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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZO5R

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00361

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **8/30/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 11/01/2017 Co.

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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,

Kamala 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: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Kamala 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: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZO5R

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2017** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

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

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17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 08/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/13/2017 (L20)

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

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

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3. Both of the Above :
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10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/15/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	07/20/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. An investigation of complaint H5346031 was completed. The complaint was not substantiated. An investigation of complaint H5346033 was completed. The complaint was not substantiated.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F 167		8/29/17

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

Electronically Signed | 08/11/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	07/20/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post notice of availability of the last three years of State Agency survey results. This had the potential to affect all 41 current residents, visitors, and staff who wished to review this information. Findings include: During initial tour of the facility on 7/17/17, at 8:35 a.m. a cabinet was observed inside the front entrance of the facility with signage that indicated: The most recent survey findings are available for review in the above drawer. Inside the cabinet drawer was a red binder containing the survey 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.	F 167	It is the Facilities intent to comply with the regulation to provide our residents the right to examine the results of the most recent survey of the facility conducted by the Federal or State surveyors and any plan of correction in effect. It is also the facilities intent to post and/or have available such survey results for the 3 preceding years in a readily accessible are to residents, family members and legal representatives of residents. Signage is clearly posted in the front entrance of the facility where to locate the previous 3 years of surveys upon request. The most recent survey results will continue to be available in the cabinet drawer in a red binder. By 8/29/2017 all residents, family members and legal representatives will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	07/20/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 2 When interviewed on 7/17/17, at 8:55 a.m. the human resources staff member (HR)-A confirmed only the most current state survey results were readily available for residents,visitors and staff. HR-A further confirmed signage identifying location of results and binder containing results did not identify 3 years of results were available upon request.	F 167	notified of the posting and availability of previous 3 years of surveys. By 8/29/2017 all staff will be educated regarding the requirements of posting the 3 preceding year□s survey results. 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.	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (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 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 about dignified care on	F 241	It is the Facilities intent to comply with the regulation to 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. It is the Facilities intent to protect and promote the rights of the resident. R3□s B&B Assessment Completed. Facility has purchased a Bariatric Commode for R3□s room.	8/29/17

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F 241	Continued From page 3 7/17/17, at 11:28 a.m. R3 stated feeling it was undignified when he needed to have a bowel movement (BM) and 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 (BIMS) score of 11 indicating moderate cognitive impairment. The MDS further identified R3 was totally dependent upon staff for transfers and toilet use and was always incontinent of bladder and bowel. The care plan last revised 7/10/17, indicated R3 was incontinent of bladder and bowel related to mobility and impaired cognitive function. When interviewed on 7/20/17, at 11:14 a.m. nursing assistant (NA)-B stated R3 was always incontinent of urine although could identify the need to have a BM. NA-B stated R3 was considered a check and change and was also able to let staff know when his incontinence product was wet. NA-B stated R3 was not toileted when needing to have a BM because he utilized a Hoyer lift. NA-B also explained R3's bathroom was not big enough to accommodate the lift into the bathroom and to transfer the resident safely onto the toilet; therefore R3 was directed to have a BM in the brief. NA-B stated, "He hates it". NA-B confirmed R3 was able communicate to staff when he needed to have a BM and indicated she had directed R3 to inform her when finished so staff could change him right away. Initially, NA-B denied there was an available commode large enough to accommodate R3 and then remembered a larger commode was available but currently utilized by another resident.	F 241	R59□s Elopement Assessment completed. R3 & R59 have had their care plans reviewed, revised & updated as needed. By 8/29/2017 audits on residents at risk for incontinence will be reviewed and assessments will be updated. Individual care plans will be reviewed, revised & updated as needed. Audits on residents at risk of elopement will be reviewed and assessments will be updated. Individual care plans will be reviewed, revised & updated as needed. Policy & Procedures will be reviewed, revised & updated as needed. Policy & Procedure for Dignified Services has been developed. By 8/29/2017 all staff who utilizes resident care plans will be educated on the need to follow interventions as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. Policy & Procedures on Elopement & Dignified Services will be review with all staff. DON or Clinical Team designees will conduct weekly audits of assessments/care plans to assure they are accurate, updated and current. Thereafter, audits will continue until the Facilities Quality Assurance team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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When interviewed on 7/20/17, at 11:24 a.m. R3 confirmed he would rather sit on the toilet for a BM than in his brief. R3 further confirmed he was able to tell staff when needing to have a BM but unable to control urination since it just comes.

When interviewed on 7/20/17, at 11:32 a.m. licensed practical nurse (LPN)-B confirmed R3's bathroom would not accommodate the Hoyer lift for toileting. LPN-B further stated the resident would need an extra large commode which was unavailable to R3 as it was being used by another resident. LPN-B stated it would be better if R3 could be toileted for BM's rather than having to clean him up.

When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) stated being unaware why a commode couldn't be used for R3 for BM toileting. DON stated she would investigate further to understand the rationale and would report the results to the surveyor.

When interviewed on 7/20/17, at 1:26 p.m. NA-E stated R3 used to use the toilet when able to use a standing lift for transfers. NA-E confirmed once the resident started utilizing the Hoyer lift he was no longer toileted as the lift did not fit in R3's bathroom well enough to safely transfer onto the toilet. NA-E stated she thought R3 would be capable of sitting on a commode if they had one large enough. NA-E further clarified the facility had one extra large commode available but since another resident was utilizing this commode, it was not available for R3. NA-E confirmed R3 had utilized the Hoyer lift for at least 2 years.

When interviewed on 7/20/17, at 2:25 p.m. the DON stated R3 could be toileted for BM's in the

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bath bay across the hall from his room. The DON confirmed the bath bay would be able to accommodate the Hoyer lift for safe transfer onto the toilet.

R59's undated face sheet, identified a diagnosis of urinary tract infection.

R59's admission MDS assessment dated 7/11/17, identified a BIMS score of 13 (cognitively intact) with no behaviors and/or wandering. The MDS further identified R59 as being occasionally incontinent of bladder and needing extensive assistance for toileting and transfers.

During interview on 7/17/17, at 2:01 p.m. a signage was noted on R59's private room door stating: Please check with nursing staff before entering. NA-B stated R59 was confined to his room due to an infection in the urine and gown and gloves were needed by staff assisting with cares.

During observation on 7/17/17, at 2:05 p.m.R59 was sitting in a wheelchair (w/c) in his room. R59's right leg was in a cast from upper thigh to ankle and a wanderguard was noted on the left ankle. At this time R59 stated he is "going banana's" and would prefer to go outside of his room but was not allowed to leave his room nor go outside. R59 indicated he was also upset that he had a wanderguard attached to his left leg.

Review of the nursing progress notes dated 7/14/17, R59 was identified with VRE (vancomycin-resistant enterococci, an infection with bacteria resistant to the antibiotic vancomycin) in the urine with contact precautions initiated, which limited R59 from leaving his room.

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During interview on 7/18/17, at 4:51 p.m. family member (F)-A stated R59 was incontinent of urine but wore an incontinent pad to contain the urine. F-A further indicated no incontinence had been noted on R59's clothing during visits. However, F-A stated R59 was not allowed to leave his room due to the infection in his urine. F-A indicated this upset R59 as he enjoyed his meals in the dining room and the fresh air outside the building. F-A further indicated she was not sure why R59 had a wanderguard placed but knew that was also upsetting R59.

On 7/18/17, at 4:59 p.m. R59 indicated he missed his friends at the dining room table, wishing he could join them for meals. R59 also stated he wasn't sure why he had to wear a wanderguard, indicating he was unable to propel himself to the door leading outside.

During interview on 7/18/17, at 5:58 p.m. R59, who was sitting in his room eating his meal with use of a disposable plate and utensils stated, it is "just like being in a prison".

During a subsequent interview on 7/19/17, at 11:50 a.m. R59 expressed frustration with the restriction to remain in his room and also the application of the wanderguard to his leg. R59 stated, "hate having to stay in here".

During interview on 7/19/17, at 12:02 p.m. NA-C stated R59 can't leave his room and that "drives him nuts". NA-C indicated being unsure of the reason R59 wore a wanderguard.

When interviewed on 7/19/17, at 12:06 p.m. social services (SS)-A stated R59 is not an

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elopement risk and did not require a wanderguard. At 12:09 p.m. SS-A confirmed R59 was indeed wearing a wanderguard on the left ankle. Neither the SS-A nor RN-A were aware of the wanderguard attached to R59 and confirmed R59 should not have this applied. RN-A immediately removed the device after learning of the wanderguard.

On 7/20/17, at 9:45 a.m. NA-B stated R59 was not incontinent on his clothes indicating the pads R59 wore contained the urine.

On 7/20/17, at 1:33 p.m. the DON stated the precautions implemented were based on CDC (Centers for Disease Control and Prevention) guidelines for VRE, and what was best for R59 and the other residents. DON stated since R59 was incontinent she didn't want R59 touching tablecloths and/or other objects in the facility which could spread the infection. The DON reiterated that keeping R59 isolated in his room was appropriate.

A facility policy titled Elopement/Wandering Policy revised 8/16/12, indicated only a resident who has the potential for elopement/wandering will have a code alert transponder placed on their ankle, wrist, or wheelchair.

A facility policy titled Isolation-Categories of Transmission-Based Precautions revised 1/2012, identified the facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections.

A facility policy was requested related to dignified services, none was provided.

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F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (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 somewhat early. R3 stated he's usually helped 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 go to bed earlier. 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	F 242	It is the Facilities intent to comply with the regulation of allowing the resident the 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. R3□s individual rights have been reviewed with resident. Care Plan reviewed, revised and updated as needed. R3□s individual request for sleep times have been updated on care sheets. By 8/29/2017 audits on residents who have specific requests for sleep time will be reviewed, revised and updated as needed. Care sheets will be reviewed, revised and updated as needed.	8/29/17

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F 242	Continued From page 9 MDS further indicated R3 required total dependence with transfers and toilet use, and extensive assistance with bed mobility, personal hygiene, and dressing. R3's annual MDS dated 8/18/16, indicated it was very important for resident to choose own bedtime. It was observed on 7/18/17, at 5:43 p.m. licensed practical nurse (LPN)-A set up and administered medications to R3 during the supper meal. The medications administered to R3 included: atorvastatin (a cholesterol lowering medication) 20 milligrams orally every night at bedtime. When questioned the rationale for R3 receiving the bedtime medication at this time, LPN-A responded that R3 always wanted to go to bed right after supper and is very vocal and adamant about that. Therefore, the atorvastatin was administered with the 5:00 p.m. medications. During continuous observation on 7/18/17, the following was observed: - 6:51 p.m.- R3 was observed propelling self into his room down the Bluebell hall. - 6:57 p.m.- R3's call light activated. - 6:59 p.m.-nursing assistant (NA)- A entered R3's room and informed R3 would return in a little bit. - 7:11 p.m.-R3's call light remained "on" and no staff had returned. - 7:19 p.m.-R3 seated in wheelchair (w/c) in room, call light remained on; no staff returned. R3 confirmed he was waiting to get ready for bed. - 7:21 p.m.-R3 propelled self out of room in w/c at this time. R3 gestured to surveyor who was seated at the end of the hallway and requested pain medication for his shoulders . After	F 242	By 8/29/2017 all staff will be educated on Resident Rights and Individual Choices. The Director of Social Services will audit weekly that resident rights are being honored. Audits will continue until the Facility□s Quality Assurance team determines substantial compliance with applicable regulations and Facility policy has been achieved.	

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explaining to R3 the request needed to be made to facility staff, R3 stated he would go to the nursing desk and request the medication. R3 slowly propelled self with one foot down the hallway; the call light remained activated.
-7:27 p.m.-NA-F was working at the end of the Bluebell hall distributing towels from a cart to resident rooms. R3 continued to make his way to the nurses desk. NA-F walked past R3 and continued to pass towels to resident rooms located on the Bluebell hall. R3 turned around and propelled self toward his room in w/c. NA-F entered R3's room, distributed the linens, walked out of the room and continued with linen distribution down the hall; R3's call light remained on. When finished with linen distribution, NA-F put the cart away and walked past R3. R3 attempted to talk to NA-F, who continued to go about her tasks and ignored R3.
- 7:32 p.m.-R3 continued to slowly propel self in w/c towards room; call light remained activated (35 minutes).
- 7:33 p.m.-R3 propelled self in w/c and entered his room.
- 7:44 p.m.-R3 wheeled self back out into the hallway and looked down the hall towards the nurses station. R3 then propelled himself in w/c down the hall; call light remained on.
- 7:48 p.m.-NA-A approached R3 in the hallway and engaged in conversation. The administrator approached NA-A and gestured toward the surveyor seated at the end of the hall outside of R3's room. NA-A then assisted R3 into his room, turned off the call light, obtained the Hoyer lift and assistance from NA-F to help R3 with bedtime cares; (50 minutes after the call light was initially activated).

