commercial Cooking : g equipment (i.e., small s microwaves, hot plates,					

Facility ID: 00361

If continuation sheet Page 4 of 10

		& MEDICAID SERVICES			OMB NO.	E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		PLETED
		245346	B. WING_		07/	18/2017
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RUMAN	SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 324	cooking in accorda * cooking facilities of compartments with with the conditions or * cooking facilities i 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, in smoke compartments with s comply with conditions under 5.4. rotected according to NFPA 96 equired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through	K 32			
	Based on docume the Facility did not of equipment is protect 96, Standard for Ve Protection of Comm	s not met as evidenced by: ntation review and interview ensure that the cooking cted in accordance with NFPA entilation Control and Fire nercial Cooking Operations. ice could effect 41 of the 41		It is the Facilities intent to comp Life Safety Code standards. Ansul system was last tested on and is scheduled to be tested ag 11/15/17 and 5/16/18 by Mankato/Fairmont Fire & Safety.	5/11/17 ain on	
	with NFPA 96, Star and Fire Protection Operations, unless * residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities	t is protected in accordance dard for Ventilation Control of Commercial Cooking : g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply				

Facility ID: 00361

If continuation sheet Page 5 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/14/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245346	B. WING	·		07/	18/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TRUMAN	I SENIOR LIVING				400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 324	or * cooking facilities i 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities pr per 9.2.3 are not re hazardous areas, b corridor. 18.3.2.5.1 through 19.3.2.5.5, 9.2.3, Th FINDINGS INCLUE On facility tour betw on 07/18/2017, duri was revealed that of located to show that system was inspect The dates of inspect	under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with a comply with conditions under .4. rotected according to NFPA 96 quired to be enclosed as ut shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through A 12-2. DE: veen 8:30 AM and 12:30 PM ng documentation review, it ocumentation could not be t the kitchen fire suppression red the required time frame. ctions were 05/17/2016 and a not within the 6 month	ĸ	324	4		
	This deficient pract Maintenance Direct NFPA 101 Subdivis Smoke Barrie Subdivision of Build Construction 2012 EXISTING Smoke barriers sha fire resistance ratin be permitted to terr Smoke dampers ar penetrations in fully an approved sprink	ce was verified by the Facility		372	2	18	8/9/17

Event ID: ZO5R21

Facility ID: 00361

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/14/2017 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245346	B. WING			07/1	8/2017
NAME OF	PROVIDER OR SUPPLIER	11			TREET ADDRESS, CITY, STATE, ZIP CODE		
	N SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 372	in REMARKS. This STANDARD in Based on observation facility failed to main construction that me 101 - 2012 edition, (1). This deficient per 41 residents by allow one smoke compared Subdivision of Build Construction 2012 EXISTING Smoke barriers shaft fire resistance ration shall be permitted to Smoke dampers are penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. FINDINGS INCLUE On facility tour betw on 07/18/2017, observe aled penetration on the following sme Evergreen Wing.	anical smoke control system s not met as evidenced by: tion and staff interview, the ntain smoke barrier walls eet the requirements of NFPA Sections 19-3.7.3 and 8.6.7.1. practice could affect 24 of the wing smoke to propagate from them to another. ding Spaces - Smoke Barrier all be constructed to a 1/2-hour g per 8.5. Smoke barriers o terminate at an atrium wall. te not required in duct of ducted HVAC systems where eller system is installed for ints adjacent to the smoke		372	It is the Facilities intent to comply v Life Safety Code standards. As of 8/09/2017 all smoke barriers ceiling grids were checked and penetrations were fire calked at that	above	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY	
D FLAN C	of CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING 01 - MAIN BUILDING 01				
		245346	B. WING			/18/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETIO DATE	
K 372	 Continued From page 7 This deficient practice was verified by the Facility Maintenance Director. 		K	372			
	NFPA 101 Electrica	I Systems - Essential Electric	K	918		7/28/17	
	 Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of 						
	competent personn stored energy powe accordance with NF circuit breakers are program for periodi components is esta manufacturer requi maintenance and te readily available. E circuits are marked Minimizing the poss emergency power s consideration for ne	el. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a cally exercising the ablished according to rements. Written records of esting are maintained and ES electrical panels and and readily identifiable. sibility of damage of the source is a design ew installations. NFPA 99), NFPA 110, NFPA					

Facility ID: 00361

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMI	PLETED	
		245346	B, WING		07/*	07/18/2017	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
RUMAN	SENIOR LIVING			400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETIO DATE	
K 918	Continued From pa	ge 8	K 91	8			
		-					
	Based on docume	ntation review and interview,		It is the Facilities intent to comp Life Safety Code standards.	oly with the		
	records of Generat	or maintenance and testing				with the major System hat the I during	
		Page 8 is not met as evidenced by: not maintenance and testing nd readily available. This could affect 41 of 41 residents. is - Essential Electric System		As of 7/28/2017 Annual generation PM was performed by Generation			
	dencient practice co	Suid allect 41 of 41 residents.		Services, Inc. It was determined			
				generator performs under full lo	ad during		
	Maintenance and T			monthly testing. Annual 4-hour scheduled for December 2017.	run is		
				scheduled for December 2017.			
	•						
	transfer switches a						
	with NFPA 110.	in an estad una statu arrangia sel					
						System hat the during	
i	competent personn	el. Maintenance and testing of					
	components is esta	ablished according to					
		ES electrical panels and					
		and readily identifiable.					
		sibility of damage of the					
	emergency power s consideration for ne						
		NFPA 99), NFPA 110, NFPA				11	

Facility ID: 00361

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PRINTED: 08/14/2017

		AND HUMAN SERVICES				FORM	08/14/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245346	B. WING			07/	18/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	N SENIOR LIVING				00 NORTH 4TH AVENUE EAST RUMAN, MN 56088		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 918	on 07/18/2017, dur annual generator m be located. Also, du Maintenance Direc monthly 30 minute generator was bein face plate rating.	70) DE: ween 8:30 AM and 12:30 PM ing documentation review, the naintenance report could not uring interview with the Facility tor it is unclear if during the load test the emergency ig exercised under 30% of the tice was verified by the Facility	K	918			

Facility ID: 00361

If continuation sheet Page 10 of 10

Truman Senior Living Inc.

Battery-operated Emergency Lights - Test Log for (Year): 2016

A 30-second monthly functional test and a 90-minute annual test must be performed on each of the facility's battery-operated emergency lights. Indicate the type of test conducted and initial each monthly entry. M = 30-second test A = 90-minute test

Unit Location Mechanical Room	Date Installed	LIRS JAN 90	ces FEB 30-3ec	MAR A	APR	MAY	JUN	JUL	AUG	SEP A	OCT M	NOV	DEC	Battery Replaced
											5			
							-							
							-							



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 2, 2017

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

Re: State Nursing Home Licensing Orders - Project Numbers S5346028, H5346031 & H5346033

Dear Ms. Craig-Paulson:

The above facility was surveyed on July 17, 2017 through July 20, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5346031 & H5346033 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Truman Senior Living August 2, 2017 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00361	B. WING		07/2	0/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		H 4TH AVEN MN 56088	IUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 08/11/17

