Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 26, 2024

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

RE: CCN: 245346
Cycle Start Date: February 27, 2024

Dear Administrator:

On April 03, 2024, April 12, 2024, and April 23, 2024, the Minnesota Departments of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2024

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

Re: Reinspection Results
Event ID: C84312

Dear Administrator:

On April 23, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 19, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 29, 2024

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

RE: CCN: 245346
Cycle Start Date: February 27, 2024

Dear Administrator:

On March 13, 2024, we informed you that we may impose enforcement remedies.

On March 19, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 27, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 27, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 27, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Truman Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 27, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 27, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 29, 2024

Administrator
Truman Senior Living
400 North 4th Avenue East
Truman, MN 56088

Re: State Nursing Home Licensing Orders
Event ID: C84311

Dear Administrator:

The above facility was surveyed on March 19, 2024 through March 19, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	C 03/19/2024

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 On 3/19/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53462021C number (MN00101639) with a deficiency cited at F695. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 695	F695 Respiratory/Tracheostomy Care	4/15/24

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

Electronically Signed | 04/05/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. BUILDING _____ B. WING _____	C 03/19/2024

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 695	Continued From page 1 review the facility failed to ensure appropriate supplemental oxygen was delivered according to physician orders and failed to revise or develop a respiratory care plan for 2 of 2 residents (R1 and R2) reviewed for respiratory care. Findings include: R1's annual Minimal Data Set (MDS) dated 10/11/23, identified R1 had moderately impaired cognition and diagnoses which included chronic obstructive pulmonary disease (disease of the lungs). R1 required staff assist with dressing, toileting, transferring, and personal hygiene. The MDS also identified use of oxygen therapy. R1's hospital Physician's Plan of Care dated 3/13/24, indicated R1 had been hospitalized for aspiration pneumonia, COVID-19, and urinary tract infections (UTI). Further ordered R1 to receive continuous supplemental oxygen (O2) therapy at 1-3 liters per minute (LPM) by nasal cannula to keep 02 saturation greater than 90%. R1's hospital Physician's Plan of Care dated 3/15/24, indicated R1 had been observed at the hospital on 3/14/24 and 3/15/24 for Hypoxia (low oxygen level) with no change to original O2 orders but to maintain O2 sats at 90-98% with use of nasal cannula or a simple mask, to ensure O2 is connected and if R1 becomes hypoxic, and check oxygen is working every shift. R1's clinic physician order updated on 3/17/24, indicated may increase O2 to 5L per simple mask as needed to maintain O2 saturation greater than 90%. R1's care plan last updated 4/13/23, identified R1	F 695	and Suctioning Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate actions taken for the residents found to have been affected include: R1: When notified, NA-A immediately retrieved a full tank to assist in switching resident from empty tank. When alerted, LPN-A immediately came to R1□s room and assessed R1. R1 was placed on O2 at ordered LPM and oxygen levels began to improve. NA-A and LPN-A assisted resident to bed with use of Hoyer. Resident was monitored and O2 sats checked throughout shift without further events. Care plan was updated with current provider□s oxygen order for R1 and marked to pull over to the Kardex to address R1□s oxygen dependence to include goals of treatment and associated interventions. Immediate just in time education/counseling was provided to	