When interviewed on 7/20/17, at 9:45 a.m. R3

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F 242	Continued From page 11 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 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION 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 by: Based on interview and document review the facility failed to ensure the appropriate equipment was available for toileting needs for 1 of 3 residents (R3) reviewed for incontinence.	F 246	It is the Facilities intent to comply with the regulation to treat each resident with dignity and respect. It is the Facilities intent to assure the residents right to reside and receive services in the facility	8/29/17

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F 246	Continued From page 12 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 (BIMS) score of 11 indicating moderate cognitive impairment. The MDS further identified R3 was totally dependent upon staff for transfers and toilet use and was always incontinent of bladder and bowel. The care plan last revised 7/10/17, indicated R3 was incontinent of bladder and bowel related to mobility and impaired cognitive function. When interviewed on 7/20/17, at 11:14 a.m. nursing assistant (NA)-B stated R3 could identify the need to have a bowel movement (BM). NA-B stated R3 was not toileted for a BM because he required a Hoyer lift and R3's bathroom was not big enough to accommodate the lift and safe transfer onto the toilet; therefore, R3 was directed to have a BM in the brief. NA-B stated, "He hates it". NA-B confirmed R3 communicated the need for a bowel movement. Initially, NA-B denied there was an available commode large enough to accommodate R3 and then remembered a larger commode was available but currently utilized by another resident. When interviewed on 7/20/17, at 11:24 a.m. R3 confirmed he would rather sit on the toilet for a BM than in his brief. R3 further confirmed he was able to tell staff when needing to have a BM. When interviewed on 7/20/17, at 11:32 a.m.	F 246	with reasonable accommodation of resident needs and preferences. R3□s B&B Assessment Completed. Facility has purchased a Bariatric Commode for R3□s room. R3□s care plan has been reviewed, revised & updated as needed. By 8/29/2017 audits on residents at risk for incontinence will be reviewed and assessments will be updated. Individual care plans will be reviewed, revised & updated as needed. Policy & Procedures will be reviewed, revised & updated as needed. Policy & Procedure for Dignified Services has been developed. By 8/29/2017 all staff who utilizes resident care plans will be educated on the need to follow interventions as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. Policy & Procedure on Dignified Services will be review with all staff. DON or Clinical Team designees will audit all resident care plans initially for appropriate interactions. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audit outcomes will be reported to the QAA Committee for review &/or comment.	

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F 246	Continued From page 13 licensed practical nurse (LPN)-B confirmed R3's bathroom would not accommodate the Hoyer lift for toileting. LPN-B further stated R3 required an extra large commode which was unavailable to R3 as was being utilized by another resident. LPN-B stated it would be better if R3 could be toileted for BM's rather than having to clean him up. When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) stated being unaware why a commode couldn't be used for R3 for BM toileting. When interviewed on 7/20/17, at 1:26 p.m. NA-E stated R3 used to be toileted on the toilet when able to use the standing lift for transfers. NA-E confirmed once the resident started utilizing the Hoyer lift he was no longer toileted as the lift did not fit in R3's bathroom well enough to safely transfer onto the toilet. NA-E stated feeling R3 would be capable of sitting on a commode if they had one large enough. NA-E further stated the facility did have one extra large commode but since another resident was utilizing was not available to R3. NA-E confirmed R3 had utilized the Hoyer lift for at least 2 years. When interviewed on 7/20/17, at 2:25 p.m. the DON stated R3 would be able to be toileted for BM's in the bath bay across the hall from his room. DON confirmed the bath bay would be able to accommodate the Hoyer lift for safe transfer onto the toilet.	F 246		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		8/29/17

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F 278	Continued From page 14 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R24) reviewed for urinary incontinence who had a catheter, for 1 of 1 resident (R24)	F 278	It is the Facilities intent to comply with the regulation to assure the accuracy of assessments that reflect the resident□s status.	

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F 278	Continued From page 15 reviewed with a colostomy, for 1 of 1 resident (R8) reviewed with pressure ulcers who had venous stasis ulcerations and for 1 of 2 residents (R27) reviewed for oral and dental services. Findings include: During observation on 7/19/17, at 11:03 a.m., R24 watching TV in his room when nursing assistance (NA)-F re-positioned R24 in his chair. R24 was noted to have a suprapubic catheter attached to a drainage bag as well as a colostomy bag. Interview with NA-F on 7/19/17, at 11:22 a.m. confirmed R24 had a supra pubic catheter as well as a colostomy in place for at least a couple of years. Review of the current quarterly Minimum Data Set (MDS) assessment dated 7/11/17, identified R24 as requiring 1 staff assistance with toileting and R24 had no bowel or bladder toileting program. R24's bladder continence was not coded due to the use of a catheter and no urine output for 7 days. R24's bowel continence was not coded due to the use of an ostomy and did not have a bowel movement for 7 days. The MDS further identified R24 did not utilize any appliances for the bowel or the bladder. Diagnosis included: neurogenic bladder and history of colon cancer/colostomy. Review of the current plan of care identified R24 as having a suprapubic catheter related to neurogenic bladder and urinary retention. Interventions included: observe output every shift and report to the nurse any noted changes in amount, clarity or color, change catheter and	F 278	R24□s MDS has been modified and submitted. R8□s has had a new MDS completed and submitted. R27 has had an Oral Assessment completed. R27□s MDS has been reviewed, revised and submitted to CMS. By 8/29/2017, all appropriate staff will be re-educated on completion of comprehensive assessments. Bi-monthly audits will be completed on all MDSs to ensure that a comprehensive assessment was completed accurately. The Director of Nursing or designee will conduct audits for accuracy of MDS on five random resident records per month for three months. Thereafter, audits will continue until Facilities Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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drainage bag as ordered, irrigate daily, provide catheter care every shift and cover collection bag. The care plan also identified R24 as having a colostomy related to a history of rectal cancer. Interventions included: provide ostomy care after every bowel movement and change colostomy wafer weekly and as needed.

Interview with the Minimum Data Set (MDS) coordinator on 7/20/17, at 8:25 a.m. confirmed the current quarterly MDS dated 7/11/17, had not been coded accurately to reflect R24's supra pubic catheter and ostomy use. The MDS coordinator further indicated she was unsure of how long the resident had these appliances but did confirm it had been at least a year.

R8's face sheet, undated indicated current diagnoses included venous insufficiency of the right lower leg and diabetes mellitus, type 2.

R8's significant change in status Minimum Data Set (MDS) assessment dated 4/27/17, identified R8 as having unhealed pressure ulcers at section M0210.. R8 was identified in section M0300 of the MDS as having two stage two pressure ulcers (defined on the MDS assessment as a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough), four stage three pressure ulcers (defined as a full thickness tissue loss involving subcutaneous fat, slough may be present) and one stage four (defined as full thickness tissue loss with exposed bone, tendon or muscle, slough or eschar may be present) at the time of this significant change in status assessment. In addition, the MDS indicated two pressure ulcers were present which were unstageable due to coverage of the wound bed by slough and/or

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eschar. Additionally, R8 was identified at section M1030 as having nine venous and arterial ulcerations present.

R8's care area assessment for pressure ulcers, dated 4/27/17 identified pressure ulcers were present, proceed to care plan, attempt to keep pressure off ulcer areas and keep him from breaking down further. Location and date of the information was listed as the progress notes, diagnoses listing, primary care provider reviews, orders and care plan.

R8's care plan for pressure ulcers, dated 8/10/15, last revised on 3/23/17 identified a problem of pressure ulcers, related to ineffective tissue perfusion related to peripheral vascular disease and venous leg ulcer. A secondary care plan problem, dated 6/15/15, last revised on 3/23/17 identified R8 as having impaired skin integrity related to peripheral vascular disease. An approach was listed as R8 wearing compression stockings to help with venous stasis and multiple wound issues on the right leg.

A physician progress note, dated 4/25/17 identified R8 as having peripheral arterial and venous insufficiency, with stasis leg ulcer. The progress note further identified R8 as having a chronic nonhealing ulcer on the lateral malleolus, progressive and chronic venous insufficiency. The note did not identify any pressure ulcers.

During interview on 7/19/17, at 1:51 p.m. the MDS coordinator stated she had "assumed" R8's wounds "were pressure to the right lower leg as they were on the outer ankle and on other areas that were pressure points", so therefore had coded these skin areas. She thought other areas

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on the toes were probably circulatory and coded some also.

During interview on 7/25/17, at 12:35 p.m., medical doctor (MD)-A confirmed R8's wounds were vascular in nature and not due to pressure.

Skin assessments for the previous six month period were requested, none were provided.

The Resident Assessment Instrument (RAI) manual, Version 1.14, dated 10/16 indicates at the instructions for section M0300A: "For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here." Additionally, the RAI coding tips at M0210 indicate "Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors."

R27's annual Minimum Data Set (MDS), dated 11/23/16 did not identify any broken or damaged teeth, no care area assessment was triggered

R27's care plan, dated 6/5/15 and last revised on 5/31/17, identified poor dentition as evidenced by oral assessments. Goal was listed of no tooth or mouth pain. Offer dental appt quarterly, FYI: only has a few broken teeth on her top half and her bottom teeth consist of teeth that have been worn down to the gum.

During observation on 7/17/17, at 10:54 a.m., R27 was observed with many broken and missing

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F 278	Continued From page 19 teeth to the lower front portion of her mouth. R27 denied having any concerns with mouth pain or dental issues. During interview on 7/19/17, at 1:51 p.m. the MDS Coordinator stated she was aware R27 had broken teeth at the time of the assessment in 11/16; however, had not coded them as they were already on the care plan and not a new problem. Oral assessments for the lookback period of the 11/23/16 MDS were requested, none were provided. The facility policy, entitled MDS Accuracy, dated 6/3/13 indicated a purpose of having accurate assessments that are completed as mandated by regulations to reflect the acuity level of our residents including diagnosis, treatments and an evaluation of their functional status using facility sources. The RAI Manual, Version 1.14, dated 10/16 indicated "Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth."	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.	F 279		8/29/17

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483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

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F 279	Continued From page 21 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was developed related to the use of psychoactive medications (antidepressants and anxiolytics) for 2 of 5 residents (R32, R33) reviewed for unnecessary medications. Findings include: R32's face sheet, dated 7/19/17 included diagnoses of dementia without behavioral disturbance and Major depression. R32's quarterly Minimum Data Set (MDS) assessment dated 5/16/17, identified a Brief Interview for Mental Status (BIMS) score of 4/15, indicative of severe cognitive impairment. R32's mood section identified feeling down or depressed 7-11 days during the lookback, and a Personal Health Questionnaire (PHQ-9) score of 2, indicative of minimal depression. The MDS also identified verbal behaviors towards others 1-3 days during the lookback and no psychosis. R32's Care Area Assessment (CAA) for	F 279	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident□s needs that are identified in the comprehensive assessment. 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 updated as needed. By 8/29/2017 all staff who utilizes resident care plans will be educated on the need to follow interventions as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time.	

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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. R32's care plan last revised 7/18/17, identified sexually inappropriate behavior towards others, to re-approach, and use two staff if necessary. The care plan did not address the anti-depressant and/or anxiolytic use. The 7/16 medication sheets indicated R32 received the medications: buspirone (anxiolytic), trazodone and citalopram (antidepressants) on a daily basis. During observation on 7/18/17, R32 was in his room, talking with visitors and had a smiling facial expression. During observation on 7/19/17, at 7:40 a.m., R32 was lying in bed, sleeping. During observation on 7/19/17, at 9:12 a.m. R32 stated he "does not know," whether he is depressed, engaged in conversation and smiled readily when conversed with surveyor. During interview on 7/19/17, at 8:06 a.m. licensed practical nurse (LPN)-B stated R32 "gets a little friendly with the staff." LPN-B stated sometimes R32 grabs at staff breasts and sometimes sits at the table and will let out a "yell" for no apparent reason. R32 also made inappropriate sexual remarks to staff. When interviewed on 7/19/17, at 8:22 a.m. the MDS coordinator stated she usually identified psychoactive medications on the care plan but	F 279	DON or Clinical Team designees shall audit all resident care plans initially for appropriate interactions. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audits will continue until Facilities Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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had not done so for R32, stating "Nope, I don't see any of those meds on there."