Electronically Signed

If continuation sheet 1 of 53

IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00361	B. WING		07/	20/2017
STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
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e Statutes/Rules, please ected" in the box available for ndicate in the electronic ess, under the heading date your orders will be ectronically submitting to the ent of Health. nd 20th, 2017, surveyors of aff, visited the above provider rection orders are issued. our electronic plan of ave reviewed these orders, when they will be completed ent of Health is documenting Correction Orders using g numbers have been ota state statutes/rules for mber appears in the far left Prefix Tag." The state impliance is listed in the nt of Deficiencies" column o Comply" portion of the s column also includes the violation of the state statute "This Rule is not met as ing the surveyors findings Method of Correction and ection. RD THE HEADING OF THE		DEFICIENC	ντ) 	
	DO361 STREET AL ADD NOR TRUMAN EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) Te 1 h orders being submitted to lithough no plan of correction e Statutes/Rules, please acted" in the box available for ndicate in the electronic ass, under the heading date your orders will be actronically submitting to the ent of Health. nd 20th, 2017, surveyors of aff, visited the above provider rection orders are issued. ur electronic plan of ave reviewed these orders, when they will be completed and of Health is documenting Correction Orders using a numbers have been to a state statutes/rules for mber appears in the far left Prefix Tag." The state mpliance is listed in the to of Deficiencies" column Comply" portion of the s column also includes the violation of the state statute "This Rule is not met as ing the surveyors findings Method of Correction and ection. RD THE HEADING OF THE WHICH STATES, J OF CORRECTION." THIS	00361 B. 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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/	20/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			8/29/17
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related o segregated or gene care staff	ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	1			
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, th trained, the frequen topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors; skills. provide to consumers in c form a description of the ne categories of employees acy of training, and the basic				
	this section.	document compliance with				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/	20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVE 1, MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
2 302	Continued From pa	age 3	2 302			
	facility failed to ens in written or electro their Alzheimer's tra	and document review, the ure consumers were provided nic format, a description of the aining program, the categories basic topics covered and the aining.	•	Corrected		
	facility social worke not provide any info	n 7/20/17, at 1:40 p.m. the er (SW) stated the facility did ormation in writing, or r knowledge to the consumers er's training.				
	administrator verific written or electronic	n 7/20/17, at 2:15 p.m., the ed that the facility did not have c materials they were providing ed to the Alzheimer's training.				
	administrator or de materials, facility p	THOD OF CORRECTION: The signee could update written ostings or website materials, to d information related to their g program.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			8/29/17
	comprehensive pla objectives and time long- and short-tern and mental and ps identified in the cor	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00361	B. WING		07/20/2017
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, 3	STATE, ZIP CODE	0772072017
TRUMAN	I SENIOR LIVING		H 4TH AVE	NUE EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MN 56088 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 560	Continued From pa	ge 4	2 560		
		dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).			
	by: Based on observati review, the facility fa was developed rela medications (antide	ent is not met as evidenced on,interview and document ailed to ensure the care plan ted to the use of psychoactive pressants and anxiolytics) for 32, R33) reviewed for rations.		Corrected	
	Findings include:				
		ated 7/19/17 included ntia without behavioral ajor depression.			
	assessment dated Interview for Menta indicative of severe mood section identi depressed 7-11 day Personal Health Qu 2, indicative of mini also identified verba	imum Data Set (MDS) 5/16/17, identified a Brief I Status (BIMS) score of 4/15, cognitive impairment. R32's fied feeling down or <i>y</i> s during the lookback, and a uestionnaire (PHQ-9) score of mal depression. The MDS al behaviors towards others lookback and no psychosis.			
	psychoactive medic indicated to procee	esessment (CAA) for cation use dated 2/22/17, d to care plan to monitor for eds and non-pharmacological			
	sexually inappropriation re-approach, and use	t revised 7/18/17, identified ate behavior towards others, to se two staff if necessary. The Idress the anti-depressant			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00361	B. WING		07/	20/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN , MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 560	Continued From pa	age 5	2 560			
	and/or anxiolytic us	Se.				
	received the medic	on sheets indicated R32 ations: buspirone (anxiolytic), lopram (antidepressants) on a				
		on 7/18/17, R32 was in his /isitors and had a smiling facial				
	During observation was lying in bed, sl	on 7/19/17, at 7:40 a.m., R32 eeping.				
	stated he "does no depressed, engage	on 7/19/17, at 9:12 a.m. R32 t know," whether he is ed in conversation and smiled ersed with surveyor.				
	practical nurse (LP friendly with the sta R32 grabs at staff the table and will le	n 7/19/17, at 8:06 a.m. licensed N)-B stated R32 "gets a little aff." LPN-B stated sometimes breasts and sometimes sits at et out a "yell" for no apparent made inappropriate sexual				
	MDS coordinator s psychoactive medie	on 7/19/17, at 8:22 a.m. the tated she usually identified cations on the care plan but r R32, stating "Nope, I don't leds on there."				
	director of nursing	n 7/19/17, at 1:21 p.m. the (DON) stated psychoactive part of the comprehensive care				
		lentified diagnoses including order, insomnia and major				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
RUMAN	N SENIOR LIVING		TH 4TH AVEN , MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 560	Continued From pa	ge 6	2 560			
	depressive disorder psychotic symptom	r recurrent, severe with s-mild, recurrent.				
	identify a BIMS sco for depression. The 3/24/17, identified a intact) and a PHQ-s depression). The M cares and verbal be	S dated 5/30/17, did not re nor a PHQ-9 assessment e 30 day medicare MDS dated a BIMS score of 13 (cognitively 9 score of 6 (minimal MDS also identified rejection of ehavioral symptoms occurred elusions or hallucinations				
	an orders for the ar Amitriptyline 10 mg	lers dated 7/2017, identified ntidepressant medication every bedtime, Zoloft 200 mg putrin 450 mg everyday				
		ted 3/7/27, did not identify the pressant medications.				
	director of nursing (antidepressant med	dications were not addressed d the expectation was to				
	Comprehensive, da facility's policy to de comprehensive car identifies the highes resident may be ex further stated the co	entitled Care Plans - ated 9/10 indicated it is the evelop and maintain a e plan for each resident that st level of functioning the pected to attain. The policy omprehensive care plan is orate identified problem areas.				
	director of nursing of plans are developed	HOD OF CORRECTION: The or designee could ensure care d to accurately reflect any iplinary or medication				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/	20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVE , MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 560	Continued From pa	ge 7 lity could update policies and	2 560			
	procedures, educat audit periodically to reflect the needs of report findings to th	e staff on these changes and ensure care plans adequately residents. The facility could e quality assurance committee endations to ensure ongoing				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			8/29/17
		omprehensive plan of care personnel involved in the				
	by: Based on observati review the facility fa care related to mon	ent is not met as evidenced on, interview, and document iled to implement the plan of itoring bruising for 1 of 3 iewed for non-pressure skin		Corrected		
	Findings include:					
	seated in wheelcha large bruise on top from the wrist to the bruise covering the	p.m. R26 was observed ir in room. The resident had a of the right forearm extending e elbow. R26 also had a large top of the left hand. When me, the resident could not ising occurred.				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/	20/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVENU I, MN 56088	JE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From par R26's care plan lass history of bruising e medications such a atorvastatin being u analyze the resident pattern/trend, to dre shirts and pants and handle the resident When interviewed of nursing assistant (N that morning with A confirmed the resid the right forearm an nursing was aware skin issue is identifit right away. NA-B s to get geri sleeves of bruises so easily bu When interviewed of LPN-B who was wo being unaware of th and surveyor entered resident's bruising, should have been r her knowledge this measured 14.5 cen The bruising was re edges and the top of black in color. The measured 4.2 cm x color.	ge 8 t reviewed 6/15/17, indicated a asily related to antiplatelet s aspirin, clopidigrel, and used. Interventions included: t's bruises to determine ess resident in long sleeve d protect extremities, and to with care during direct care. on 7/20/17, at 9:05 a.m. IA)-B confirmed assisting R26 M cares. NA-B further ent had significant bruising to ad top of left hand and stated of it. NA-B stated when a new ed it is reported to the nurse tated she had asked nursing for the resident because she it this hadn't happened. on 7/20/17, at 11:48 a.m. rking on R26's wing, stated he resident's bruising. LPN-B ed R26's room to observe the LPN-B confirmed the bruising eported to the nurse and to did not occur. LPN-B uises. The right arm bruising timeters (cm) x (by) 8 cm. eddish purple around the of the arm was a brownish top of R26's left hand bruise 6 cm and was dark red in	2 565	DEFICIENC	SY)	
	top of right fore arm	uising on top of left hand and a. Area on top of left hand cm dark burgundy in color,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/	20/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, ST	ATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVENU I, MN 56088	JE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 9	2 565			
	cm dark purple in c	forearm measures 14.5 x 8 olor around the edges with area in the center. Majority of color.				
	DON stated with ne bruising, would exp into the progress ne communication she interdisciplinary tea also be notified and would notify the phy significant and staff cause or if suspicio adult (VA) report an constraint. During a DON at approximat a VA incident report state agency relate SUGGESTED MET The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon	on 7/20/17, at 12:43 p.m. the aw skin issues such as beet the nurse to make an entry ote and also on the daily beet to be investigated by the m. The resident's family would d if a significant new skin issue ysician. Also, if bruising was were unable to identify the us, would file a vulnerable and investigate within the time subsequent interview with tely 1:30 p.m., DON indicated t had been submitted to the d to R26's bruising. THOD OF CORRECTION: sing (DON) or designee could policies and procedures related the plan for each individual the director of nursing or velop a system to educate staff itoring system to ensure staff as directed by the written plan				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			8/29/17
	care must be review	. A comprehensive plan of wed and revised by an m that includes the attending				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00361	B. WING		07/20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
RUMAN	N SENIOR LIVING		TH 4TH AVE I, MN 56088	NUE EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET
	for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requireme by: Based on observati review the facility fa include the use of a	resident, the resident's legal representative at least seven days of the revision of resident assessment required		Corrected	
	hemiplegia and her non-dominant side. R33's quarterly Min 5/30/17, did not ide Mental Status (BIM medicare MDS date score of 13 (cogniti also identified a fun of upper and lower well as extensive as dressing and groon R33's progress note had ROM issues or	imum Data Set (MDS) dated ntify a Brief Interview for S) score. The 30 day ed 3/24/17, identified a BIMS vely intact). The 5/30/17 MDS ctional limitation impairment extremities on one side as ssistance needed with			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00361	B. WING		07/	20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
TRUMAN SENIOR LIVING 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	age 11	2 570				
	recommendation to dated 3/1/16. The R33 had left hand to place resting hand to be worn all night R33's care plan dat an activity of daily lif functional/rehabilitat mobility. The care the resting hand sp On 7/17/17, at 10:3 have left hand clen palm of hand. R33 and stated she was hand but it was lost On 7/20/17, at 7:26 her room with a resised bedside table. R33	ted 3/7/27 indicated R33 had iving (ADL) ation limitation in physical plan did not identify the use of lint. 32 a.m. R33 was observed to ched and nails digging into the 5 had a brace to the left foot 5 to have a splint on her left t. 5 a.m. R33 was observed in sting hand splint lying on the 3 stated staff had just found the nair this morning (7/20/17).					
	During interview on assistant (NA) E sta was previously loca which was applied morning. During interview on registered nurse (R moved to a differen	a 7/20/17, at 8:10 a.m. nursing ated she worked the hall R33 ated and R33 had a hand splin every night and removed in the a 7/20/17, at 12:32 p.m. RN) A stated R33 had recently at room and the splint may					
	director of nursing	on 7/20/17, at 2:22 p.m. the (DON) stated she would he resting hand splint to be					