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 _____	C 03/19/2024

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 695	Continued From page 2 was at high risk for respiratory infections related to COPD and because of the COPD placed her at increased risk for breathing problems. Further identified R1 used oxygen at night. R1's goal was for O2 sats will remain 89% or greater on room air during the day when assessed. Associated interventions directed staff to monitor for difficulty breathing, remind R1 not to push beyond her endurance level, monitor for signs/symptoms of acute respiratory insufficiency, monitor/document/report as needed any signs/symptoms of respiratory infection. The care plan was not revised after R2's hospital visits and therefor inconsistent with physician orders. R1's visual Kardex (abbreviated care plan) report dated 3/19/24, did not address R1's oxygen dependence. During observation and interview on 3/19/24 at 11:27 a.m., R1 was sitting in her wheelchair in the doorway of her room with head hanging down, eyes closed, and not responding to voice. R1 had O2 nasal cannula tubing on and hooked up to a portable liquid oxygen tank on the back of her wheelchair with the control knob was set at 2.5 LPM. The portable oxygen tank content gauge on the regulator was observed to be in the red zone which indicated the tank was empty and there was no oxygen flow. This surveyor immediately requested assistance of staff. Nursing assistant (NA)-A responded at 11:32 a.m. and verified the O2 tank was empty. Further stated, she had last checked the tank at 9:00 a.m. (approximately 2 hours prior) and it was not empty at that time. NA-A stated they do not have any set time to check the tanks [for working order], "just every couple of hours". NA-A indicated she would get "a good tank". This	F 695	NA-A, NA-B and LPN-A by RN. R2: NA-A immediately turned on R2□s oxygen when alerted that it was off. NA-A reported to LPN-A, who assessed resident and monitored resident throughout shift. Care plan was updated with current provider□s oxygen order for R1 and marked to pull over to the Kardex to address R2□s oxygen dependence to include goals of treatment and associated interventions. Immediate just in time education/counseling was provided to NA-A, NA-B and LPN-A by RN. Immediate education, for both incidents, including but not limited to, change of condition and immediately notifying nurse, oxygen roles according to scope practice including oxygen orders and assessments, and proper use of oxygen including monitoring the gauge on the regulator to check contents left in the tank, was provided to all direct care staff on 3/19/2024. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with a provider□s order for supplemental oxygen have the potential to be affected. There are 3 residents at this time that require supplemental oxygen. R1, R2 and a third resident who has an order for oxygen at nighttime only.	

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 _____	C 03/19/2024

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 695	Continued From page 3 surveyor then requested a nurse to assess R1 due to non-responsiveness. Licensed practical nurse (LPN)-A responded with NA-A at 11:38 a.m. to check R1's O2 level. R1's O2 level at that time was 86% and was slow to respond with physical touch. O2 tank was replaced and at 11:42 a.m., R1's O2 levels were improving at 91-92%. LPN-A stated, "the tank must have run out, [R1] will usually tell us if she is short of breath". NA-A and LPN-A used a mechanical lift to lay R1 in bed and at 11:47 a.m., O2 level was 98-100%. R2's admission MDS dated 10/25/23, indicated R1 had mild cognitive impairment and diagnoses of respiratory failure and diabetes. R2 was dependent on staff for all cares and received oxygen therapy. R2's physician Order Summary Report dated 3/19/24, included the order for O2 at 0.5 to 4 LPN via nasal cannula for sats less than 90% related to chronic respiratory failure. R2's care plan dated 10/30/23, identified R2 was considered high risk for respiratory infections related to co-morbidities and part of the high risk population and communal living environment. The care plan did not specifically address R2's dependence on oxygen therapy that included goals of treatment and associated interventions. R2's visual Kardex report dated 3/19/24, did not address R2's oxygen dependence. During an observation on 3/19/24 at 12:40 p.m., R2 was observed sitting in her wheelchair at the dining room table with nasal cannula oxygen	F 695	Care plan for 3rd resident identified was reviewed and updated to include oxygen problem, goals and interventions and was pulled into the Kardex. All education that was provided to direct care staff would be pertinent to all residents who require supplemental oxygen. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator will ensure that the facility policies and procedures are consistent with the requirements stated in the regulations for this deficiency. The Administrator will educate the Director of Nursing on roles of direct staff regarding oxygen use and what is within their scope of practice. The Director of Nursing Services conducted an in-service education program with the assistance of our oxygen and respiratory supply vendor Northwest Respiratory that was held on 3/28/2024. The education that was provided, addressed, but was not limited to, the roles of oxygen administration according to scope of practice, who any problems with oxygen or resident condition should be relayed to immediately, the significance of providing appropriate oxygen concentrators, tanks, and supplies to a resident requiring supplemental oxygen. Direct care staff attended in person and those that were not in attendance for the in-person	