During interview on 7/19/17, at 1:21 p.m. the director of nursing (DON) stated psychoactive drugs should be a part of the comprehensive care plan.

R33's face sheet identified diagnoses including phobic anxiety disorder, insomnia and major depressive disorder recurrent, severe with psychotic symptoms-mild, recurrent.

R33's quarterly MDS dated 5/30/17, did not identify a BIMS score nor a PHQ-9 assessment for depression. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact) and a PHQ-9 score of 6 (minimal depression). The MDS also identified rejection of cares and verbal behavioral symptoms occurred 1-3 days and no delusions or hallucinations occurred.

R33's physician orders dated 7/2017, identified an orders for the antidepressant medication Amitriptyline 10 mg every bedtime, Zoloft 200 mg everyday and Wellbutrin 450 mg everyday

R33's care plan dated 3/7/27, did not identify the use of the 3 antidepressant medications.

During interview on 7/20/17, at 2:22 p.m. the director of nursing (DON) verified the antidepressant medications were not addressed on the care plan and the expectation was to include these as part of the care plan.

The facility policy, entitled Care Plans - Comprehensive, dated 9/10 indicated it is the

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F 279	Continued From page 24 facility's policy to develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The policy further stated the comprehensive care plan is designed to incorporate identified problem areas.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280		8/29/17

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F 280	Continued From page 25 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) 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. (C) A nurse aide 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 and their resident representative is determined not practicable for the development of the resident's care plan.	F 280		

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F 280	Continued From page 26 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include the use of a resting hand splint for 1 of 3 resident (R33) reviewed for range of motion (ROM) Findings include: R33's face sheet identified diagnoses including hemiplegia and hemiparesis on the left non-dominant side. R33's quarterly Minimum Data Set (MDS) 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 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 accident). Review of R33's medical record identified a recommendation to care givers from therapy	F 280	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident□s needs that are identified in the comprehensive assessment and periodically review and revise the care plan as the residents changes in care occur. R33□s Care plan and care sheets have been reviewed, revised & updated as needed. Splint has been located and is being applied per therapy recommendations. By 8/29/2017 all residents with specialized adaptive equipment will be reviewed for monitoring protocols and their care plans updated as needed. Care plan updates will be completed as changes occur but at least quarterly with MDS□. By 8/29/2017 all staff will be educated regarding specialized adaptive equipment protocol. DON or Clinical Team designees shall audit all resident care plans initially for	

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	245346	A. BUILDING _____ B. WING _____	07/20/2017

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F 280	Continued From page 27 dated 3/1/16. The recommendation indicated R33 had left hand tightness and staff were to place resting hand splint on left hand every night to be worn all night. R33's care plan dated 3/7/27 indicated R33 had an activity of daily living (ADL) functional/rehabilitation limitation in physical mobility. The care plan did not identify the use of the resting hand splint. On 7/17/17, at 10:32 a.m. R33 was observed to have left hand clenched and nails digging into the palm of hand. R33 had a brace to the left foot and stated she was to have a splint on her left hand but it was lost. On 7/20/17, at 7:26 a.m. R33 was observed in her room with a resting hand splint lying on the bedside table. R33 stated staff had just found the splint behind her chair this morning (7/20/17). R33 also stated, "I wear that at night". During interview on 7/20/17, at 8:10 a.m. nursing assistant (NA) E stated she worked the hall R33 was previously located and R33 had a hand splint which was applied every night and removed in the morning. 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 expect the use of the resting hand splint to be identified on the care plan.	F 280	appropriate interactions. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audits will continue until Facilities Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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F 282	Continued From page 28	F 282		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement the plan of care related to monitoring bruising for 1 of 3 residents (R26) reviewed for non-pressure skin conditions. Findings include: On 7/18/17, at 1:36 p.m. R26 was observed seated in wheelchair in room. The resident had a large bruise on top of the right forearm extending from the wrist to the elbow. R26 also had a large bruise covering the top of the left hand. When interviewed at the time, the resident could not identify how the bruising occurred. 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 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.	F 282	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident□s needs that are identified in the comprehensive assessment and periodically review and revise the care plan as the resident□s changes in care occur. R26□s care plan has been reviewed, revised & updated as needed. Geri sleeves have been put in place. By 8/29/2017 all residents care plans will be reviewed, revised & updated as needed. Policy & Procedure for Prevention and Treatment of Skin Breakdown will be reviewed, revised & updated. By 8/29/2017 all appropriate staff will be re-educated on the importance of following the Facilities Policy & Procedure for Prevention and Treatment of Skin Breakdown and reporting all skin issues to	8/29/17

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F 282	Continued From page 29 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 11:48 a.m. LPN-B who was working on R26's wing, stated being unaware of the resident's bruising. LPN-B and surveyor entered R26's room to observe 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 bruises. The right arm bruising measured 14.5 centimeters (cm) x (by) 8 cm. The bruising was reddish purple around the edges and the top of the arm was a brownish black in color. The top of R26's left hand bruise measured 4.2 cm x 6 cm and was dark red in color. The progress note dated 7/20/17, at 11:54 a.m. by LPN-B indicated: Notified by state inspector that resident has bruising on top of left hand and top of right fore arm. Area on top of left hand measures 4.2 x 6.0 cm dark burgundy in color, area on top of right forearm measures 14.5 x 8 cm dark purple in color around the edges with some red colored area in the center. Majority of bruise is tannish in color. When interviewed on 7/20/17, at 12:43 p.m. the DON stated with new skin issues such as bruising, would expect the nurse to make an entry into the progress note and also on the daily	F 282	Charge Nurse. DON or Clinical Team designees will audit all resident care plans initially for appropriate interactions. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audits will continue until Facilities Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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F 282	Continued From page 30 communication sheet to be investigated by the interdisciplinary team. The resident's family would also be notified and if a significant new skin issue would notify the physician. Also, if bruising was significant and staff were unable to identify the cause or if suspicious, would file a vulnerable adult (VA) report and investigate within the time constraint. During subsequent interview with DON at approximately 1:30 p.m., DON indicated a VA incident report had been submitted to the state agency related to R26's bruising.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		8/29/17

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F 309	Continued From page 31 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to monitor bruising for 1 of 3 residents (R26) reviewed for non-pressure skin conditions. Findings include: On 7/18/17, at 1:36 p.m. R26 was observed seated in wheelchair in room. The resident had a large bruise on top of the right forearm extending from the wrist to the elbow. R26 also had a large bruise covering the top of the left hand. When interviewed at the time, R26 was unable to explain how the bruising occurred. R26's quarterly Minimum Data Set (MDS) assessment included a brief interview of mental status (BIMS) score of 7 indicating severe cognitive impairment. The MDS also identified R26 required total dependence on staff for transfers, toilet use, and locomotion on and off the unit, and extensive assistance with personal hygiene, dressing, and bed mobility. R26's care plan last reviewed 6/15/17, indicated a history of bruising easily related to antiplatelet medications such as aspirin, clopidigrel, and	F 309	It is the Facilities intent to comply with the regulation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident□s needs that are identified in the comprehensive assessment and periodically review and revise the care plan as the resident□s changes in care occur. R26□s care plan has been reviewed, revised & updated as needed. Geri sleeves have been put in place. By 8/29/2017 all residents care plans will be reviewed, revised & updated as needed. Policy & Procedure for Prevention and Treatment of Skin Breakdown will be reviewed, revised & updated. By 8/29/2017, all appropriate staff will be re-educated on the importance of following the Facilities Policy & Procedure for Prevention and Treatment of Skin Breakdown and reporting all skin issues to Charge Nurse.	

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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 on bath days. LPN-C stated being unaware 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 and surveyor entered R26's room to observe 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 bruises. The right arm bruising measured 14.5 centimeters (cm) x (by) 8 cm.	F 309	DON or Clinical Team designees will audit nurse□s notes regarding changes in skin condition for appropriateness and effectiveness of interventions and for use of proper protocol per Facility policy. Audits will be conducted weekly until Facility□s Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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F 309	Continued From page 33	F 309		

The bruising was reddish purple around the edges and the top of the arm was a brownish black in color. The top of R26's left hand bruise measured 4.2 cm x 6 cm and was dark red in color. LPN-B stated she would notify R26's physician and family of the bruising and would also notify the director of nursing (DON) and the administrator due to the size of the bruising.

The progress note dated 7/20/17, at 11:54 a.m. by LPN-B indicated: Notified by state inspector that resident has bruising on top of left hand and top of right fore arm. Area on top of left hand measures 4.2 x 6.0 cm dark burgundy in color, area on top of right forearm measures 14.5 x 8 cm dark purple in color around the edges with some red colored area in the center. Majority of bruise is tannish in color.

When interviewed on 7/20/17, at 12:43 p.m. the DON stated that new skin issues noted, such as bruising, she would expect the nurse to make an entry into the progress note and also on the daily communication sheet to be investigated by the interdisciplinary team. The resident's family would also be notified and if a significant new skin issue would notify the physician. Also, if bruising was significant and staff were unable to identify the cause or if suspicious, would file a vulnerable adult (VA) report and investigate within the time constraint. During subsequent interview with DON at approximately 1:30 p.m., DON indicated a VA incident report had been submitted to the state agency related to R26's bruising.

On 7/20/17, at 12:57 p.m. (after LPN-B and DON had been informed of R26's bruising) R26 was observed seated in wheelchair at the dining room table being assisted by NA-B with eating. The

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F 309	Continued From page 34 resident was wearing padded geri-sleeves bilaterally that covered the entire arm to protect the resident's skin. The policy titled, Policy and Procedure for the Prevention and Treatment of Skin Breakdown dated 6/16/12 included: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder	F 315		8/29/17

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F 315	Continued From page 35 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting in a manner to restore as much normal bowel and bladder function for 2 of 3 (R3, R33) residents reviewed for fecal 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 (BM) he was instructed 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 (BIMS) score of 11 indicating moderate cognitive impairment. The MDS further identified R3 was totally dependent upon staff for transfers and toilet use and was always incontinent of bowel. The care plan last revised 7/10/17, indicated R3 was incontinent of bladder and bowel related to mobility and impaired cognitive function. When interviewed on 7/20/17, at 11:14 a.m. nursing assistant (NA)-B stated R3 was always incontinent of urine although could identify and	F 315	It is the Facilities intent to comply with the regulation to treat each resident with dignity and respect. It is the Facilities intent to assure the residents right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. 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 needed. By 8/29/2017 audits on residents at risk for incontinence will be reviewed and assessments will be updated. Individual care plans reviewed, revised & updated as needed. Policy & Procedures will be reviewed, revised & updated as needed. By 8/29/2017 all staff who utilizes resident care plans will be educated on the need to follow interventions as outlined in the plan of care and should entries/interventions be noted to be no longer relevant, to report those changes immediately to the	

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F 315	Continued From page 36 communicate to staff when he needed to have a bowel movement (BM). NA-B stated R3 was not toileted when needing to have a BM because he utilized a Hoyer lift. NA-B indicated R3's bathroom was not big enough to accommodate the lift into the bathroom and safely transfer onto the toilet, therefore R3 was directed to have a BM in the brief. NA-B stated, "He hates it". NA-B confirmed she instructed R3 to inform her when finished so staff could change him right away. Initially, NA-B denied there was an available commode large enough to accommodate R3 and then remembered a larger commode was available but currently utilized by another resident. When interviewed on 7/20/17, at 11:24 a.m. R3 confirmed he would rather sit on the toilet for a BM than in his brief. R3 further confirmed he was able to tell staff when needing to have a BM. When interviewed on 7/20/17, at 11:32 a.m. licensed practical nurse (LPN)-B confirmed R3's bathroom would not accommodate the Hoyer lift for toileting. LPN-B further stated R3 would require an extra large commode which was unavailable as it was being used for another resident. LPN-B stated it would be better if R3 could be toileted for BM's rather than having to clean him up. When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) stated being unaware that a commode couldn't be used for R3 for BM toileting. When interviewed on 7/20/17, at 1:26 p.m. NA-E stated R3 used to use the toilet when able to use a standing lift for transfers. NA-E confirmed once	F 315	DON or designee who will update the plan of care at that time. DON or Clinical Team designees will audit all resident care plans initially for appropriate interactions. Thereafter, care plans shall be reviewed as needed with resident changes but at least quarterly with all MDS□. Audits will continue until Facilities Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

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F 315	Continued From page 37	F 315		

R3 started using the Hoyer lift he was no longer was toileted as the lift did not fit in R3's bathroom well enough to safely transfer him onto the toilet. NA-E stated she thought R3 would be capable of sitting on a commode if they had one large enough. NA-E further clarified the facility had one extra large commode available but since another resident was utilizing this commode, it was not available for R3. NA-E confirmed R3 had utilized the Hoyer lift for at least 2 years.