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/	20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
RUMAN	N SENIOR LIVING		TH 4TH AVEN 1, MN 56088	IUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 570	Continued From pa	ge 12	2 570			
	The director of nurs care plans are revis necessary interdisc concerns. The faci procedures, educat audit periodically to reflect the needs of report findings to th for further recomme compliance.	THOD OF CORRECTION: sing or designee could ensure sed to accurately reflect any iplinary or medication lity could update policies and e staff on these changes and ensure care plans adequately residents. The facility could e quality assurance committee endations to ensure ongoing				
2 830) Subp. 1 Adequate and re; General	2 830			8/29/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	1			
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview, and document illed to monitor bruising for 1) reviewed for non-pressure		Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		E SURVEY PLETED	
		00361	B. WING		07/20/2017		
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	ET ADDRESS, CITY, STATE, ZIP CODE				
DI IM V V	I SENIOR LIVING	400 NOR	TH 4TH AVEN	JE EAST			
		TRUMAN	, MN 56088				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 13	2 830				
	skin conditions.						
	Findings include:						
	seated in wheelcha large bruise on top from the wrist to the bruise covering the	5 p.m. R26 was observed air in room. The resident had a of the right forearm extending e elbow. R26 also had a large top of the left hand. When ime, R26 was unable to uising occurred.					
	assessment include status (BIMS) score cognitive impairme R26 required total of transfers, toilet use	nimum Data Set (MDS) ed a brief interview of mental e of 7 indicating severe nt. The MDS also identified dependence on staff for e, and locomotion on and off sive assistance with personal and bed mobility.					
	history of bruising e medications such a atorvastatin being u were to analyze the determine pattern/t sleeve shirts and p	at reviewed 6/15/17, indicated a easily related to antiplatelet as aspirin, clopidigrel, and used. Interventions included e resident's bruises to trend, to dress resident in long ants and protect extremities, esident with care during direct					
	nursing assistant (I that morning with A confirmed the resid the right forearm an nursing was aware skin issue is identif right away. NA-B s	on 7/20/17, at 9:05 a.m. NA)-B confirmed assisting R26 M cares. NA-B further Jent had significant bruising to nd top of left hand and stated of it. NA-B stated when a new ied it is reported to the nurse stated she had asked nursing for the resident because she					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
			-	Dino			
		00361	B. WING		07/20/2017		
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
RUMAN	I SENIOR LIVING		TH 4TH AVEN 1, MN 56088	UE EAST			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE	
2 830	Continued From pa	age 14	2 830				
	bruises so easily b	ut this hadn't happened.					
	When interviewed	on 7/20/17, at 11:42 a.m.					
		urse (LPN)-C stated when a					
		lentified such as a bruise, the l, family and physician are					
		ent is completed in the					
		ion, an order will also be					
		the bruise daily and measure					
		-C stated being unaware of not assigned to the resident's					
		N-C checked R26's orders and					
		no orders to monitor bruising.					
	When interviewed	on 7/20/17, at 11:48 a.m.					
		orking on R26's wing, stated					
		he resident's bruising. LPN-B					
		ed R26's room to observe the LPN-B confirmed the bruising	1				
		reported to the nurse and to					
		did not occur. LPN-B					
		uises. The right arm bruising					
		ntimeters (cm) x (by) 8 cm. eddish purple around the					
		of the arm was a brownish					
	black in color. The	top of R26's left hand bruise					
		6 cm and was dark red in					
		d she would notify R26's ly of the bruising and would					
		ctor of nursing (DON) and the					
		o the size of the bruising.					
		dated 7/20/17, at 11:54 a.m.					
		I: Notified by state inspector					
		ruising on top of left hand and n. Area on top of left hand					
) cm dark burgundy in color,					
		forearm measures 14.5 x 8					
	cm dark purple in c	olor around the edges with					
	some red colored a	area in the center. Majority of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>`</i>	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
RUMAN	I SENIOR LIVING		RTH 4TH AVEN N, MN 56088	JE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 15	2 830			
	bruise is tannish in	color.				
	DON stated that ne bruising, she would entry into the progr communication she interdisciplinary tea also be notified and would notify the phy significant and staff cause or if suspicio adult (VA) report ar constraint. During DON at approxima	on 7/20/17, at 12:43 p.m. the ew skin issues noted, such as I expect the nurse to make an ess note and also on the daily eet to be investigated by the im. The resident's family would d if a significant new skin issue ysician. Also, if bruising was f were unable to identify the bus, would file a vulnerable ind investigate within the time subsequent interview with tely 1:30 p.m., DON indicated t had been submitted to the d to R26's bruising.	Ł			
	had been informed observed seated in table being assisted resident was wearing	57 p.m. (after LPN-B and DON of R26's bruising) R26 was wheelchair at the dining room d by NA-B with eating. The ng padded geri-sleeves ered the entire arm to protect				
	Prevention and Tre dated 6/16/12 inclu daily with cares by	blicy and Procedure for the atment of Skin Breakdown ded: Skin will be observed the nursing assistant. If any noted, they are to be reported designated nurse.				
	The director of nurs resident records to issues are being m preventive measure risk for skin injuries	THOD OF CORRECTION: sing or designee could audit ensure bruises and skin onitored, assessed and es are at place for residents at s, and to ensure falls e care-planned are being				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/20/2017	
		00361	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRUMAN	N SENIOR LIVING		FH 4TH AVEN MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	consistently implem nursing or designee procedures related and falls as approp these changes. Fir reported to the qual further recommend compliance.	ge 16 nented. The director of e could revise policies and to skin care and monitoring, riate, and educate staff on ndings of audit activity could be lity assurance committee for ations to ensure ongoing R CORRECTION: Twenty-one	2 830			
2 910	Incontinence Subp. 5. Incontiner have a continuous p management to rec unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident' that catheterization B. a resident wh receives appropriat prevent urinary trac	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder luce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and ho is incontinent of bladder e treatment and services to t infections and to restore as er function as possible.	2 910			8/29/17
	by: Based on observati review, the facility fa manner to restore a	ent is not met as evidenced on, interview and document ailed to provide toileting in a as much normal bowel and 2 of 3 (R3, R33) residents		Corrected		