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 _____	C 03/19/2024

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 695	Continued From page 4 tubing in her nose that was connected to a portable liquid oxygen tank on the back of the wheelchair. The tank control knob on the regulator was set to 2 LPM, but the tank was in the red zone, indicating no oxygen was being delivered to R2. NA-A was assisting R2 with eating and observed that the portable oxygen tank was turned off and not delivering any oxygen to R2. NA-A turned valve on the regulator counterclockwise which allowed for oxygen delivery. NA-A told NA-B that she had not turned R2's [oxygen] tank on when she got her up [out of bed]. NA-B replied she had turned it on but must have bumped it and shut it off at some time. R2's O2 levels were unknown at that time but R2 did not demonstrate any symptoms of respiratory distress. During an interview on 3/19/24 at 1:25 p.m., NA-B indicated she had helped NA-A assist R2 out of bed just prior to lunch but could not remember what time. NA-B stated she had turned R2's O2 tank on but "may have bumped it and turned it off accidentally" when moving her. Further stated she was unsure how long portable O2 tanks last but guessed about 5 hours. During an interview on 3/19/24 at 2:01 p.m., NA-A verified R2's O2 tank was not turned on at 12:40 p.m. and she had turned it on at that time. Further stated she did not know how long the portable tanks last but was dependent on what the liter flow rate was set to. During an interview on 3/19/24 at 5:00 p.m., NA-C indicated she did not recall getting any training on the use of O2 at this facility. Further indicated portable oxygen tanks were checked when putting them on a resident and then at least	F 695	training will complete the written vendor oxygen training and competency test with opportunity for Q&A with DON. The Director of Nursing Services and/or designee and the nursing management team will review each resident with oxygen to ensure the presence of an oxygen concentrator, etank, and necessary supplies as ordered or for immediate use if needed. Care plans were updated for R1, R2, and third identified resident, with current provider□s oxygen order and marked to pull over to the Kardex to address oxygen dependence and to include goals of treatment and associate interventions. All residents that start on oxygen or admit to our facility on oxygen will be assessed for complete orders and be care planned accordingly. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Audit tools will be used to ensure deficient practice is corrected. They will be completed, reviewed and corrections made as needed. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that R1 and R2 have their oxygen on as ordered, have proper respiratory assessments and monitoring by licensed staff.	

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 _____	C 03/19/2024

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 695	Continued From page 5 once a shift. During an interview on 3/19/24 at 5:07 p.m., LPN-A indicated the portable O2 tanks last depending on the amount of oxygen being delivered and guessed about 4-5 hours but was not sure. During an interview on 3/19/24 at 2:05 p.m., the Northwest Respiratory Senior Representative (NRSR) indicated if a portable O2 tank was in the red zone, it was not delivering any O2 to the resident and the tank needed to be changed immediately. NRSR explained the duration of the portable O2 tank was dependent on the size of the tank and the amount of O2 [LPM] flow that was given. Further indicated there was no recent record of any training provided to the facility's staff. During an interview on 3/19/24 at 3:10 p.m., the director of nursing (DON) indicated awareness of the two incidents of O2 portable tanks not delivering oxygen and further explained the expectation of staff was to check the O2 tanks at every contact with the resident to assure they were working (delivering O2). The staff were to refer to the physician's orders or the Kardex for direction. Then verified that oxygen use was not addressed on the Kardex. On the spot training was in process and a more formal training was being scheduled. Review of facility policy titled Oxygen administration, revised October 2010, directed staff to review the care plan and check the mask, tank, etc. to be sure they are in good working order and securely fastened. The policy lacked direction on which staff were allowed to assist	F 695	The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that resident dependent on supplemental oxygen will have their oxygen on as ordered, have proper respiratory assessments and monitoring by licensed staff. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that direct care staff are working within their scope regarding oxygen use for residents. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that oxygen concentrators, etanks and supplies are maintained in a clean and operable condition and are available for immediate use if necessary. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that care plans and Kardex remain updated to reflect the oxygen problem, goal, and interventions for current and future residents with oxygen needs/orders. The plan of correction for F695 will be integrated into our QAPI program. QAPI	