When interviewed on 7/20/17, at 2:25 p.m. the DON confirmed R3 would be able to be toileted for BM's in the bathbay located across the hall from his room and thus be provided appropriate toileting services to maintain continence.
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.

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F 315	Continued From page 38	F 315		

R33's medical record was reviewed. No assessment of bladder function was noted in the medical record.

During interview on 7/17/17, at 10:26 a.m R33 stated it takes so long for the staff to get here that 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 my light and she said she had to go get help and would be right back".

It was observed on 7/19/17, at 1:23 p.m. no staff had returned to assist R33 as staff were in a resident room down the hall from R33's room. At this time, R33 turned on the call light and at 1:25 p.m. licensed practical nurse (LPN)-B walked by and asked R33 what she needed. R33 replied, "I need to go to the bathroom". LPN-B stated she needed to go get additional help. At 1:27 p.m. LPN-B and nursing assistant (NA)-F helped R33 onto the commode. At 1:35 p.m. NA-F stated R33 was continent of bowel but was very incontinent of urine and NA-F confirmed the brief was soaked.

During interview on 7/19/17, at 7:42 NA-E stated R33 will tell staff when she has to have a bowel movement (BM) but is always incontinent of urine. She stated she knows when she needs to go (urine) but doesn't tell us.

During interview on 7/20/17, at 8:30 a.m. NA-G stated that on night shift staff just check and change R33. NA-G stated R33 doesn't use the

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F 315	Continued From page 39 bedpan nor the commode at night. During interview on 7/20/17, at 8:35 a.m. NA-F stated R33 is always incontinent of urine; sometimes she will ask but is usually incontinent anyway. NA-F indicated R33 will request to go to the bathroom when needing to have a BM. When interviewed on 7/20/17, at 12:20 p.m. registered nurse (RN)-A stated that a bladder assessment was not available for review as the facility does not conduct them. When interviewed on 7/20/17, at 2:20 p.m. the director of nursing (DON) stated bladder assessments should be conducted to determine continence status and then individualized interventions could be implemented, such as a toileting program.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or	F 329		8/29/17

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F 329	Continued From page 40 discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure target behavior monitoring was completed for anti-psychotic medications for 2 of 5 residents (R51, R33) reviewed for unnecessary medications. Findings include: R51's face sheet, undated, indicated diagnoses of unspecified dementia with behavioral disturbance and Parkinson's disease. R51's admission Minimum Data Set (MDS) assessment dated 5/30/17, indicated no mood or behavioral concerns, and identified a Personal Health Questionnaire (PHQ-9) score was not	F 329	It is the Facility□s intent for resident□s drug regimen to be free from unnecessary drugs. R51 & R33□s medication regime has been reviewed. Sleep study has been implemented utilizing the Facility sleep log. Monitoring of medications will be completed as detailed in the Pharmaceutical Services Policy and Procedures Manual. On a monthly basis, nursing staff shall chart a summary of observed dose-responses of the administered medications. Audits will be	

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F 329	Continued From page 41 completed on this 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. R51's care plan, last revised 5/31/17, identified psychotropic drug use - resident receives antidepressant and anti-psychotic medication related to dementia without behaviors and REM sleep disorder. A goal was listed identified: not exhibiting signs of drug related sedation, hypotension, or anticholinergic symptoms. A target behavior listed for inability to sleep, with approaches of offering a snack, follow bedtime routine and allow him to vent. No other target behaviors were listed. The current physician's orders dated 7/17, identified R51 was on Abilify 5 milligrams daily for unspecified dementia without behavioral disturbance. A pharmacy consultant review, completed 5/24/17, with a return fax date from the nurse practitioner of 5/30/17, indicated the condition the Abilify was being administered was Parkinson's dementia with psychosis. R51's medication and treatment sheets dated 7/17, lacked evidence of any monitoring of R51's sleep pattern and/or other specific target behavior monitoring related to his Abilify usage. During interview on 7/19/17, at 8:08 a.m. licensed	F 329	completed on a monthly basis to ensure completion of necessary monitoring and charting. Director of Nursing or designated staff will audit documentation to support the necessity of ongoing utilization of pharmacological sleep agents. Audits will continue until the Facility□s Quality Assurance Team determines substantial compliance with applicable regulations and Facility policy has been achieved.	

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practical nurse (LPN)-B stated R51 was impulsive with transfers; however, she had not observed any other behaviors. LPN-B stated R51 wore a wander guard alarm to alert staff if attempts to go out the front doors, as often was looking for his wife.

During interview on 7/19/17, at 9:02 a.m. the social worker (SW) stated they only were documenting on behaviors for R51 during the look back period related to the MDS assessment and could not identify any specific target behavior charting being documented anywhere in the record related to his anti-psychotic usage.

During observation on 7/19/17, at 9:10 a.m. R51 was wheeling back from breakfast, appeared neat in appearance, propelling himself in his wheelchair. R51 was noted to have a flat facial affect.

During observation on 7/19/17, at 10:56 a.m. R51 was seated in his wheelchair, with family (F)-B at his side. R51 appeared neat in appearance and shaven. R51 was able to state he took an anxiolytic for sleep because "I would fall out of sleep otherwise, this has been under good control for years"; however, was unable to state the reason he took the anti-psychotic. F-B stated she was unsure the specific behaviors would have been for the prescribed anti-psychotic medication, and stated R51 was scheduled for a medication review with the neurologist today.

During interview on 7/19/17, at 1:21 p.m. the director of nursing (DON) stated the facility relied on a consultant pharmacist to identify concerns with unnecessary medications and would have expected target behaviors to be identified and

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monitored for anti-psychotic medications.

R33's face sheet identified diagnoses including phobic anxiety disorder, insomnia and major depressive disorder recurrent, severe with psychotic symptoms-mild, recurrent.

R33's quarterly MDS assessment dated 5/30/17, did not identify a Brief Interview for Mental Status (BIMS) score nor a PHQ-9 an assessment for depression. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact) and a PHQ-9 score of 6 (minimal depression). The MDS also identified rejection of cares and verbal behavioral symptoms occurred 1-3 days and no delusions or hallucinations occurred.

R33's physician orders dated 6/24/17 through 7/24/17, identified an order for Zyprexa (anti-psychotic medication used to treat psychosis) 5 milligrams (mg) every day.

R33's progress notes from 3/22/17 through 7/20/17, indicated verbally abusive behavior occurred 2 days. No other behaviors were documented.

R33's care plan dated 3/7/17, indicated R33 received anti-psychotic medication related to Major depression with psychosis. Approaches included: monitor residents behavior and response to medication monthly and identified a target behavior of aggression: leave safe and return later, allow to vent frustrations and 1:1 visits.

During interview on 7/20/17 at 2:22 p.m. the

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F 329	Continued 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. Policies related to anti-psychotic medication usage were requested, none were provided.	F 329		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		8/29/17

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F 431	Continued From page 45 (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a system to ensure periodic reconciliation of overflow schedule IV medications to prevent potential diversion for 4 of 4 resident (R9, R13, R31, R51) medications reviewed whose overflow schedule IV medications were stored in a locked cabinet in the medication room. Findings include: On 7/19/17, at 1:58 p.m. the medication room	F 431	It is the Facilities intent to have systems 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.	

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F 431	Continued From page 46 was observed with licensed practical nurse (LPN)-A. The right side of the medication room was noted to have 2 locked cabinets which contained resident overflow medications not stored in the medication carts. The medications were separated by resident into small crate-like bins; the medications were packaged on blister-pack cards containing up to #30 of the medication on each card . The schedule IV medications observed in the locked cabinets were as follows: (1) R9 - lorazepam 0.5 milligrams (mg) 1/2 tablets (0.25 mg dose): (a) 1 card of #30 1/2 tablets filled 9/12/16 (b) 2 cards of #30 1/2 tablets (#60 total) filled 10/10/16 (c) 1 card of #30 1/2 tablets filled 11/7/16 (d) 3 cards of #30 1/2 tablets (#90 total) filled 12/5/16 (e) 3 cards of #30 1/2 tablets (#90 total) filled 1/3/17 (f) 1 card of #30 1/2 tablets filled 2/27/17 (g) 2 cards of #30 1/2 tablets (#60 total) filled 3/22/17 (h) 1 card of #30 1/2 tablets filled 5/16/17 (i) 1 card of #30 1/2 tablets filled 6/14/17 Total = 450 1/2 tablets (2) R9-lorazepam 0.5 mg (full tablets): (a) 1 card of #30 tablets filled 1/3/17 (b) 2 cards of #30 tablets (#60 total) filled 3/22/17 (c) 1 card of #30 tablets filled 5/16/17 Total = 120 full tablets (3) R13-Tramadol HCL 50 mg 1/2 tablets (25 mg dose) (a) 6 cards of #30 tablets (#180 total) filled 6/1/17 (4) R31-lorazepam 0.5 mg (full tablets) (a) 1 card of #30 tablets filled 4/17/15	F 431	All residents with Scheduled IV medications have been logged for future ability to reconcile according the Facility□s Policy & Procedure. By 8/29/2017 all licensed staff will be educated on the work flow process. Policy & Procedure will be reviewed. Director of Nursing or designated staff will audit the Schedule IV Classification log monthly to ensure compliance with applicable regulations and Facility policy. Audit findings will be reported to Facility□s Quality Assurance Team.	

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F 431	Continued From page 47 (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.	F 431		

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F 431	Continued From page 48 R9's medical record was reviewed. R9's signed physician orders dated 6/23/17, identified diagnoses including Major depressive disorder and anxiety disorder. The physician orders indicated R9 could receive lorazepam 0.5 mg orally once daily at 8:00 a.m. for anxiety disorder and 1/2 tab (0.25 mg) up to three times a day as needed for agitation/anxiety. R13's medical record was reviewed. R13's signed physician orders dated 7/7/17, identified diagnoses including scoliosis and osteoarthritis of the knee. The physician orders indicated R13 could receive tramadol 25 mg orally every 6 hours for chronic pain. R31's medical record was reviewed. R31's signed physician orders dated 7/12/17, identified diagnoses including major depressive disorder and anxiety disorder. The physician orders indicated R31 could receive lorazepam 0.5 mg 1/2 tablet (0.25 mg dose) orally once daily for generalized anxiety disorder. R51's medical record was reviewed. R51's signed physician orders dated 7/7/17, indicated R51 could receive clonazepam 1 mg orally at bedtime for REM sleep behavior disorder.	F 431		
F 469 SS=F	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate pest	F 469	It is the Facilities intent to provide a clean and safe environment for our residents.	8/29/17

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F 469	Continued From page 49 control was maintained to control crawling insects throughout the facility. This deficient practice had the potential to affect all 41 residents residing in the facility. Findings include: During interview on 7/17/17, at 10:58, R16 (who resided down the Aster Wing of the facility) stated, "There are bugs in here, I killed two black ones in my room today." During observation on 7/19/17, at 7:37 a.m. a black/brown colored crawling insect, approximately one inch long ran across the floor by the central nursing 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 crawling 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." During interview on 7/20/17, at 9:05 a.m. maintenance assistant (M)-A stated the facility was having more difficulty with bugs than usual, and they had an exterminator come once a month for routine pest control. M-A further stated "As soon as he [pest contractor] sprays, they	F 469	The Facility will maintain an agreement with a licensed pest control contractor to carefully consider all available pest control techniques and subsequent integration of appropriate measures that discourage the development of pest populations and keep pesticides and other interventions to levels that are economically justified and reduce or minimize risks to human health and the environment. The Facility will make every effort to control pest populations in and around the premises and understands that the eradication of all pests is impossible. Risk assessment will include the characterization of biological control agents, health risks, environmental risks and efficacy. Monthly applications of pesticides to the premises will conform to federal, state, and local regulations and be documented. Regular daily observation will be conducted by all staff and reported to the ESD and/or Administrator. Additional applications will be made when necessary and during the summer months when populations peak due to species development cycles and climate changes. By 8/29/2017 all staff will be educated on Facility□s Pest Control Policy & Procedure. The Environmental Services Director or designee will monitor facility daily to ensure facility is free of pests and rodents.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 469	Continued From page 50 come out and die and all we can do is sweep them up. They come up underneath the walls." During observation on 7/20/17, at 11:40 a.m. two dead beetles of the same black/brown variety were noted on the floor on the Evergreen Wing. During observation on 7/20/17, at 11:42 a.m., another dead beetle was noted outside the conference room hallway adjacent to the Evergreen Wing. 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. During observation and interview on 7/20/17, at 12:43 4 dead black beetles on the floor under the wash sink and 3 black beetles on the floor of the dry storage room. Cook (C)-A stated at this time she had noticed them on the floor of the dry storage room at times. During interview on 7/20/17, at 12:26 p.m. the ESD stated he "I doubt it," if the pest control contractor had seen the beetles during his 6/26/17 and was aware of the extent of the current concern. The ESD stated on 6/26/17 Pest Pro had treated the interior and exterior of Blue Bird Wing for earwigs, another type of insect. The ESD further stated "We all sweep up when we can, I think it has to do with moisture." The ESD supplied a Pest Pro log report, which indicated the contractor had been there on 6/26/17, and had treated areas of interior to control general crawling insects of earwigs. The report further stated "No other pest problems noted." The log indicated Demand CS - 1/2%	F 469	Audits will continue until Facilities Quality Assurance Team determines substantial compliance with applicable regulations and Facility policies has been achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	07/20/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 469	Continued From page 51	F 469		

pesticide solution was used. The ESD further stated he had actually called Pest Pro back the day after their last treatment on 6/27/17, and he had returned to repeat a treatment, but could not find the paperwork and would get this from Pest Pro. A message was left with Pest Pro at this time to return a call.