STATE FORM

ZO5R11

If continuation sheet 17 of 53

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 17	2 910			
	reviewed for fecal a	and urinary incontinence.				
	Findings include:					
	When interviewed on 7/17/17, at 11:28 a.m. stated when he needed to have a bowel movement was to just go in his "diaper".					
	assessment dated Interview for Menta indicating moderate MDS further identifi upon staff for transf always incontinent revised 7/10/17, inc	num Data Set (MDS) 5/16/17 included a Brief I Status (BIMS) score of 11 e cognitive impairment. The ied R3 was totally dependent fers and toilet use and was of bowel. The care plan last dicated R3 was incontinent of related to mobility and function.				
	nursing assistant (N incontinent of urine communicate to sta bowel movement (E toileted when needi utilized a Hoyer lift. bathroom was not b the lift into the bath the toilet, therefore in the brief. NA-B s confirmed she instr finished so staff cou Initially, NA-B denie commode large end then remembered a	on 7/20/17, at 11:14 a.m. NA)-B stated R3 was always although could identify and aff when he needed to have a BM). NA-B stated R3 was not ing to have a BM because he NA-B indicated R3's big enough to accommodate room and safely transfer onto R3 was directed to have a BM stated, "He hates it". NA-B ucted R3 to inform her when uld change him right away. ed there was an available bugh to accommodate R3 and a larger commode was ntly utilized by another				
		on 7/20/17, at 11:24 a.m. R3 I rather sit on the toilet for a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
RUMAN	SENIOR LIVING		H 4TH AVEN MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 910	BM than in his brief able to tell staff whe When interviewed o	R3 further confirmed he was en needing to have a BM. on 7/20/17, at 11:32 a.m.	2 910			
	bathroom would no for toileting. LPN-B require an extra larg unavailable as it wa resident. LPN-B sta	urse (LPN)-B confirmed R3's t accommodate the Hoyer lift further stated R3 would ge commode which was is being used for another ated it would be better if R3 r BM's rather than having to				
	director of nursing (on 7/20/17, at 12:58 p.m. the (DON) stated being unaware uldn't be used for R3 for BM				
	stated R3 used to u a standing lift for tra R3 started using the was toileted as the well enough to safe NA-E stated she the sitting on a commo enough. NA-E furth extra large commo resident was utilizin	on 7/20/17, at 1:26 p.m. NA-E use the toilet when able to use ansfers. NA-E confirmed once e Hoyer lift he was no longer lift did not fit in R3's bathroom ly transfer him onto the toilet. ought R3 would be capable of de if they had one large her clarified the facility had one de available but since another og this commode, it was not A-E confirmed R3 had utilized least 2 years.				
	DON confirmed R3 for BM's in the bath from his room and t	on 7/20/17, at 2:25 p.m. the would be able to be toileted bay located across the hall thus be provided appropriate maintain continence.				
		ndated, identified diagnoses a and hemiparesis on the left				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00361	B. WING		07/	20/2047	
	PROVIDER OR SUPPLIER		B. WING 07/20/20 T ADDRESS, CITY, STATE, ZIP CODE 07/20/20				
			TH 4TH AVEN				
RUMAN	N SENIOR LIVING	TRUMAN	I, MN 56088				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 19	2 910				
	non-dominant side						
	assessment dated Interview for Menta day medicare MDS BIMS score of 13 (5/30/17 MDS also	nimum Data Set (MDS) 5/30/17, did not identify a Brief al Status (BIMS) score. The 30 6 dated 3/24/17, identified a cognitively intact). The identified R33 did not have a nd was always incontinent of					
	R33 as incontinent mobility impairmen needing to void. T regain the ability to voids per day by th included: total lift in on staff for toileting	st revised 6/11/17, identified of urine related to hemiplegia, t and lack of sensation when he care plan identified a goal to have one or more continent e next review. Approaches hout of bed, totally dependent g, incontinent brief and provide after each incontinent episode.	5				
		ord was reviewed. No dder function was noted in the					
		n 7/17/17, at 10:26 a.m R33 ong for the staff to get here tha continent.	t				
	stated "I have a co bathroom and she lunch time so I had go to the bathroom	n 7/19/17, at 1:10 p.m. R33 mplaint! I asked to go to the told me no it was too close to I to sit through lunch having to I. I turned on my light and she get help and would be right					
	had returned to as	i 7/19/17, at 1:23 p.m. no staff sist R33 as staff were in a n the hall from R33's room. At					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RUMA	N SENIOR LIVING		TH 4TH AVENU I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 910	this time, R33 turner p.m. licensed practia and asked R33 what need to go to the bat needed to go get ad LPN-B and nursing onto the commode. R33 was continent incontinent of urine was soaked. During interview on R33 will tell staff wh movement (BM) bu urine. She stated s go (urine) but doesn During interview on stated that on night change R33. NA-G bedpan nor the com During interview on stated R33 is alway sometimes she will anyway. NA-F indic the bathroom when When interviewed of registered nurse (R assessment was no facility does not cor When interviewed of director of nursing (assessments shoul continence status a	ed on the call light and at 1:25 ical nurse (LPN)-B walked by at she needed. R33 replied, "I athroom". LPN-B stated she dditional help. At 1:27 p.m. assistant (NA)-F helped R33 . At 1:35 p.m. NA-F stated of bowel but was very and NA-F confirmed the brief 7/19/17, at 7:42 NA-E stated hen she has to have a bowel t is always incontinent of she knows when she needs to n't tell us. 7/20/17, at 8:30 a.m. NA-G shift staff just check and stated R33 doesn't use the nmode at night. 7/20/17, at 8:35 a.m. NA-F vs incontinent of urine; ask but is usually incontinent tated R33 will request to go to needing to have a BM. on 7/20/17, at 12:20 p.m. N)-A stated that a bladder of available for review as the	2 910			

				(X3) DATE SURVEY COMPLETED	
	00361	B. WING		07/	20/2017
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
I SENIOR LIVING			JE EAST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 21	2 910			
including hemiplegi	and hemiparesis on the left				
assessment dated Interview for Menta day medicare MDS BIMS score of 13 (5/30/17 MDS also i	5/30/17, did not identify a Brief I Status (BIMS) score. The 30 dated 3/24/17, identified a cognitively intact). The dentified R33 did not have a				
R33 as incontinent mobility impairment needing to void. The regain the ability to voids per day by the included: total lift in on staff for toileting	of urine related to hemiplegia, t and lack of sensation when he care plan identified a goal to have one or more continent e next review. Approaches /out of bed, totally dependent , incontinent brief and provide	2			
stated it takes so lo	ong for the staff to get here that	t			
stated "I have a con bathroom and she lunch time so I had go to the bathroom	mplaint! I asked to go to the told me no it was too close to to sit through lunch having to . I turned on my light and she				
	OF CORRECTION PROVIDER OR SUPPLIER I SENIOR LIVING SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From par R33's face sheet un including hemipleginon-dominant side. R33's quarterly Min assessment dated Interview for Mentar day medicare MDS BIMS score of 13 (5/30/17 MDS also in toileting program and urine. R33's care plan lass R33 as incontinent mobility impairment needing to void. The regain the ability to voids per day by the included: total lift in on staff for toileting incontinence care and R33's medical record assessment of blact medical record. During interview ond stated it takes so loc I am often times ind During interview ond stated "I have a cord bathroom and she lunch time so I had go to the bathroom said she had to go	OF CORRECTION IDENTIFICATION NUMBER: 00361 PROVIDER OR SUPPLIER STREET A SENIOR LIVING 400 NOF TRUMAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 R33's face sheet undated, identified diagnoses including hemiplegia and hemiparesis on the left non-dominant side. R33's quarterly Minimum Data Set (MDS) assessment dated 5/30/17, did not identify a Brief Interview for Mental Status (BIMS) score. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact). The 5/30/17 MDS also identified R33 did not have a toileting program and was always incontinent of urine. R33's care plan last revised 6/11/17, identified R33 as incontinent of urine related to hemiplegia, mobility impairment and lack of sensation when needing to void. The care plan identified a goal to regain the ability to have one or more continent voids per day by the next review. Approaches included: total lift in/out of bed, totally dependent on staff for toileting, incontinent brief and provide incontinence care after each incontinent episode. R33's medical record was reviewed. No assessment of bladder function was noted in the medical record. During interview on 7/17/17, at 1:10 p.m. R33 stated it takes so long for the staff to get here tha I am often times incontinent. During interview on 7/19/17, at 1:10 p.m. R33 stated "I have a complaint! I asked to go to the bathroom and she told me no it was too close to lunch time so I had to sit through lunch having to go to the bathroom. I turned on	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A.BUILDING: 00361 B.WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH ATH AVENUE EAST TRUMAN, MN 56088 ONORTH ATH AVENUE EAST TRUMAN, MN 56088 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) R33's face sheet undated, identified diagnoses including hemiplegia and hemiparesis on the left non-dominant side. 2910 R33's quarterly Minimum Data Set (MDS) assessment dated 5/30/17, did not identify a Brief Interview for Mental Status (BIMS) score. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact). The 5/30/17 MDS also identified R33 did not have a toileting program and was always incontinent of urine. R33's care plan last revised 6/11/17, identified R33 as incontinent of urine related to hemiplegia, mobility impairment and lack of sensation when needing to void. The care plan identified a goal to regain the ability to have one or more continent voids per day by the next review. Approaches included: total lift in/out of bed, totally dependent on staff for toileting, incontinent brief and provide incontinence care after each incontinent episode. R33's medical record. During interview on 7/17/17, at 10:26 a.m R33 stated if takes so long for the staff to get here that 1 am often time	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00361 B. WING 077 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN, STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LG: DENTIFYING INFORMATION) ID REGULATORY OR LG: DENTIFYING INFORMATION) ID PREFIX PRCHOLENCY Continued From page 21 2 910 2 910 CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY R33's face sheet undated, identified diagnoses including hemiplegia and hemiparesis on the left non-dominant side. 2 910 CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY R33's gare and Data Set (MDS) assessment dated 5/30/17, did not identify a Brief Interview for Mental Status (BIMS) score. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact). The 5/30/17 MDS also identified R33 did not have a toileting program and was always incontinent of urine. R33's acre plan last revised 6/11/17, identified a STATE Status (BIMS) score of more or continent voids per day by the next review. Approaches included: total lift invout ob bed, totally dependent on staff for toileting, incontinent brief and provide incontinence care after each incontinent episode. R33's medical record. R33's medical record was reviewed. No assessment of bladder function was noted in the medical record. R33's medical r

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	N SENIOR LIVING		TH 4TH AVEN 1, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 910	had returned to ass resident room dowr this time, R33 turne p.m. licensed pract and asked R33 wha need to go to the ba needed to go get ac LPN-B and nursing onto the commode. R33 was continent incontinent of urine was soaked. During interview on R33 will tell staff wh movement (BM) bu urine. She stated s go (urine) but does During interview on stated that on night change R33. NA-G bedpan nor the com During interview on stated R33 is alway sometimes she will anyway. NA-F indic the bathroom when When interviewed of registered nurse (R assessment was no facility does not cor	 A state of the second state of the se		DEFICIENC	εΥ)	
	director of nursing (assessments shoul continence status a	DON) stated bladder (DON) stated bladder d be conducted to determine and then individualized be implemented, such as a				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00361		B. WING		07/20/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa toileting program.	ge 23	2 910			
	The director of nurse policies and proced bladder assessmen educate staff on the nursing or designee residents who are in appropriate assess director of nursing of residents to ensure place as a result of implemented effect	HOD OF CORRECTION: sing or designee could revise ures related to bowel and at and toileting programs, and ese changes. The director of a could audit to ensure ments are put into place. The or designee could audit the interventions put into assessments are being ively. Results of audits could quality assurance committee endations to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21426	Prevention And Cor	A.04 Subd. 3 Tuberculosis htrol e provider must establish and	21426			8/29/17
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	bernovider must establish and bensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of action, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of technical assistance intation of the guidelines.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
	00361		B. WING		07/20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
RUMAN	SENIOR LIVING		H 4TH AVE MN 56088	NUE EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
21426	Continued From pa	ge 24	21426		
	(b) Written complia be maintained by th	ance with this subdivision must le nursing home.			
	by: Based on interview facility failed to perf test (TST) for 1 of addition, the facility screening compone employees (E2, E3)	ent is not met as evidenced and document review the form a two-step tuberculin skin 5 employees (E)-1. In failed to ensure baseline TB ents were completed for 2 of 5) per current Center for d Prevention (CDC) and facility policy.		Corrected	
	Findings include:				
	documented baselin first step TST dated	of 8/5/16, and had a ne TB symptom screen and I 8/5/16. The file did not second step TST had been			
	documented TST's previous employer. symptom screen co TST's were more th	of 5/18/17, and had on 7/19/16 and 8/8/16 from a Although E2 had a TB ompleted on 5/18/17, the nan 90 days from date of hire. ence the facility had completed ication.			
	a previous employe symptom screen co	of 4/24/17, and had on 12/1/16 and 12/8/16 from er. Although E3 had a TB ompleted on 4/24/17, the nan 90 days from date of hire.			