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 _____	C 03/19/2024

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 695	Continued From page 6 with O2, how often to check for proper working order, how to determine when to replace a tank, and implementing a respiratory care plan and interventions required.	F 695	program members will review the completed audits every week. Audits will end when QAPI determines significant compliance is met. Audit reviews will be presented to QAA quarterly. QAA members will identify any trends or patterns and make recommendations to revise the Plan of Correction as needed. The plan of correction will be reported to the QAA on 4/29/2024. The above corrective action measures will be completed on or before 4/15/2024.	

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 _____	03/19/2024

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: On 3/19/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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 _____	03/19/2024

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	Continued From page 1 The following complaints were reviewed: H53462021C (MN00101639) with licensing order issued at 1520. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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 _____	03/19/2024

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	Continued From page 2 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		
21520	MN Rule 4658.1300 Subp. 1-4 Medications and Pharmacy Services; Definition Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4. Subp. 2. Schedule II drugs. "Schedule II drugs" means drugs with a high potential for abuse that have established medical uses as defined in Minnesota Statutes, section 152.02, subdivision 3. Subp. 3. Pharmacy services. "Pharmacy services" means services to ensure the accurate acquiring, receiving, and administering of all drugs to meet the needs of each resident. Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure appropriate supplemental oxygen was delivered according to physician orders and failed to revise or develop a respiratory care plan for 2 of 2 residents (R1 and R2) reviewed for respiratory care. Findings include:	21520	F695 Respiratory/Tracheostomy Care and Suctioning Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents,	4/15/24

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 _____	03/19/2024

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
21520	Continued From page 3 R1's annual Minimal Data Set (MDS) dated 10/11/23, identified R1 had moderately impaired cognition and diagnoses which included chronic obstructive pulmonary disease (disease of the lungs). R1 required staff assist with dressing, toileting, transferring, and personal hygiene. The MDS also identified use of oxygen therapy. R1's hospital Physician's Plan of Care dated 3/13/24, indicated R1 had been hospitalized for aspiration pneumonia, COVID-19, and urinary tract infections (UTI). Further ordered R1 to receive continuous supplemental oxygen (O2) therapy at 1-3 liters per minute (LPM) by nasal cannula to keep 02 saturation greater than 90%. R1's hospital Physician's Plan of Care dated 3/15/24, indicated R1 had been observed at the hospital on 3/14/24 and 3/15/24 for Hypoxia (low oxygen level) with no change to original O2 orders but to maintain O2 sats at 90-98% with use of nasal cannula or a simple mask, to ensure O2 is connected and if R1 becomes hypoxic, and check oxygen is working every shift. R1's clinic physician order updated on 3/17/24, indicated may increase O2 to 5L per simple mask as needed to maintain O2 saturation greater than 90%. R1's care plan last updated 4/13/23, identified R1 was at high risk for respiratory infections related to COPD and because of the COPD placed her at increased risk for breathing problems. Further identified R1 used oxygen at night. R1's goal was for O2 sats will remain 89% or greater on room air during the day when assessed. Associated interventions directed staff to monitor for difficulty breathing, remind R1 not to push beyond her endurance level, monitor for signs/symptoms of	21520	or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate actions taken for the residents found to have been affected include: R1: When notified, NA-A immediately retrieved a full tank to assist in switching resident from empty tank. When alerted, LPN-A immediately came to R1's room and assessed R1. R1 was placed on O2 at ordered LPM and oxygen levels began to improve. NA-A and LPN-A assisted resident to bed with use of Hoyer. Resident was monitored and O2 sats checked throughout shift without further events. Care plan was updated with current provider's oxygen order for R1 and marked to pull over to the Kardex to address R1's oxygen dependence to include goals of treatment and associated interventions. Immediate "just in time" education/counseling was provided to NA-A, NA-B and LPN-A by RN. R2: NA-A immediately turned on R2's oxygen when alerted that it was off. NA-A reported to LPN-A, who assessed resident and monitored resident throughout shift. Care plan was updated with current provider's oxygen order for R1 and	