During interview on 7/20/17, at 1:03 p.m. a service representative from Syngenta, manufacturer of Demand CS control chemical stated the facility can re-treat the floor every 21 days, and it would normally take more than one application to control beetles. If a high level of infestation was occurring, normally a contractor would spray around the entire exterior perimeter of the facility and to put up a barrier to prevent bugs trying to enter the building.

On 7/24/17, at 3:58 p.m. a representative from Pest Pro returned a call. The technician, who had completed the 6/26/17, insecticide treatment at the facility denied receiving a return call on 6/27/17 to relay the increased level of insects noticed inside the facility. He indicated he was not aware of the extent of the issue until "last Friday," which was during the facility inspection. He denied seeing the beetles noted at the facility, and stated he only treated some of the doorways and entries with spray inside the facility. "If I had known it was bad I would have done a full sweep outside with the ATV to put a wide band [of insecticide] around the building." The technician also stated "it is the facility's responsibility to repair their door gaskets, which are worn out and badly in need of repair," and indicated the doors were a source of entry for crawling insects.

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	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2017**

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TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST** **TRUMAN, MN 56088**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Truman Senior Living was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2017**

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K 000	Continued From page 1 <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Truman Senior Living is a one-story building with no basement, and is fully sprinklered. The original 1970 building along with the 1975 and 1987 building additions were determined to be of Type II(000) construction. The 1996 building addition was determined to be of Type V(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by rated 2-hour fire wall assemblies, which include opening protectives consisting of factory labeled, self-closing, positive latching 90-minute fire door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 41 at time of the survey.	K 000		

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	245346	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2017**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 41 out of 41 residents. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:30 PM on 07/18/2017, documentation could not be located to show that the annual 90 minute test was conducted on the Battery Back-up Emergency Lights. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	It is the Facilities intent to comply with the Life Safety Code standards. When Maintenance Assistant returned, documentation was located. The Annual 90 minute test was conducted in September 2016. See Attachment K291 Annual test is scheduled for the month of September 2017.	8/29/17
K 300 SS=E	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 300		8/11/17

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TRUMAN SENIOR LIVING	**400 NORTH 4TH AVENUE EAST** **TRUMAN, MN 56088**

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K 300	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to maintain complete documentation on the Annual Fire/Smoke Door Inspection per NFPA 80. The deficient practice could affect 41 out of 41 residents. Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. FINDINGS INCLUDE: On facility tour between 08:30 AM and 12:30 PM on 07/18/2017, documentation could not be located to indicate that the Annual Fire and Smoke Door Inspection had occurred per the NFPA 80. This deficient practice was verified by the Facility Maintenance Director.	K 300	It is the Facilities intent to comply with the Life Safety Code standards. As of 8/11/2017, The Annual Inspection of Fire Door Assemblies has been completed.	
K 324 SS=F	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		8/29/17

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K 324	Continued From page 4 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice could effect 41 of the 41 residents. Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324	It is the Facilities intent to comply with the Life Safety Code standards. Ansul system was last tested on 5/11/17 and is scheduled to be tested again on 11/15/17 and 5/16/18 by Mankato/Fairmont Fire & Safety.	

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K 324	Continued From page 5 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2. FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:30 PM on 07/18/2017, during documentation review, it was revealed that documentation could not be located to show that the kitchen fire suppression system was inspected the required time frame. The dates of inspections were 05/17/2016 and 05/11/2017 which is not within the 6 month inspection requirement. This deficient practice was verified by the Facility Maintenance Director.	K 324		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		8/9/17

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K 372	Continued From page 6 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1.(1). This deficient practice could affect 24 of the 41 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:30 AM on 07/18/2017, observation during the inspection revealed penetrations above the lay-in ceiling tiles on the following smoke barriers: Aster Wing and Evergreen Wing. NOTE: All smoke barriers need to be checked for compliance.	K 372	It is the Facilities intent to comply with the Life Safety Code standards. As of 8/09/2017 all smoke barriers above ceiling grids were checked and penetrations were fire calked at that time.	

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K 372	Continued From page 7 This deficient practice was verified by the Facility Maintenance Director.	K 372		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric 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 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		7/28/17

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K 918	Continued From page 8 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 41 of 41 residents. 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 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918	It is the Facilities intent to comply with the Life Safety Code standards. As of 7/28/2017 Annual generator major PM was performed by Generator System Services, Inc. It was determined that the generator performs under full load during monthly testing. Annual 4-hour run is scheduled for December 2017.	

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K 918	Continued From page 9 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:30 PM on 07/18/2017, during documentation review, the annual generator maintenance report could not be located. Also, during interview with the Facility Maintenance Director it is unclear if during the monthly 30 minute load test the emergency generator was being exercised under 30% of the face plate rating. This deficient practice was verified by the Facility Maintenance Director.	K 918		

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	Date Installed	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Battery Replaced
Mechanical Room	~~2-15-16~~ NA	90m A	30-sec A	M	M	M	M	M	M/A	A	M	M	M	2-18-16

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

"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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00361	A. BUILDING: _____ B. WING _____	07/20/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 17, 18, 19 and 20th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		8/29/17

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided in written or electronic format, a description of the their Alzheimer's training program, the categories of staff trained, the basic topics covered and the frequency of the training. Findings include: During interview on 7/20/17, at 1:40 p.m. the facility social worker (SW) stated the facility did not provide any information in writing, or electronically to her knowledge to the consumers related to Alzheimer's training. During interview on 7/20/17, at 2:15 p.m., the administrator verified that the facility did not have written or electronic materials they were providing to consumers related to the Alzheimer's training. SUGGESTED METHOD OF CORRECTION: The administrator or designee could update written materials, facility postings or website materials, to include the required information related to their Alzheimer's training program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care	2 560		8/29/17

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2 560	Continued From page 4 must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation,interview and document review, the facility failed to ensure the care plan was developed related to the use of psychoactive medications (antidepressants and anxiolytics) for 2 of 5 residents (R32, R33) reviewed for unnecessary medications. Findings include: R32's face sheet, dated 7/19/17 included diagnoses of dementia without behavioral disturbance and Major depression. R32's quarterly Minimum Data Set (MDS) assessment dated 5/16/17, identified a Brief Interview for Mental Status (BIMS) score of 4/15, indicative of severe cognitive impairment. R32's mood section identified feeling down or depressed 7-11 days during the lookback, and a Personal Health Questionnaire (PHQ-9) score of 2, indicative of minimal depression. The MDS also identified verbal behaviors towards others 1-3 days during the lookback and no psychosis. R32's Care Area Assessment (CAA) for psychoactive medication use dated 2/22/17, indicated to proceed to care plan to monitor for effectiveness of meds and non-pharmacological interventions. R32's care plan last revised 7/18/17, identified sexually inappropriate behavior towards others, to re-approach, and use two staff if necessary. The care plan did not address the anti-depressant	2 560	Corrected	

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2 560	Continued From page 5 and/or anxiolytic use. The 7/16 medication sheets indicated R32 received the medications: buspirone (anxiolytic), trazodone and citalopram (antidepressants) on a daily basis. During observation on 7/18/17, R32 was in his room, talking with visitors and had a smiling facial expression. During observation on 7/19/17, at 7:40 a.m., R32 was lying in bed, sleeping. During observation on 7/19/17, at 9:12 a.m. R32 stated he "does not know," whether he is depressed, engaged in conversation and smiled readily when conversed with surveyor. During interview on 7/19/17, at 8:06 a.m. licensed practical nurse (LPN)-B stated R32 "gets a little friendly with the staff." LPN-B stated sometimes R32 grabs at staff breasts and sometimes sits at the table and will let out a "yell" for no apparent reason. R32 also made inappropriate sexual remarks to staff. When interviewed on 7/19/17, at 8:22 a.m. the MDS coordinator stated she usually identified psychoactive medications on the care plan but had not done so for R32, stating "Nope, I don't see any of those meds on there." During interview on 7/19/17, at 1:21 p.m. the director of nursing (DON) stated psychoactive drugs should be a part of the comprehensive care plan. R33's face sheet identified diagnoses including phobic anxiety disorder, insomnia and major	2 560		

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2 560	Continued From page 6 depressive disorder recurrent, severe with psychotic symptoms-mild, recurrent. R33's quarterly MDS dated 5/30/17, did not identify a BIMS score nor a PHQ-9 assessment for depression. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact) and a PHQ-9 score of 6 (minimal depression). The MDS also identified rejection of cares and verbal behavioral symptoms occurred 1-3 days and no delusions or hallucinations occurred. R33's physician orders dated 7/2017, identified an orders for the antidepressant medication Amitriptyline 10 mg every bedtime, Zoloft 200 mg everyday and Wellbutrin 450 mg everyday R33's care plan dated 3/7/27, did not identify the use of the 3 antidepressant medications. During interview on 7/20/17, at 2:22 p.m. the director of nursing (DON) verified the antidepressant medications were not addressed on the care plan and the expectation was to include these as part of the care plan. The facility policy, entitled Care Plans - Comprehensive, dated 9/10 indicated it is the facility's policy to develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The policy further stated the comprehensive care plan is designed to incorporate identified problem areas. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure care plans are developed to accurately reflect any necessary interdisciplinary or medication	2 560		

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2 560	Continued From page 7 concerns. The facility could update policies and procedures, educate staff on these changes and audit periodically to ensure care plans adequately reflect the needs of residents. The facility could report findings to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement the plan of care related to monitoring bruising for 1 of 3 residents (R26) reviewed for non-pressure skin conditions. Findings include: On 7/18/17, at 1:36 p.m. R26 was observed seated in wheelchair in room. The resident had a large bruise on top of the right forearm extending from the wrist to the elbow. R26 also had a large bruise covering the top of the left hand. When interviewed at the time, the resident could not identify how the bruising occurred.	2 565	Corrected	8/29/17

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2 565	Continued From page 8	2 565		

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 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 11:48 a.m. LPN-B who was working on R26's wing, stated being unaware of the resident's bruising. LPN-B and surveyor entered R26's room to observe 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 bruises. The right arm bruising measured 14.5 centimeters (cm) x (by) 8 cm. The bruising was reddish purple around the edges and the top of the arm was a brownish black in color. The top of R26's left hand bruise measured 4.2 cm x 6 cm and was dark red in color.