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa There was no evide a second TST appl	ence the facility had completed	21426			
	director of nursing lacking a second st employed by facility "to do" list and creat monitor new employ The DON indicated previous employer sufficient if dated w An undated facility Two-Step Tubercul No previous TST re TST's. Previous do < (less than) 12 mo single TST needed will be the 2nd step other persons who basis, a previous T a subsequent TST, associated with sev shock, which are st events.	policy titled, Indications for in skin Tests, included: esults; two-step baseline ocumented negative TST resul onths before new employment; for baseline testing; this test o. For newly hired HCW's and will be tested on a routine ST is not a contraindication to unless the test was vere ulceration or anaphylactic ubstantially rare adverse	t			
	DON or designee of the tuberculosis sci employees to ensu screenings are bein CDC recommenda designee could upor related to tuberculin staff and residents related to the change	-				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00361	B. WING		07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN , MN 56088	IUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21535	MN Rule4658.1315 Drug Usage; Genei	Subp.1 ABCD Unnecessary al	21535			8/29/17
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is ind available through th	quate indications for its use; or nce of adverse consequences lose should be reduced or rug regimen review required in e nursing home must comply ie Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the lth and Human Services, ing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not				
	by: Based on observati review, the facility fa monitoring was con medications for 2 o	ent is not met as evidenced on, interview and document ailed to ensure target behavior npleted for anti-psychotic f 5 residents (R51, R33) essary medications.		Corrected		
	Findings include:					
	R51's face sheet, u of unspecified demo	ndated, indicated diagnoses				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	00361		B. WING		07/20/2017	
			DDRESS, CITY, S	TATE, ZIP CODE		
TRUMAN	I SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From pa	age 27	21535			
	disturbance and Pa	arkinson's disease.				
	assessment dated behavioral concern	linimum Data Set (MDS) 5/30/17, indicated no mood or is, and identified a Personal ire (PHQ-9) score was not assessment.				
	R51's Care Area Assessment (CAA) for psychoactive medications dated 5/30/17, indicated R51 had been admitted from the emergency room following a fall at home, and continued on Abilify (antipsychotic) daily for management of dementia-psychosis, depression, and REM sleep disorder.					
	psychotropic drug of antidepressant and related to dementia sleep disorder. A g exhibiting signs of hypotension, or and target behavior list approaches of offe	st revised 5/31/17, identified use - resident receives d anti-psychotic medication a without behaviors and REM goal was listed identified: not drug related sedation, ticholinergic symptoms. A ted for inability to sleep, with ring a snack, follow bedtime im to vent. No other target ed.				
	identified R51 was	ian's orders dated 7/17, on Abilify 5 milligrams daily for itia without behavioral				
	5/24/17, with a retu practitioner of 5/30	Itant review, completed Irn fax date from the nurse /17, indicated the condition the dministered was Parkinson's chosis.				
· -		and treatment sheets dated				
ATE FOR	epartment of Health M		⁶⁸⁹⁹ ZO	O5R11	If continuati	on sheet 28

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00361		00361	B. WING			07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
TRUMAN	SENIOR LIVING		TH 4TH AVENU I, MN 56088	JE EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE	
21535	Continued From pa	ige 28	21535				
		nce of any monitoring of R51's or other specific target behavior to his Abilify usage.	r				
	practical nurse (LP with transfers; how any other behaviors wander guard alarn	7/19/17, at 8:08 a.m. licensed N)-B stated R51 was impulsive ever, she had not observed s. LPN-B stated R51 wore a n to alert staff if attempts to go as often was looking for his)				
	social worker (SW) documenting on be look back period re and could not ident charting being docu	7/19/17, at 9:02 a.m. the stated they only were haviors for R51 during the lated to the MDS assessment ify any specific target behavior umented anywhere in the s anti-psychotic usage.					
	was wheeling back neat in appearance	on 7/19/17, at 9:10 a.m. R51 from breakfast, appeared e, propelling himself in his as noted to have a flat facial					
	was seated in his w his side. R51 appe shaven. R51 was a anxiolytic for sleep	on 7/19/17, at 10:56 a.m. R51 /heelchair, with family (F)-B at ared neat in appearance and able to state he took an because "I would fall out of					
	for years"; howeve reason he took the was unsure the spe been for the prescr	is has been under good contro r, was unable to state the anti-psychotic. F-B stated she ecific behaviors would have ibed anti-psychotic medication s scheduled for a medication)				
	review with the neu						

ZO5R11

If continuation sheet 29 of 53

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING	B. WING		20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	N SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 29	21535			
	on a consultant pha with unnecessary n expected target be monitored for anti-p R33's face sheet id phobic anxiety diso	(DON) stated the facility relied armacist to identify concerns nedications and would have haviors to be identified and osychotic medications. lentified diagnoses including order, insomnia and major r recurrent, severe with as-mild, recurrent.				
	did not identify a Br (BIMS) score nor a depression. The 30 3/24/17, identified a intact) and a PHQ- depression). The N cares and verbal be	PS assessment dated 5/30/17, rief Interview for Mental Status PHQ-9 an assessment for day medicare MDS dated a BIMS score of 13 (cognitively 9 score of 6 (minimal MDS also identified rejection of ehavioral symptoms occurred elusions or hallucinations	,			
	7/24/17, identified a (anti-psychotic med	ders dated 6/24/17 through an order for Zyprexa dication used to treat rams (mg) every day.				
	7/20/17, indicated v	es from 3/22/17 through /erbally abusive behavior lo other behaviors were				
	received anti-psych Major depression w included: monitor re response to medica target behavior of a	ted 3/7/17, indicated R33 notic medication related to vith psychosis. Approaches esidents behavior and ation monthly and identified a aggression: leave safe and o vent frustrations and 1:1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
00361		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN I, MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	ge 30	21535			
	director of nursing (document in the pr behaviors; in addition need to be document verified R33 did not related to the use of effectiveness and re Policies related to a usage were reques SUGGESTED MET The director of nurs policies and proced monitoring of psych facility could educar procedures, and au compliance. The factor	7/20/17 at 2:22 p.m. the (DON) stated staff need to orgress notes and comment or on, the nursing assistants enting behaviors. The DON t have behavior monitoring of a psychotropic medication sc esponse could be evaluated. Anti-psychotic medication ted, none were provided. THOD OF CORRECTION: sing or designee could develop lures for the use and noactive medications. The te staff on these policies and udit resident records for acility could report findings to ce committee, for further to ensure ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21610	MN Rule 4658.1340 and Preparation Are	0 Subp. 1 Medicine Cabinet ea;Storage	21610			8/29/17
	must store all drugs under proper tempe	e of drugs. A nursing home s in locked compartments erature controls, and permit sing personnel to have				
	This MN Requiremo	ent is not met as evidenced				
	Based on observati	on, interview and document ailed to develop a system to		Corrected		