The progress note dated 7/20/17, at 11:54 a.m. by LPN-B indicated: Notified by state inspector that resident has bruising on top of left hand and top of right fore arm. Area on top of left hand measures 4.2 x 6.0 cm dark burgundy in color,

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2 565	Continued From page 9 area on top of right forearm measures 14.5 x 8 cm dark purple in color around the edges with some red colored area in the center. Majority of bruise is tannish in color. When interviewed on 7/20/17, at 12:43 p.m. the DON stated with new skin issues such as bruising, would expect the nurse to make an entry into the progress note and also on the daily communication sheet to be investigated by the interdisciplinary team. The resident's family would also be notified and if a significant new skin issue would notify the physician. Also, if bruising was significant and staff were unable to identify the cause or if suspicious, would file a vulnerable adult (VA) report and investigate within the time constraint. During subsequent interview with DON at approximately 1:30 p.m., DON indicated a VA incident report had been submitted to the state agency related to R26's bruising. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending	2 570		8/29/17

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2 570	Continued From page 10 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include the use of a resting hand splint for 1 of 3 resident (R33) reviewed for range of motion (ROM) Findings include: R33's face sheet identified diagnoses including hemiplegia and hemiparesis on the left non-dominant side. R33's quarterly Minimum Data Set (MDS) 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 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 accident).	2 570	Corrected	

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2 570	Continued From page 11 Review of R33's medical record identified a recommendation to care givers from therapy dated 3/1/16. The recommendation indicated R33 had left hand tightness and staff were to place resting hand splint on left hand every night to be worn all night. R33's care plan dated 3/7/27 indicated R33 had an activity of daily living (ADL) functional/rehabilitation limitation in physical mobility. The care plan did not identify the use of the resting hand splint. On 7/17/17, at 10:32 a.m. R33 was observed to have left hand clenched and nails digging into the palm of hand. R33 had a brace to the left foot and stated she was to have a splint on her left hand but it was lost. On 7/20/17, at 7:26 a.m. R33 was observed in her room with a resting hand splint lying on the bedside table. R33 stated staff had just found the splint behind her chair this morning (7/20/17). R33 also stated, "I wear that at night". During interview on 7/20/17, at 8:10 a.m. nursing assistant (NA) E stated she worked the hall R33 was previously located and R33 had a hand splint which was applied every night and removed in the morning. 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 expect the use of the resting hand splint to be identified on the care plan.	2 570		

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2 570	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure care plans are revised to accurately reflect any necessary interdisciplinary or medication concerns. The facility could update policies and procedures, educate staff on these changes and audit periodically to ensure care plans adequately reflect the needs of residents. The facility could report findings to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to monitor bruising for 1 of 3 residents (R26) reviewed for non-pressure	2 830	Corrected	8/29/17

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TRUMAN SENIOR LIVING	400 NORTH 4TH AVENUE EAST TRUMAN, MN 56088

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2 830	Continued From page 13 skin conditions. Findings include: On 7/18/17, at 1:36 p.m. R26 was observed seated in wheelchair in room. The resident had a large bruise on top of the right forearm extending from the wrist to the elbow. R26 also had a large bruise covering the top of the left hand. When interviewed at the time, R26 was unable to explain how the bruising occurred. R26's quarterly Minimum Data Set (MDS) assessment included a brief interview of mental status (BIMS) score of 7 indicating severe cognitive impairment. The MDS also identified R26 required total dependence on staff for transfers, toilet use, and locomotion on and off the unit, and extensive assistance with personal hygiene, dressing, and bed mobility. 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 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	2 830		

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2 830	Continued From page 14 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 on bath days. LPN-C stated being unaware 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 and surveyor entered R26's room to observe 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 bruises. The right arm bruising measured 14.5 centimeters (cm) x (by) 8 cm. The bruising was reddish purple around the edges and the top of the arm was a brownish black in color. The top of R26's left hand bruise measured 4.2 cm x 6 cm and was dark red in color. LPN-B stated she would notify R26's physician and family of the bruising and would also notify the director of nursing (DON) and the administrator due to the size of the bruising. The progress note dated 7/20/17, at 11:54 a.m. by LPN-B indicated: Notified by state inspector that resident has bruising on top of left hand and top of right fore arm. Area on top of left hand measures 4.2 x 6.0 cm dark burgundy in color, area on top of right forearm measures 14.5 x 8 cm dark purple in color around the edges with some red colored area in the center. Majority of	2 830		

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2 830	Continued From page 15 bruise is tannish in color. When interviewed on 7/20/17, at 12:43 p.m. the DON stated that new skin issues noted, such as bruising, she would expect the nurse to make an entry into the progress note and also on the daily communication sheet to be investigated by the interdisciplinary team. The resident's family would also be notified and if a significant new skin issue would notify the physician. Also, if bruising was significant and staff were unable to identify the cause or if suspicious, would file a vulnerable adult (VA) report and investigate within the time constraint. During subsequent interview with DON at approximately 1:30 p.m., DON indicated a VA incident report had been submitted to the state agency related to R26's bruising. On 7/20/17, at 12:57 p.m. (after LPN-B and DON had been informed of R26's bruising) R26 was observed seated in wheelchair at the dining room table being assisted by NA-B with eating. The resident was wearing padded geri-sleeves bilaterally that covered the entire arm to protect the resident's skin. The policy titled, Policy and Procedure for the Prevention and Treatment of Skin Breakdown dated 6/16/12 included: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident records to ensure bruises and skin issues are being monitored, assessed and preventive measures are at place for residents at risk for skin injuries, and to ensure falls precautions that are care-planned are being	2 830		

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2 830	Continued From page 16 consistently implemented. The director of nursing or designee could revise policies and procedures related to skin care and monitoring, and falls as appropriate, and educate staff on these changes. Findings of audit activity could be reported to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting in a manner to restore as much normal bowel and bladder function for 2 of 3 (R3, R33) residents	2 910	Corrected	8/29/17

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2 910	Continued From page 17 reviewed for fecal 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". R3's 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 MDS further identified R3 was totally dependent upon staff for transfers and toilet use and was always incontinent of bowel. The care plan last revised 7/10/17, indicated R3 was incontinent of bladder and bowel related to mobility and impaired cognitive function. When interviewed on 7/20/17, at 11:14 a.m. nursing assistant (NA)-B stated R3 was always incontinent of urine although could identify and communicate to staff when he needed to have a bowel movement (BM). NA-B stated R3 was not toileted when needing to have a BM because he utilized a Hoyer lift. NA-B indicated R3's bathroom was not big enough to accommodate the lift into the bathroom and safely transfer onto the toilet, therefore R3 was directed to have a BM in the brief. NA-B stated, "He hates it". NA-B confirmed she instructed R3 to inform her when finished so staff could change him right away. Initially, NA-B denied there was an available commode large enough to accommodate R3 and then remembered a larger commode was available but currently utilized by another resident. When interviewed on 7/20/17, at 11:24 a.m. R3 confirmed he would rather sit on the toilet for a	2 910		

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2 910	Continued From page 18	2 910		

BM than in his brief. R3 further confirmed he was able to tell staff when needing to have a BM.

When interviewed on 7/20/17, at 11:32 a.m. licensed practical nurse (LPN)-B confirmed R3's bathroom would not accommodate the Hoyer lift for toileting. LPN-B further stated R3 would require an extra large commode which was unavailable as it was being used for another resident. LPN-B stated it would be better if R3 could be toileted for BM's rather than having to clean him up.

When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) stated being unaware that a commode couldn't be used for R3 for BM toileting.

When interviewed on 7/20/17, at 1:26 p.m. NA-E stated R3 used to use the toilet when able to use a standing lift for transfers. NA-E confirmed once R3 started using the Hoyer lift he was no longer was toileted as the lift did not fit in R3's bathroom well enough to safely transfer him onto the toilet. NA-E stated she thought R3 would be capable of sitting on a commode if they had one large enough. NA-E further clarified the facility had one extra large commode available but since another resident was utilizing this commode, it was not available for R3. NA-E confirmed R3 had utilized the Hoyer lift for at least 2 years.

When interviewed on 7/20/17, at 2:25 p.m. the DON confirmed R3 would be able to be toileted for BM's in the bathbay located across the hall from his room and thus be provided appropriate toileting services to maintain continence.

R33's face sheet undated, identified diagnoses including hemiplegia and hemiparesis on the left

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2 910	Continued From page 19 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 10:26 a.m R33 stated it takes so long for the staff to get here that 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 my light and she said she had to go get help and would be right back". It was observed on 7/19/17, at 1:23 p.m. no staff had returned to assist R33 as staff were in a resident room down the hall from R33's room. At	2 910		

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2 910	Continued From page 20 this time, R33 turned on the call light and at 1:25 p.m. licensed practical nurse (LPN)-B walked by and asked R33 what she needed. R33 replied, "I need to go to the bathroom". LPN-B stated she needed to go get additional help. At 1:27 p.m. LPN-B and nursing assistant (NA)-F helped R33 onto the commode. At 1:35 p.m. NA-F stated R33 was continent of bowel but was very incontinent of urine and NA-F confirmed the brief was soaked. During interview on 7/19/17, at 7:42 NA-E stated R33 will tell staff when she has to have a bowel movement (BM) but is always incontinent of urine. She stated she knows when she needs to go (urine) but doesn't tell us. During interview on 7/20/17, at 8:30 a.m. NA-G stated that on night shift staff just check and change R33. NA-G stated R33 doesn't use the bedpan nor the commode at night. During interview on 7/20/17, at 8:35 a.m. NA-F stated R33 is always incontinent of urine; sometimes she will ask but is usually incontinent anyway. NA-F indicated R33 will request to go to the bathroom when needing to have a BM. When interviewed on 7/20/17, at 12:20 p.m. registered nurse (RN)-A stated that a bladder assessment was not available for review as the facility does not conduct them. When interviewed on 7/20/17, at 2:20 p.m. the director of nursing (DON) stated bladder assessments should be conducted to determine continence status and then individualized interventions could be implemented, such as a toileting program.	2 910		

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2 910	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 10:26 a.m R33 stated it takes so long for the staff to get here that 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 my light and she said she had to go get help and would be right back". It was observed on 7/19/17, at 1:23 p.m. no staff	2 910		

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2 910	Continued From page 22	2 910		

had returned to assist R33 as staff were in a resident room down the hall from R33's room. At this time, R33 turned on the call light and at 1:25 p.m. licensed practical nurse (LPN)-B walked by and asked R33 what she needed. R33 replied, "I need to go to the bathroom". LPN-B stated she needed to go get additional help. At 1:27 p.m. LPN-B and nursing assistant (NA)-F helped R33 onto the commode. At 1:35 p.m. NA-F stated R33 was continent of bowel but was very incontinent of urine and NA-F confirmed the brief was soaked.

During interview on 7/19/17, at 7:42 NA-E stated R33 will tell staff when she has to have a bowel movement (BM) but is always incontinent of urine. She stated she knows when she needs to go (urine) but doesn't tell us.

During interview on 7/20/17, at 8:30 a.m. NA-G stated that on night shift staff just check and change R33. NA-G stated R33 doesn't use the bedpan nor the commode at night.

During interview on 7/20/17, at 8:35 a.m. NA-F stated R33 is always incontinent of urine; sometimes she will ask but is usually incontinent anyway. NA-F indicated R33 will request to go to the bathroom when needing to have a BM.

When interviewed on 7/20/17, at 12:20 p.m. registered nurse (RN)-A stated that a bladder assessment was not available for review as the facility does not conduct them.

When interviewed on 7/20/17, at 2:20 p.m. the director of nursing (DON) stated bladder assessments should be conducted to determine continence status and then individualized interventions could be implemented, such as a

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2 910	Continued From page 23 toileting program. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could revise policies and procedures related to bowel and bladder assessment and toileting programs, and educate staff on these changes. The director of nursing or designee could audit to ensure residents who are incontinent to ensure appropriate assessments are put into place. The director of nursing or designee could audit residents to ensure the interventions put into place as a result of assessments are being implemented effectively. Results of audits could be reported to the quality assurance committee for further recommendations to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		8/29/17

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21426	Continued From page 24 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to perform a two-step tuberculin skin test (TST) for 1 of 5 employees (E)-1. In addition, the facility failed to ensure baseline TB screening components were completed for 2 of 5 employees (E2, E3) per current Center for Disease Control and Prevention (CDC) recommendations and facility policy. Findings include: E1 had a hire date of 8/5/16, and had a documented baseline TB symptom screen and first step TST dated 8/5/16. The file did not include evidence a second step TST had been completed. E2 had a hire date of 5/18/17, and had documented TST's on 7/19/16 and 8/8/16 from a previous employer. Although E2 had a TB symptom screen completed on 5/18/17, the TST's were more than 90 days from date of hire. There was no evidence the facility had completed a second TST application. E3 had a hire date of 4/24/17, and had documented TST's on 12/1/16 and 12/8/16 from a previous employer. Although E3 had a TB symptom screen completed on 4/24/17, the TST's were more than 90 days from date of hire.	21426	Corrected	

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21426	Continued From page 25 There was no evidence the facility had completed a second TST application. When interviewed on 7/20/17, at 11:04 a.m. director of nursing (DON) confirmed E1 was lacking a second step TST and was currently employed by facility. The DON stated she had a "to do" list and creating a tracking system to monitor new employee TB testing dates was on it. The DON indicated E2 and E3 had TST's from a previous employer and thought they were sufficient if dated within the year. An undated facility policy titled, Indications for Two-Step Tuberculin skin Tests, included: No previous TST results; two-step baseline TST's. Previous documented negative TST result < (less than) 12 months before new employment; single TST needed for baseline testing; this test will be the 2nd step. For newly hired HCW's and other persons who will be tested on a routine basis, a previous TST is not a contraindication to a subsequent TST, unless the test was associated with severe ulceration or anaphylactic shock, which are substantially rare adverse events. SUGGESTED METHOD OF CORRECTION: The DON or designee could monitor for compliance of the tuberculosis screening process for all employees to ensure the TST and baseline TB screenings are being completed according to CDC recommendations. The administrator or designee could update their current policies related to tuberculin testing and TB screening for staff and residents and educate responsible staff related to the changes TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure target behavior monitoring was completed for anti-psychotic medications for 2 of 5 residents (R51, R33) reviewed for unnecessary medications. Findings include: R51's face sheet, undated, indicated diagnoses of unspecified dementia with behavioral	21535	Corrected	8/29/17

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21535	Continued From page 27 disturbance and Parkinson's disease. R51's admission Minimum Data Set (MDS) assessment dated 5/30/17, indicated no mood or behavioral concerns, and identified a Personal Health Questionnaire (PHQ-9) score was not completed on this 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. R51's care plan, last revised 5/31/17, identified psychotropic drug use - resident receives antidepressant and anti-psychotic medication related to dementia without behaviors and REM sleep disorder. A goal was listed identified: not exhibiting signs of drug related sedation, hypotension, or anticholinergic symptoms. A target behavior listed for inability to sleep, with approaches of offering a snack, follow bedtime routine and allow him to vent. No other target behaviors were listed. The current physician's orders dated 7/17, identified R51 was on Abilify 5 milligrams daily for unspecified dementia without behavioral disturbance. A pharmacy consultant review, completed 5/24/17, with a return fax date from the nurse practitioner of 5/30/17, indicated the condition the Abilify was being administered was Parkinson's dementia with psychosis. R51's medication and treatment sheets dated	21535		

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21535	Continued From page 28 7/17, lacked evidence of any monitoring of R51's sleep pattern and/or other specific target behavior monitoring related to his Abilify usage. During interview on 7/19/17, at 8:08 a.m. licensed practical nurse (LPN)-B stated R51 was impulsive with transfers; however, she had not observed any other behaviors. LPN-B stated R51 wore a wander guard alarm to alert staff if attempts to go out the front doors, as often was looking for his wife. During interview on 7/19/17, at 9:02 a.m. the social worker (SW) stated they only were documenting on behaviors for R51 during the look back period related to the MDS assessment and could not identify any specific target behavior charting being documented anywhere in the record related to his anti-psychotic usage. During observation on 7/19/17, at 9:10 a.m. R51 was wheeling back from breakfast, appeared neat in appearance, propelling himself in his wheelchair. R51 was noted to have a flat facial affect. During observation on 7/19/17, at 10:56 a.m. R51 was seated in his wheelchair, with family (F)-B at his side. R51 appeared neat in appearance and shaven. R51 was able to state he took an anxiolytic for sleep because "I would fall out of sleep otherwise, this has been under good control for years"; however, was unable to state the reason he took the anti-psychotic. F-B stated she was unsure the specific behaviors would have been for the prescribed anti-psychotic medication, and stated R51 was scheduled for a medication review with the neurologist today. During interview on 7/19/17, at 1:21 p.m. the	21535		

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21535	Continued From page 29	21535		

director of nursing (DON) stated the facility relied on a consultant pharmacist to identify concerns with unnecessary medications and would have expected target behaviors to be identified and monitored for anti-psychotic medications.

R33's face sheet identified diagnoses including phobic anxiety disorder, insomnia and major depressive disorder recurrent, severe with psychotic symptoms-mild, recurrent.

R33's quarterly MDS assessment dated 5/30/17, did not identify a Brief Interview for Mental Status (BIMS) score nor a PHQ-9 an assessment for depression. The 30 day medicare MDS dated 3/24/17, identified a BIMS score of 13 (cognitively intact) and a PHQ-9 score of 6 (minimal depression). The MDS also identified rejection of cares and verbal behavioral symptoms occurred 1-3 days and no delusions or hallucinations occurred.

R33's physician orders dated 6/24/17 through 7/24/17, identified an order for Zyprexa (anti-psychotic medication used to treat psychosis) 5 milligrams (mg) every day.

R33's progress notes from 3/22/17 through 7/20/17, indicated verbally abusive behavior occurred 2 days. No other behaviors were documented.

R33's care plan dated 3/7/17, indicated R33 received anti-psychotic medication related to Major depression with psychosis. Approaches included: monitor residents behavior and response to medication monthly and identified a target behavior of aggression: leave safe and return later, allow to vent frustrations and 1:1 visits.

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21535	Continued From page 30 During interview on 7/20/17 at 2:22 p.m. the 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. Policies related to anti-psychotic medication usage were requested, none were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures for the use and monitoring of psychoactive medications. The facility could educate staff on these policies and procedures, and audit resident records for compliance. The facility could report findings to the quality assurance committee, for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a system to	21610	Corrected	8/29/17

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21610	Continued From page 31	21610		

ensure periodic reconciliation of overflow schedule IV medications to prevent potential diversion for 4 of 4 resident (R9, R13, R31, R51) medications reviewed whose overflow schedule IV medications were stored in a locked cabinet in the medication room.

Findings include:

On 7/19/17, at 1:58 p.m. the medication room was observed with licensed practical nurse (LPN)-A. The right side of the medication room was noted to have 2 locked cabinets which contained resident overflow medications not stored in the medication carts. The medications were separated by resident into small crate-like bins; the medications were packaged on blister-pack cards containing up to #30 of the medication on each card . The schedule IV medications observed in the locked cabinets were as follows:
(1) R9 - lorazepam 0.5 milligrams (mg) 1/2 tablets (0.25 mg dose):
(a) 1 card of #30 1/2 tablets filled 9/12/16
(b) 2 cards of #30 1/2 tablets (#60 total) filled 10/10/16
(c) 1 card of #30 1/2 tablets filled 11/7/16
(d) 3 cards of #30 1/2 tablets (#90 total) filled 12/5/16
(e) 3 cards of #30 1/2 tablets (#90 total) filled 1/3/17
(f) 1 card of #30 1/2 tablets filled 2/27/17
(g) 2 cards of #30 1/2 tablets (#60 total) filled 3/22/17
(h) 1 card of #30 1/2 tablets filled 5/16/17
(i) 1 card of #30 1/2 tablets filled 6/14/17
Total = 450 1/2 tablets
(2) R9-lorazepam 0.5 mg (full tablets):
(a) 1 card of #30 tablets filled 1/3/17
(b) 2 cards of #30 tablets (#60 total) filled

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21610	Continued From page 32 3/22/17 (c) 1 card of #30 tablets filled 5/16/17 Total = 120 full tablets (3) R13-Tramadol HCL 50 mg 1/2 tablets (25 mg dose) (a) 6 cards of #30 tablets (#180 total) filled 6/1/17 (4) R31-lorazepam 0.5 mg (full tablets) (a) 1 card of #30 tablets filled 4/17/15 (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	21610		

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21610	Continued From page 33 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. R9's medical record was reviewed. R9's signed physician orders dated 6/23/17, identified diagnoses including Major depressive disorder and anxiety disorder. The physician orders indicated R9 could receive lorazepam 0.5 mg orally once daily at 8:00 a.m. for anxiety disorder and 1/2 tab (0.25 mg) up to three times a day as needed for agitation/anxiety. R13's medical record was reviewed. R13's signed physician orders dated 7/7/17, identified diagnoses including scoliosis and osteoarthritis of the knee. The physician orders indicated R13 could receive tramadol 25 mg orally every 6 hours for chronic pain. R31's medical record was reviewed. R31's signed physician orders dated 7/12/17, identified diagnoses including major depressive disorder and anxiety disorder. The physician orders indicated R31 could receive lorazepam 0.5 mg 1/2 tablet (0.25 mg dose) orally once daily for generalized anxiety disorder. R51's medical record was reviewed. R51's signed physician orders dated 7/7/17, indicated R51 could receive clonazepam 1 mg orally at bedtime for REM sleep behavior disorder. SUGGESTED METHOD OF CORRECTION: The director of nursing and consultant pharmacist	21610		

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21610	Continued From page 34 could develop policies and procedures, to ensure all controlled substance supplies are reconciled. The director of nursing or designee could educate nursing staff related to these changes, audit periodically for compliance. Findings could be reported to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate pest control was maintained to control crawling insects throughout the facility. This deficient practice had the potential to affect all 41 residents residing in the facility. Findings include: During interview on 7/17/17, at 10:58, R16 (who resided down the Aster Wing of the facility) stated, "There are bugs in here, I killed two black ones in my room today." During observation on 7/19/17, at 7:37 a.m. a	21730	Corrected	8/29/17

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21730	Continued From page 35	21730		

black/brown colored crawling insect, approximately one inch long ran across the floor by the central nursing 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 crawling 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."

During interview on 7/20/17, at 9:05 a.m. maintenance assistant (M)-A stated the facility was having more difficulty with bugs than usual, and they had an exterminator come once a month for routine pest control. M-A further stated "As soon as he [pest contractor] sprays, they come out and die and all we can do is sweep them up. They come up underneath the walls."

During observation on 7/20/17, at 11:40 a.m. two dead beetles of the same black/brown variety were noted on the floor on the Evergreen Wing.

During observation on 7/20/17, at 11:42 a.m., another dead beetle was noted outside the conference room hallway adjacent to the Evergreen Wing.

During observation of the lunch meal on 7/20/17, at approximately 12:15 p.m. five dead and

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21730	Continued From page 36 several crawling beetles were noted on the floor of the common dining area. During observation and interview on 7/20/17, at 12:43 4 dead black beetles on the floor under the wash sink and 3 black beetles on the floor of the dry storage room. Cook (C)-A stated at this time she had noticed them on the floor of the dry storage room at times. During interview on 7/20/17, at 12:26 p.m. the ESD stated he "I doubt it," if the pest control contractor had seen the beetles during his 6/26/17 and was aware of the extent of the current concern. The ESD stated on 6/26/17 Pest Pro had treated the interior and exterior of Blue Bird Wing for earwigs, another type of insect. The ESD further stated "We all sweep up when we can, I think it has to do with moisture." The ESD supplied a Pest Pro log report, which indicated the contractor had been there on 6/26/17, and had treated areas of interior to control general crawling insects of earwigs. The report further stated "No other pest problems noted." The log indicated Demand CS - 1/2% pesticide solution was used. The ESD further stated he had actually called Pest Pro back the day after their last treatment on 6/27/17, and he had returned to repeat a treatment, but could not find the paperwork and would get this from Pest Pro. A message was left with Pest Pro at this time to return a call. During interview on 7/20/17, at 1:03 p.m. a service representative from Syngenta, manufacturer of Demand CS control chemical stated the facility can re-treat the floor every 21 days, and it would normally take more than one application to control beetles. If a high level of infestation was occurring, normally a contractor	21730		

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21730	Continued From page 37 would spray around the entire exterior perimeter of the facility and to put up a barrier to prevent bugs trying to enter the building. On 7/24/17, at 3:58 p.m. a representative from Pest Pro returned a call. The technician, who had completed the 6/26/17, insecticide treatment at the facility denied receiving a return call on 6/27/17 to relay the increased level of insects noticed inside the facility. He indicated he was not aware of the extent of the issue until "last Friday," which was during the facility inspection. He denied seeing the beetles noted at the facility, and stated he only treated some of the doorways and entries with spray inside the facility. "If I had known it was bad I would have done a full sweep outside with the ATV to put a wide band [of insecticide] around the building." The technician also stated "it is the facility's responsibility to repair their door gaskets, which are worn out and badly in need of repair," and indicated the doors were a source of entry for crawling insects. SUGGESTED METHOD OF CORRECTION: The environmental services director or designee could increase the frequency of pest control visits to the facility until the insect levels were under control, and assess for damaged doorways or crevices that are a potential source of entry into the building. The environmental services director could develop policies related to pest control, and educate responsible staff. The environmental services director could make periodic inspections for pests, and report findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		

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21805	Continued From page 38	21805		
21805	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 in his "diaper". R3's 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 MDS further identified R3 was totally dependent upon staff for transfers and toilet use and was always incontinent of bladder and bowel. The care plan last revised 7/10/17, indicated R3 was incontinent of bladder and bowel related to mobility and impaired cognitive function. When interviewed on 7/20/17, at 11:14 a.m.	21805	Corrected	8/29/17

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nursing assistant (NA)-B stated R3 was always incontinent of urine although could identify the need to have a bowel movement (BM). NA-B stated R3 was considered a check and change and R3 was also able to let staff know when his incontinence product was wet. NA-B stated R3 was not toileted when needing to have a BM because he utilized a Hoyer lift. NA-B indicated R3's bathroom was not big enough to accommodate the lift into the bathroom and transferring the resident safely onto the toilet; therefore R3 was directed to have a BM in the brief. NA-B stated, "He hates it". NA-B confirmed R3 was able communicate to staff when he needed to have a BM and indicated she had directed R3 to inform her when finished so staff could change him right away. Initially, NA-B denied there was an available commode large enough to accommodate R3 and then remembered a larger commode was available but currently utilized by another resident.