STATE FORM

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00361		B. WING		- 07/20/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN 1, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	ige 31	21610			
	schedule IV medica diversion for 4 of 4 medications review IV medications wer the medication roor Findings include: On 7/19/17, at 1:58 was observed with (LPN)-A. The right was noted to have 2 contained resident stored in the medic were separated by bins; the medication blister-pack cards of medication on each medications observ as follows: (1) R9 - lorazepam (0.25 mg dose): (a) 1 card of #3 (b) 2 cards of # 10/10/16 (c) 1 card of #3 (d) 3 cards of # 1/3/17 (f) 1 card of #30 (g) 2 cards of # 3/22/17 (h) 1 card of #30 (i) 1 card of #30 (i) 1 card of #30 (i) 1 card of #30 (c) R9-lorazepam 0	 a b. p.m. the medication room licensed practical nurse side of the medication room 2 locked cabinets which overflow medications not ation carts. The medications resident into small crate-like ns were packaged on containing up to #30 of the n card . The schedule IV ved in the locked cabinets were 0.5 milligrams (mg) 1/2 tablets (mg) 1/2 tablets filled 9/12/16 30 1/2 tablets filled 9/12/16 30 1/2 tablets (#60 total) filled 30 1/2 tablets (#90 total) filled 30 1/2 tablets (#60 total) filled 30 1/2 tablets (#60 total) filled 30 1/2 tablets filled 2/27/17 30 1/2 tablets filled 5/16/17 0 1/2 tablets filled 5/16/17 0 1/2 tablets filled 5/16/17 tablets filled 5/16/17 0 1/2 tablets filled 5/16/17 0 1/2	8			
	(a) 1 card of #3	30 tablets filled 1/3/17 30 tablets (#60 total) filled				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
0036		00361	B. WING	B. WING		20/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FRUMAN	SENIOR LIVING		TH 4TH AVEN 1, MN 56088	UE EAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLETI
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
21610	Continued From pa	ige 32	21610			
	3/22/17					
		0 tablets filled 5/16/17				
	Total = 120 full					
		HCL 50 mg 1/2 tablets (25 mg				
	dose) (a) 6 cards of # 6/1/17	30 tablets (#180 total) filled				
		0.5 mg (full tablets)				
		30 tablets filled 4/17/15				
		0 tablets filled 12/24/16				
	Total = 60 full ta					
		5) R51-clonazepam 0.5 mg 1/2 tablets (0.25 mg dose)				
		4 tablets filled 4/10/17				
		n 0.5 mg (full tablets)				
		3 tablets filled 4/10/17				
	()	2 tablets filled 5/17/17				
	(c) 1 card of #3 Total = 45 full ta	0 tablets filled 6/23/17 ablets				
		on 7/19/17, at 1:58 p.m. LPN-/	A			
		staff did not count/reconcile				
		erflow medications stored in in the medication room.				
		a card of medication is taken				
		abinet and placed into the				
		at card of medications is				
		nented in the eMAR (electronic				
		stration record). LPN-A is no record-keeping system ir				
		ount of overflow schedule IV				
		rther confirmed if medication				
	was missing they w	ould have no knowledge.				
		on 7/20/17, at 11:36 a.m. the				
		cist stated that there was no				
		for reconciliation of schedule				
		ugh must conduct periodic consulting pharmacist				
		ty should have some system ir				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVENU I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21610	Continued From pa	ige 33	21610			
	place to reconcile s substances.	supply of controlled				
	director of nursing (be a system in plac	on 7/20/17, at 1:00 p.m. the (DON) confirmed there should the to account for/reconcile ations stored in the medication version.				
	physician orders da diagnoses including and anxiety disorde indicated R9 could orally once daily at	d was reviewed. R9's signed ated 6/23/17, identified g Major depressive disorder er. The physician orders receive lorazepam 0.5 mg 8:00 a.m. for anxiety disorder ng) up to three times a day as n/anxiety.				
	signed physician or diagnoses including the knee. The phys	rd was reviewed. R13's ders dated 7/7/17, identified g scoliosis and osteoarthritis of sician orders indicated R13 adol 25 mg orally every 6 hours				
	signed physician or diagnoses including and anxiety disorde indicated R31 could	rd was reviewed. R31's ders dated 7/12/17, identified g major depressive disorder er. The physician orders d receive lorazepam 0.5 mg dose) orally once daily for y disorder.				
	signed physician or R51 could receive of	rd was reviewed. R51's ders dated 7/7/17, indicated clonazepam 1 mg orally at leep behavior disorder.				
		HOD OF CORRECTION: sing and consultant pharmacist	t			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		.E CONSTRUCTION (>	(3) DATE SURVEY COMPLETED
		00361	B. WING		07/20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
TRUMAN	SENIOR LIVING		TH 4TH AVE MN 56088	NUE EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
21610	all controlled substa The director of nurs nursing staff related periodically for com reported to the qual further recommend	ies and procedures, to ensure ance supplies are reconciled. sing or designee could educate to these changes, audit pliance. Findings could be lity assurance committee for	21610		
21730	Subp. 11. Insect ar condition on the site conducive to the ha insects, rodents, or eliminated immedia control program mu personnel. This MN Requireme by:	eration, & Maintenance nd rodent control. Any e or in the nursing home inborage or breeding of other vermin must be ately. A continuous pest ist be maintained by qualified ent is not met as evidenced	21730	Connected	8/29/17
	review, the facility fa control was maintai throughout the facil the potential to affe the facility. Findings include: During interview on resided down the A stated, "There are b ones in my room to	on, interview and document ailed to ensure adequate pest ined to control crawling insects ity. This deficient practice had ct all 41 residents residing in 7/17/17, at 10:58, R16 (who ster Wing of the facility) bugs in here, I killed two black day." on 7/19/17, at 7:37 a.m. a		Corrected	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RUMAN	I SENIOR LIVING		TH 4TH AVEN 1, MN 56088	UE EAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21730	Continued From pa	ge 35	21730			
	by the central nursi	inch long ran across the floor ng station, and was observed				
	to hide underneath a garbage can. During observation on 7/20/17, at 8:37 a.m. another of these same crawling insects, approximately 3/4 inches long was noted crawlin in the hallway in the Bluebell wing. When retrieved and shown to the environmental services director (ESD), he stated "they are harmless beetles, we have had numerous complaints, especially down the Aster Wing." The ESD stated Pest Pro, the facility's pest contractor had been to the facility on 6/26/17 an was due again at the end of 7/16 at the facility. The ESD further stated "They are usually dying after they get in, so we know the spray is killing them, there is not much I can do about it."	3				
	maintenance assist was having more d and they had an ex month for routine p "As soon as he [per come out and die a	7/20/17, at 9:05 a.m. tant (M)-A stated the facility ifficulty with bugs than usual, terminator come once a est control. M-A further stated st contractor] sprays, they nd all we can do is sweep me up underneath the walls."				
	dead beetles of the	on 7/20/17, at 11:40 a.m. two same black/brown variety loor on the Evergreen Wing.				
	another dead beetle	on 7/20/17, at 11:42 a.m., e was noted outside the allway adjacent to the				
		of the lunch meal on 7/20/17, 2:15 p.m. five dead and				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	N SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21730	Continued From par several crawling be of the common dini During observation 12:43 4 dead black wash sink and 3 bla dry storage room. she had noticed the storage room at tim During interview on ESD stated he "I do contractor had see 6/26/17 and was av current concern. T Pest Pro had treate Blue Bird Wing for insect. The ESD fu when we can, I thin The ESD supplied a indicated the contra 6/26/17, and had tr control general crav report further stated noted." The log ind pesticide solution w stated he had actua day after their last thad returned to rep find the paperwork	age 36 eetles were noted on the floor ing area. and interview on 7/20/17, at k beetles on the floor under the ack beetles on the floor of the Cook (C)-A stated at this time em on the floor of the dry nes. 7/20/17, at 12:26 p.m. the bubt it," if the pest control in the beetles during his ware of the extent of the he ESD stated on 6/26/17 ed the interior and exterior of earwigs, another type of urther stated "We all sweep up k it has to do with moisture." a Pest Pro log report, which actor had been there on eated areas of interior to wling insects of earwigs. The d "No other pest problems licated Demand CS - 1/2% vas used. The ESD further ally called Pest Pro back the treatment on 6/27/17, and he beat a treatment, but could not and would get this from Pest as left with Pest Pro at this	21730			
	service representat manufacturer of De stated the facility ca days, and it would r application to contr	a 7/20/17, at 1:03 p.m. a tive from Syngenta, emand CS control chemical an re-treat the floor every 21 normally take more than one ol beetles. If a high level of eurring, normally a contractor				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00361	B. WING		07/20/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21730	Continued From pa	ge 37	21730			
		I the entire exterior perimeter put up a barrier to prevent the building.				
	Pest Pro returned a had completed the at the facility denied 6/27/17 to relay the noticed inside the fa not aware of the ex Friday," which was He denied seeing th and stated he only the and entries with spr known it was bad I outside with the ATV insecticide] around also stated "it is the repair their door gas badly in need of rep	p.m. a representative from call. The technician, who 6/26/17, insecticide treatment d receiving a return call on increased level of insects acility. He indicated he was tent of the issue until "last during the facility inspection. he beetles noted at the facility, treated some of the doorways ray inside the facility. "If I had would have done a full sweep V to put a wide band [of the building." The technician facility's responsibility to skets, which are worn out and pair," and indicated the doors ntry for crawling insects.				
	The environmental could increase the to to the facility until th control, and assess crevices that are a the building. The e could develop polic educate responsible services director co for pests, and repon assurance committe					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED	
	00361	B. WING		07/20/2017	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
I SENIOR LIVING			NUE EAST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
Continued From pa	age 38	21805			
		21805		8/29/17	
residents have the courtesy and respe	right to be treated with ect for their individuality by ersons providing service in a				
by: Based on observat review, the facility f dignified manner for reviewed for dignity independence for 1 with restriction to re precautions and to	ion, interview and document ailed to provide toileting in a or 1 of 3 residents (R3) y and to promote I of 1 resident (R59) reviewed emain in room while on contact wear a wanderguard on the		Corrected		
Findings include:					
stated feeling it was	s undignified that when he				
assessment dated Interview for Menta indicating moderate MDS further identif upon staff for trans always incontinent care plan last revis incontinent of blade	5/16/17 included a Brief al Status (BIMS) score of 11 e cognitive impairment. The ied R3 was totally dependent fers and toilet use and was of bladder and bowel. The ed 7/10/17, indicated R3 was der and bowel related to				
	OF CORRECTION PROVIDER OR SUPPLIER I SENIOR LIVING SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From part MN St. Statute 144 Residents of HC Factor Subd. 5. Courteor residents have the courtesy and respective employees of or per- health care facility. This MN Requirerererererererererererererererererere	OF CORRECTION IDENTIFICATION NUMBER: 00361 00361 PROVIDER OR SUPPLIER STREET AE SENIOR LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting in a dignified manner for 1 of 3 residents (R3) reviewed for dignity and to promote independence for 1 of 1 resident (R59) reviewed with restriction to remain in room while on contact precautions and to wear a wanderguard on the leg without risk of elopement. Findings include: When interviewed on 7/17/17, at 11:28 a.m. R3 stated feeling it was undignified that when he needed to have a bowel movement was to just go	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00361 B. WING	OF CORRECTION IDENTIFICATION NUMBER A. BUILDING: 00361 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088 PREVIDER LIVING 10 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG Continued From page 38 21805 Subd, 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. Corrected This MN Requirement is not met as evidenced by: Corrected Corrected Based on observation, interview and document review, the facility failed to provide toileting in a dignified manner for 1 of 3 residents (R3) reviewed for dignity and to provide toileting in a dignified manner for 1 of 3 resident (R5) reviewed with restriction to remain in room while on contact precautions and to wear a wanderguard on the leg without risk of elopement. Corrected Findings include: When interviewed on 7/17/17, at 11:28 a.m. R3 stated feeling it was undignified that when he needed to have a bowel movement was to just go in his "diaper". R3's quarterly Minimum Data Set (MDS) assessment dated 5/16/17 included a Brief Interview for Mental Status (BiN) score of 11 indicating moderate cognitive impairment. The MDS further identifi	

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07//	20/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, ST	ATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVENI I, MN 56088	JE EAST		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESID(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXREGULATORY OR LSC IDENTIFYING INFORMATION)TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21805	-	ige 39 NA)-B stated R3 was always	21805			COMPLET
	need to have a bow stated R3 was cons and R3 was also at incontinence produ was not toileted wh because he utilized R3's bathroom was accommodate the I transferring the res therefore R3 was d brief. NA-B stated, confirmed R3 was a when he needed to had directed R3 to staff could change denied there was a enough to accomm	lift into the bathroom and ident safely onto the toilet; irected to have a BM in the "He hates it". NA-B able communicate to staff have a BM and indicated she inform her when finished so him right away. Initially, NA-B n available commode large todate R3 and then ler commode was available bur	t			
	confirmed he would BM than in his brief able to tell staff who	on 7/20/17, at 11:24 a.m. R3 d rather sit on the toilet for a f. R3 further confirmed he was en needing to have a BM but rination since it just comes.	3			
	licensed practical n bathroom would no for toileting. LPN-E would need an extr unavailable to R3 a another resident. L	on 7/20/17, at 11:32 a.m. hurse (LPN)-B confirmed R3's at accommodate the Hoyer lift of further stated the resident a large commode which was as was being utilized by LPN-B stated it would be better ted for BM's rather than having				
nesota D		on 7/20/17, at 12:58 p.m. the (DON) stated being unaware				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
RUMAN	N SENIOR LIVING		TH 4TH AVEN , MN 56088	JE EAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
21805	Continued From pa	ge 40	21805			
	toileting. DON state	ouldn't be used for R3 for BM ed she would investigate nd the rationale and would o the surveyor.				
	stated R3 used to u a standing lift for tra the resident started no longer toileted a bathroom well enou- toilet. NA-E stated capable of sitting on large enough. NA- had one extra large another resident wa was not available for utilized the Hoyer lift When interviewed of DON stated R3 cou- bath bay across the confirmed the bath	on 7/20/17, at 1:26 p.m. NA-E use the toilet when able to use ansfers. NA-E confirmed once utilizing the Hoyer lift he was s the lift did not fit in R3's ugh to safely transfer onto the she thought R3 would be n a commode if they had one E further clarified the facility commode available but since as utilizing this commode, it or R3. NA-E confirmed R3 had ft for at least 2 years.				
	R59's undated face of urinary tract infe	sheet, identified a diagnosis ction.				
	identified a BIMS so with no behaviors a further identified R	DS assessment dated 7/11/17 core of 13 (cognitively intact) ind/or wandering. The MDS 59 as being occasionally ler and needing extensive ting and transfers.				
	signage was noted stating: Please che	7/17/17, at 2:01 p.m. a on R59's private room door eck with nursing staff before ted R59 was confined to his				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00361	B. WING		07/	20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	N SENIOR LIVING		TH 4TH AVEN 1, MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ige 41	21805			
		ection in the urine and gown eeded by staff assisting with				
	was sitting in a whe R59's right leg was ankle and a wander ankle. At this time banana's" and wou room but was not a go outside. R59 ind	on 7/17/17, at 2:05 p.m.R59 eelchair (w/c) in his room. in a cast from upper thigh to rguard was noted on the left R59 stated he is "going Id prefer to go outside of his Illowed to leave his room nor dicated he was also upset that ard attached to his left leg.				
	7/14/17, R59 was id (vancomycin-resista with bacteria resista vancomycin) in the	ant enterococci, an infection				
	member (F)-A state urine but wore an ir urine. F-A further in been noted on R59 However, F-A state leave his room due F-A indicated this u meals in the dining the building. F-A fu	7/18/17, at 4:51 p.m. family ed R59 was incontinent of incontinent pad to contain the idicated no incontinence had 's clothing during visits. d R59 was not allowed to to the infection in his urine. pset R59 as he enjoyed his room and the fresh air outside inther indicated she was not a wanderguard placed but upsetting R59.				
	his friends at the di could join them for wasn't sure why he	p.m. R59 indicated he missed ning room table, wishing he meals. R59 also stated he had to wear a wanderguard, nable to propel himself to the e.	ŀ			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00361	B. WING		07/	20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
TRUMAN	SENIOR LIVING		TH 4TH AVEN I, MN 56088	UE EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
21805	Continued From pa	ge 42	21805				
	who was sitting in h	7/18/17, at 5:58 p.m. R59, is room eating his meal with plate and utensils stated, it is prison".	6				
	11:50 a.m. R59 exp restriction to remain	nt interview on 7/19/17, at pressed frustration with the n in his room and also the anderguard to his leg. R59 g to stay in here".					
	stated R59 can't lea	7/19/17, at 12:02 p.m. NA-C ave his room and that "drives ndicated being unsure of the wanderguard.					
	social services (SS elopement risk and wanderguard. At 1 was indeed wearing ankle. Neither the the wanderguard at R59 should not hav	on 7/19/17, at 12:06 p.m.)-A stated R59 is not an did not require a 2:09 p.m. SS-A confirmed R59 g a wanderguard on the left SS-A nor RN-A were aware of tached to R59 and confirmed re this applied. RN-A ed the device after learning of					
		a.m. NA-B stated R59 was his clothes indicating the pads d the urine.					
	precautions implem (Centers for Diseas guidelines for VRE, and the other reside was incontinent she tablecloths and/or c	p.m. the DON stated the nented were based on CDC e Control and Prevention) and what was best for R59 ents. DON stated since R59 e didn't want R59 touching other objects in the facility the infection. The DON					