When interviewed on 7/20/17, at 11:24 a.m. R3 confirmed he would rather sit on the toilet for a BM than in his brief. R3 further confirmed he was able to tell staff when needing to have a BM but unable to control urination since it just comes.

When interviewed on 7/20/17, at 11:32 a.m. licensed practical nurse (LPN)-B confirmed R3's bathroom would not accommodate the Hoyer lift for toileting. LPN-B further stated the resident would need an extra large commode which was unavailable to R3 as was being utilized by another resident. LPN-B stated it would be better if R3 could be toileted for BM's rather than having to clean him up.

When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) stated being unaware

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why a commode couldn't be used for R3 for BM toileting. DON stated she would investigate further to understand the rationale and would report the results to the surveyor.

When interviewed on 7/20/17, at 1:26 p.m. NA-E stated R3 used to use the toilet when able to use a standing lift for transfers. NA-E confirmed once the resident started utilizing the Hoyer lift he was no longer toileted as the lift did not fit in R3's bathroom well enough to safely transfer onto the toilet. NA-E stated she thought R3 would be capable of sitting on a commode if they had one large enough. NA-E further clarified the facility had one extra large commode available but since another resident was utilizing this commode, it was not available for R3. NA-E confirmed R3 had utilized the Hoyer lift for at least 2 years.

When interviewed on 7/20/17, at 2:25 p.m. the DON stated R3 could be toileted for BM's in the bath bay across the hall from his room. The DON confirmed the bath bay would be able to accommodate the Hoyer lift for safe transfer onto the toilet.

R59's undated face sheet, identified a diagnosis of urinary tract infection.

R59's admission MDS assessment dated 7/11/17, identified a BIMS score of 13 (cognitively intact) with no behaviors and/or wandering. The MDS further identified R59 as being occasionally incontinent of bladder and needing extensive assistance for toileting and transfers.

During interview on 7/17/17, at 2:01 p.m. a signage was noted on R59's private room door stating: Please check with nursing staff before entering. NA-B stated R59 was confined to his

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21805	Continued From page 41 room due to an infection in the urine and gown and gloves were needed by staff assisting with cares. During observation on 7/17/17, at 2:05 p.m.R59 was sitting in a wheelchair (w/c) in his room. R59's right leg was in a cast from upper thigh to ankle and a wanderguard was noted on the left ankle. At this time R59 stated he is "going banana's" and would prefer to go outside of his room but was not allowed to leave his room nor go outside. R59 indicated he was also upset that he had a wanderguard attached to his left leg. Review of the nursing progress notes dated 7/14/17, R59 was identified with VRE (vancomycin-resistant enterococci, an infection with bacteria resistant to the antibiotic vancomycin) in the urine with contact precautions initiated, which limited R59 from leaving his room. During interview on 7/18/17, at 4:51 p.m. family member (F)-A stated R59 was incontinent of urine but wore an incontinent pad to contain the urine. F-A further indicated no incontinence had been noted on R59's clothing during visits. However, F-A stated R59 was not allowed to leave his room due to the infection in his urine. F-A indicated this upset R59 as he enjoyed his meals in the dining room and the fresh air outside the building. F-A further indicated she was not sure why R59 had a wanderguard placed but knew that was also upsetting R59. On 7/18/17, at 4:59 p.m. R59 indicated he missed his friends at the dining room table, wishing he could join them for meals. R59 also stated he wasn't sure why he had to wear a wanderguard, indicating he was unable to propel himself to the door leading outside.	21805		

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21805	Continued From page 42 During interview on 7/18/17, at 5:58 p.m. R59, who was sitting in his room eating his meal with use of a disposable plate and utensils stated, it is "just like being in a prison". During a subsequent interview on 7/19/17, at 11:50 a.m. R59 expressed frustration with the restriction to remain in his room and also the application of the wanderguard to his leg. R59 stated, "hate having to stay in here". During interview on 7/19/17, at 12:02 p.m. NA-C stated R59 can't leave his room and that "drives him nuts". NA-C indicated being unsure of the reason R59 wore a wanderguard. When interviewed on 7/19/17, at 12:06 p.m. social services (SS)-A stated R59 is not an elopement risk and did not require a wanderguard. At 12:09 p.m. SS-A confirmed R59 was indeed wearing a wanderguard on the left ankle. Neither the SS-A nor RN-A were aware of the wanderguard attached to R59 and confirmed R59 should not have this applied. RN-A immediately removed the device after learning of the wanderguard. On 7/20/17, at 9:45 a.m. NA-B stated R59 was not incontinent on his clothes indicating the pads R59 wore contained the urine. On 7/20/17, at 1:33 p.m. the DON stated the precautions implemented were based on CDC (Centers for Disease Control and Prevention) guidelines for VRE, and what was best for R59 and the other residents. DON stated since R59 was incontinent she didn't want R59 touching tablecloths and/or other objects in the facility which could spread the infection. The DON	21805		

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21805	Continued From page 43 reiterated that keeping R59 isolated in his room was appropriate. A facility policy titled Elopement/Wandering Policy revised 8/16/12, indicated only a resident who has the potential for elopement/wandering will have a code alert transponder placed on their ankle, wrist, or wheelchair. A facility policy titled Isolation-Categories of Transmission-Based Precautions revised 1/2012, identified the facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections. A facility policy was requested related to dignified services, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could revise policies and procedures related to dignified care of residents and the observed concerns and educate staff on these changes. The director of nursing or designee could audit periodically to ensure compliance with the education and changes, and report findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means	21810		8/29/17

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21810	Continued From page 44 care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the appropriate equipment was available for toileting needs for 1 of 3 residents (R3) reviewed for toileting. Findings include: When interviewed about dignified care on 7/17/17, at 11:28 a.m. R3 stated feeling it was undignified when he needed to have a bowel movement (BM) and 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 (BIMS) score of 11 indicating moderate cognitive impairment. The MDS further identified R3 was totally dependent upon staff for transfers and toilet use and was always incontinent of bladder and bowel. The care plan last revised 7/10/17, indicated R3 was incontinent of bladder and bowel related to mobility and impaired cognitive function. When interviewed on 7/20/17, at 11:14 a.m. nursing assistant (NA)-B stated R3 could identify the need to have a bowel movement (BM). NA-B stated R3 was not toileted for a BM because he required a Hoyer lift and R3's bathroom was not big enough to accommodate the lift and safe transfer onto the toilet; therefore, R3 was directed	21810	Corrected	

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to have a BM in the brief. NA-B stated, "He hates it". NA-B confirmed R3 communicated the need for a bowel movement. Initially, NA-B denied there was an available commode large enough to accommodate R3 and then remembered a larger commode was available but currently utilized by another resident.

When interviewed on 7/20/17, at 11:24 a.m. R3 confirmed he would rather sit on the toilet for a BM than in his brief. R3 further confirmed he was able to tell staff when needing to have a BM.

When interviewed on 7/20/17, at 11:32 a.m. licensed practical nurse (LPN)-B confirmed R3's bathroom would not accommodate the Hoyer lift for toileting. LPN-B further stated R3 required an extra large commode which was unavailable to R3 as was being utilized by another resident. LPN-B stated it would be better if R3 could be toileted for BM's rather than having to clean him up.

When interviewed on 7/20/17, at 12:58 p.m. the director of nursing (DON) stated being unaware why a commode couldn't be used for R3 for BM toileting.

When interviewed on 7/20/17, at 1:26 p.m. NA-E stated R3 used to be toileted on the toilet when able to use the standing lift for transfers. NA-E confirmed once the resident started utilizing the Hoyer lift he was no longer toileted as the lift did not fit in R3's bathroom well enough to safely transfer onto the toilet. NA-E stated feeling R3 would be capable of sitting on a commode if they had one large enough. NA-E further stated the facility did have one extra large commode but since another resident was utilizing was not available to R3. NA-E confirmed R3 had utilized

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21810	Continued From page 46 the Hoyer lift for at least 2 years. When interviewed on 7/20/17, at 2:25 p.m. the DON stated R3 would be able to be toileted for BM's in the bath bay across the hall from his room. DON confirmed the bath bay would be able to accommodate the Hoyer lift for safe transfer onto the toilet. SUGGESTED METHOD OF CORRECTION: The director of nurses' could conduct an assessment to ensure residents are toileting according to needs and preferences. An audit could be periodically conducted to ensure staff implement the assessed need. The results could be reviewed at the quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is	21830		8/29/17

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21830	Continued From page 47 unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member 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 planning, unless the facility knows or has reason to believe the resident 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 planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that	21830		

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21830	Continued From page 48 the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN 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:	21830	Corrected	

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21830	Continued From page 49 When interviewed on 7/17/17, at 10:50 a.m. R3 stated he liked to get to bed somewhat early. R3 stated he's usually helped 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 go to bed earlier. 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 MDS further indicated R3 required total dependence with transfers and toilet use, and extensive assistance with bed mobility, personal hygiene, and dressing. R3's annual MDS dated 8/18/16, indicated it was very important for resident to choose own bedtime. It was observed on 7/18/17, at 5:43 p.m. licensed practical nurse (LPN)-A set up and administered medications to R3 during the supper meal. The medications administered to R3 included: atorvastatin (a cholesterol lowering medication) 20 milligrams orally every night at bedtime. When questioned the rationale for R3 receiving the bedtime medication at this time, LPN-A responded that R3 always wanted to go to bed right after supper and is very vocal and adamant about that. Therefore, the atorvastatin was administered with the 5:00 p.m. medications. During continuous observation on 7/18/17, the following was observed: - 6:51 p.m.- R3 was observed propelling self into his room down the Bluebell hall.	21830		

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21830	Continued From page 50 - 6:57 p.m.- R3's call light activated. - 6:59 p.m.-nursing assistant (NA)- A entered R3's room and informed R3 would return in a little bit. - 7:11 p.m.-R3's call light remained "on" and no staff had returned. - 7:19 p.m.-R3 seated in wheelchair (w/c) in room, call light remained on; no staff returned. R3 confirmed he was waiting to get ready for bed. - 7:21 p.m.-R3 propelled self out of room in w/c at this time. R3 gestured to surveyor who was seated at the end of the hallway and requested pain medication for his shoulders . After explaining to R3 the request needed to be made to facility staff, R3 stated he would go to the nursing desk and request the medication. R3 slowly propelled self with one foot down the hallway; the call light remained activated. -7:27 p.m.-NA-F was working at the end of the Bluebell hall distributing towels from a cart to resident rooms. R3 continued to make his way to the nurses desk. NA-F walked past R3 and continued to pass towels to resident rooms located on the Bluebell hall. R3 turned around and propelled self toward his room in w/c. NA-F entered R3's room, distributed the linens, walked out of the room and continued with linen distribution down the hall; R3's call light remained on. When finished with linen distribution, NA-F put the cart away and walked past R3. R3 attempted to talk to NA-F, who continued to go about her tasks and ignored R3. - 7:32 p.m.-R3 continued to slowly propel self in w/c towards room; call light remained activated (35 minutes). - 7:33 p.m.-R3 propelled self in w/c and entered his room. - 7:44 p.m.-R3 wheeled self back out into the hallway and looked down the hall towards the nurses station. R3 then propelled himself in w/c	21830		

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down the hall; call light remained on.
- 7:48 p.m.-NA-A approached R3 in the hallway and engaged in conversation. The administrator approached NA-A and gestured toward the surveyor seated at the end of the hall outside of R3's room. NA-A then assisted R3 into his room, turned off the call light, obtained the Hoyer lift and assistance from NA-F to help R3 with bedtime cares; (50 minutes after the call light was initially activated).

When interviewed on 7/20/17, at 9:45 a.m. R3 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.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could audit resident preferences for awakening and bedtimes, update written care plans and care guides and educate staff on this information. The director or designee could audit times resident cares are being completed, to ensure resident preferences are honored. Findings of audits could be reported to

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 52 the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		