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
TRUMAN	N SENIOR LIVING		TH 4TH AVENU I, MN 56088	JE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 43	21805			
	reiterated that keep was appropriate.	ing R59 isolated in his room				
	revised 8/16/12, in has the potential for	d Elopement/Wandering Policy dicated only a resident who r elopement/wandering will ansponder placed on their elchair.				
	Transmission-Base identified the facility the least restrictive	d Isolation-Categories of d Precautions revised 1/2012, v shall make every effort to use approach to managing entially communicable				
	A facility policy was services, none was	requested related to dignified provided.				
	The director of nurs policies and proced of residents and the educate staff on the nursing or designee ensure compliance	HOD OF CORRECTION: sing or designee could revise ures related to dignified care observed concerns and ese changes. The director of could audit periodically to with the education and t findings to the quality ee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			8/29/17
	residents shall have medical and persor	iate health care. Patients and the right to appropriate hal care based on individual care for residents means				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00361	B. WING		07/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
TRUMAN	SENIOR LIVING		H 4TH AVE MN 56088	NUE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21810	care designed to er highest level of phy This right is limited	ige 44 nable residents to achieve their rsical and mental functioning. where the service is not blic or private resources.	21810			
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review the ure the appropriate equipment illeting needs for 1 of 3 ewed for toileting.		Corrected		
	7/17/17, at 11:28 a. undignified when he	about dignified care on m. R3 stated feeling it was e needed to have a bowel d was to just go in his				
	assessment dated Interview for Menta indicating moderate MDS further identifi upon staff for trans always incontinent care plan last revise incontinent of blado	mum Data Set (MDS) 5/16/17 included a Brief I Status (BIMS) score of 11 e cognitive impairment. The ied R3 was totally dependent fers and toilet use and was of bladder and bowel. The ed 7/10/17, indicated R3 was der and bowel related to ed cognitive function.				
	nursing assistant (N the need to have a stated R3 was not t required a Hoyer lif big enough to acco	on 7/20/17, at 11:14 a.m. NA)-B stated R3 could identify bowel movement (BM). NA-B toileted for a BM because he t and R3's bathroom was not mmodate the lift and safe ilet; therefore, R3 was directed				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
RUMAN	SENIOR LIVING		TH 4TH AVENU , MN 56088	JE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21810	to have a BM in the it". NA-B confirmed for a bowel movement there was an availa accommodate R3 a commode was availa another resident. When interviewed of BM than in his brief able to tell staff whe When interviewed of licensed practical n bathroom would not for toileting. LPN-B extra large commod R3 as was being ut LPN-B stated it would toileted for BM's rat up. When interviewed of director of nursing (why a commode co toileting. When interviewed of stated R3 used to b able to use the start confirmed once the Hoyer lift he was not not fit in R3's bathro transfer onto the toi would be capable o had one large enout	ge 45 brief. NA-B stated, "He hates d R3 communicated the need ent. Initially, NA-B denied ble commode large enough to and then remembered a larger lable but currently utilized by on 7/20/17, at 11:24 a.m. R3 I rather sit on the toilet for a . R3 further confirmed he was en needing to have a BM. on 7/20/17, at 11:32 a.m. urse (LPN)-B confirmed R3's t accommodate the Hoyer lift of urther stated R3 required an de which was unavailable to ilized by another resident. Jud be better if R3 could be her than having to clean him on 7/20/17, at 12:58 p.m. the DON) stated being unaware outdn't be used for R3 for BM on 7/20/17, at 1:26 p.m. NA-E resident started utilizing the o longer toileted as the lift did pom well enough to safely let. NA-E stated feeling R3 f sitting on a commode if they gh. NA-E further stated the e extra large commode but	21810	DEFICIENC	ΣY)	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00361		B. WING		07/	20/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVEN , MN 56088	UE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21810	Continued From pa	age 46	21810			
	the Hoyer lift for at	least 2 years.				
	DON stated R3 wo BM's in the bath bar room. DON confirm able to accommoda transfer onto the to SUGGESTED MET The director of nurs assessment to ens according to needs could be periodical implement the asse	on 7/20/17, at 2:25 p.m. the uld be able to be toileted for ny across the hall from his med the bath bay would be ate the Hoyer lift for safe ilet. THOD OF CORRECTION: ses' could conduct an ure residents are toileting and preferences. An audit ly conducted to ensure staff essed need. The results could quality assurance committee				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21830	Residents of HC Fa Subd. 10. Particip notification of famil (a) Residents sha in the planning of th	bation in planning treatment; y members. Il have the right to participate heir health care. This right	21830			8/29/17
	alternatives with ind opportunity to requi- care conferences, a family member or o both. In the event to present, a family m chosen by the resid conferences.	tunity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative dent may be included in such who enters a facility is				

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/2	20/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
TRUMAN	SENIOR LIVING		TH 4TH AVEN , MN 56088	UE EAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETE DATE
21830	Continued From pa	ge 47	21830			
	unconscious or con	natose or is unable to				
	communicate, the f	acility shall make reasonable				
	efforts as required u	under paragraph (c) to notify				
		ber or a person designated in				
		writing by the resident as the person to contact in				
	an emergency that the resident has been					
	admitted to the facility. The facility shall allow the family member to participate in treatment					
		e facility knows or has reason				
		ent has an effective advance				
	directive to the contrary or knows the resident has		;			
	specified in writing that they do not want a family					
	member included in treatment planning. After					
	notifying a family member but prior to allowing a family member to participate in treatment					
		/ must make reasonable				
		vith reasonable medical				
		ne if the resident has				
	•	ce directive relative to the				
	esident's health car	e decisions. For purposes of				
		asonable efforts" include:				
	•	e personal effects of the				
	resident;	modical records of the				
		e medical records of the session of the facility;				
	•	ny emergency contact or				
		tacted under this section				
	whether the resider	whether the resident has executed an advance				
	directive and wheth	er the resident has a				
		the resident normally goes for				
	care; and					
		e physician to whom the				
		oes for care, if known, nt has executed an advance				
		y notifies a family member or				
		ncy contact or allows a family				
		ate in treatment planning in				
		s paragraph, the facility is not				
		r damages on the grounds that				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		E SURVEY PLETED		
	00361		B. WING		07/20/2017			
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	RESS, CITY, STATE, ZIP CODE				
TRUMAN	I SENIOR LIVING		TH 4TH AVE , MN 56088	NUE EAST				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
21830	Continued From pa	ige 48	21830					
	emergency contact family member was patient's privacy rig (c) In making rea family member or of the facility shall atter members or a desig examining the pers and the medical rea possession of the fa- to notify a family me emergency contact admission, the facil social service agen agency that the res the facility has been member or designat county social service enforcement agence identifying and notif designated emergency service agency or le that assists a facilit subdivision is not lia damages on the gra the family member	asonable efforts to notify a lesignated emergency contact, empt to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the lity shall notify the county cy or local law enforcement ident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social local law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper						
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview, and document ailed to ensure bedtime nonored for 1 of 3 residents hoices.		Corrected				
	Findings include:							
nnesota De ATE FORM	epartment of Health		6899	ZO5R11	If continuati			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF I	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
RUMAN	SENIOR LIVING		TH 4TH AVEN	UE EAST		
			N, MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	ge 49	21830			
	stated he liked to g stated he's usually p.m. or later and or R3 stated it doesn't to bed earlier. R3 p	on 7/17/17, at 10:50 a.m. R3 et to bed somewhat early. R3 helped to bed around 8:30 he night as late as 9:00 p.m. do any good to ask staff to go pointed to the wall and stated, that wall; you get the same				
	assessment dated Interview for Menta indicating moderate MDS further indicat dependence with tr	num Data Set (MDS) 5/16/17, included a Brief I Status (BIMS) score of 11 e cognitive impairment. The red R3 required total ansfers and toilet use, and ce with bed mobility, personal ing.				
		ated 8/18/16, indicated it was esident to choose own				
	practical nurse (LPI medications to R3 of medications admini- atorvastatin (a chol 20 milligrams orally When questioned to the bedtime medica responded that R3 right after supper an about that. Therefore	7/18/17, at 5:43 p.m. licensed N)-A set up and administered during the supper meal. The istered to R3 included: esterol lowering medication) v every night at bedtime. he rationale for R3 receiving ation at this time, LPN-A always wanted to go to bed nd is very vocal and adamant ore, the atorvastatin was he 5:00 p.m. medications.				
	following was obser	s observed propelling self into				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED		
		00361	B. WING		07/20/2017			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE				
		400 NOR	TH 4TH AVEN	UE EAST				
IRUMA	N SENIOR LIVING	TRUMAN	, MN 56088					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)		
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE		
21830	Continued From pa	ge 50	21830					
	R3's room and infor bit. - 7:11 p.mR3's cal staff had returned. - 7:19 p.mR3 seat room, call light remarks R3 confirmed he wa - 7:21 p.mR3 prop this time. R3 gestur seated at the end o pain medication for explaining to R3 the to facility staff, R3 s nursing desk and re slowly propelled sel hallway; the call ligh -7:27 p.mNA-F wa Bluebell hall distribut resident rooms. R3 the nurses desk. N continued to pass to located on the Blue and propelled self to entered R3's room, out of the room and distribution down th on. When finished v put the cart away an attempted to talk to about her tasks and - 7:32 p.mR3 cont w/c towards room; o (35 minutes). - 7:33 p.mR3 prop	assistant (NA)- A entered rmed R3 would return in a little I light remained "on" and no ed in wheelchair (w/c) in ained on; no staff returned. as waiting to get ready for bed. belled self out of room in w/c at red to surveyor who was f the hallway and requested his shoulders . After e request needed to be made stated he would go to the equest the medication. R3 f with one foot down the nt remained activated. as working at the end of the uting towels from a cart to 8 continued to make his way to A-F walked past R3 and oward his room in w/c. NA-F distributed the linens, walked I continued with linen e hall; R3's call light remained with linen distribution, NA-F nd walked past R3. R3 NA-F, who continued to go						
	his room. - 7:44 p.mR3 whe hallway and looked	eled self back out into the down the hall towards the hen propelled himself in w/c						

	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00361	B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
TRUMA	N SENIOR LIVING		TH 4TH AVENU , MN 56088	JE EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21830	down the hall; call li - 7:48 p.mNA-A ap and engaged in cor approached NA-A a surveyor seated at R3's room. NA-A th turned off the call lig assistance from NA cares; (50 minutes activated). When interviewed of stated he preferred p.m. and 7:30 p.m. (7/19/17) staff assis p.m. R3 stated, "Th further stated it's so he's assisted to be When interviewed of director of nursing (resident's right to ge DON stated the exp wanted to go to be accommodated. The Care Providers Federal and Minnes 11/28/16, includes: make choices about the facility that are so SUGGESTED MET The director of nursing preferences for awa written care plans a staff on this informatic could audit times references	ight remained on. oproached R3 in the hallway oversation. The administrator and gestured toward the the end of the hall outside of en assisted R3 into his room, ght, obtained the Hoyer lift and A-F to help R3 with bedtime after the call light was initially on 7/20/17, at 9:45 a.m. R3 to get to bed between 7:00 R3 indicated that last night sted him to bed around 8:00 ney're set in their ways". R3 ometimes 9:00 p.m. before d. on 7/20/17, at 12:58 p.m. the (DON) confirmed it is a to bed per their choice. The bectation was if a resident				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					-	
		00361	B. WING		07/2	20/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST RTH 4TH AVENI			
RUMAN	I SENIOR LIVING		N, MN 56088			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	ige 52	21830			
	the quality assurance recommendations.	ce committee for further				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				