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 _____	03/19/2024

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
21520	Continued From page 4 acute respiratory insufficiency, monitor/document/report as needed any signs/symptoms of respiratory infection. The care plan was not revised after R2's hospital visits and therefor inconsistent with physician orders. R1's visual Kardex (abbreviated care plan) report dated 3/19/24, did not address R1's oxygen dependence. During observation and interview on 3/19/24 at 11:27 a.m., R1 was sitting in her wheelchair in the doorway of her room with head hanging down, eyes closed, and not responding to voice. R1 had O2 nasal cannula tubing on and hooked up to a portable liquid oxygen tank on the back of her wheelchair with the control knob was set at 2.5 LPM. The portable oxygen tank content gauge on the regulator was observed to be in the red zone which indicated the tank was empty and there was no oxygen flow. This surveyor immediately requested assistance of staff. Nursing assistant (NA)-A responded at 11:32 a.m. and verified the O2 tank was empty. Further stated, she had last checked the tank at 9:00 a.m. (approximately 2 hours prior) and it was not empty at that time. NA-A stated they do not have any set time to check the tanks [for working order], "just every couple of hours". NA-A indicated she would get "a good tank". This surveyor then requested a nurse to assess R1 due to non-responsiveness. Licensed practical nurse (LPN)-A responded with NA-A at 11:38 a.m. to check R1's O2 level. R1's O2 level at that time was 86% and was slow to respond with physical touch. O2 tank was replaced and at 11:42 a.m., R1's O2 levels were improving at 91-92%. LPN-A stated, "the tank must have run out, [R1] will usually tell us if she is	21520	marked to pull over to the Kardex to address R2's oxygen dependence to include goals of treatment and associated interventions. Immediate "just in time" education/counseling was provided to NA-A, NA-B and LPN-A by RN. Immediate education, for both incidents, including but not limited to, change of condition and immediately notifying nurse, oxygen roles according to scope practice including oxygen orders and assessments, and proper use of oxygen including monitoring the gauge on the regulator to check contents left in the tank, was provided to all direct care staff on 3/19/2024. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with a provider's order for supplemental oxygen have the potential to be affected. There are 3 residents at this time that require supplemental oxygen. R1, R2 and a third resident who has an order for oxygen at nighttime only. Care plan for 3rd resident identified was reviewed and updated to include oxygen problem, goals and interventions and was pulled into the Kardex. All education that was provided to direct care staff would be pertinent to all residents who require supplemental oxygen.	

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 _____	03/19/2024

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
21520	Continued From page 5 short of breath". NA-A and LPN-A used a mechanical lift to lay R1 in bed and at 11:47 a.m., O2 level was 98-100%. R2's admission MDS dated 10/25/23, indicated R1 had mild cognitive impairment and diagnoses of respiratory failure and diabetes. R2 was dependent on staff for all cares and received oxygen therapy. R2's physician Order Summary Report dated 3/19/24, included the order for O2 at 0.5 to 4 LPN via nasal cannula for sats less than 90% related to chronic respiratory failure. R2's care plan dated 10/30/23, identified R2 was considered high risk for respiratory infections related to co-morbidities and part of the high risk population and communal living environment. The care plan did not specifically address R2's dependence on oxygen therapy that included goals of treatment and associated interventions. R2's visual Kardex report dated 3/19/24, did not address R2's oxygen dependence. During an observation on 3/19/24 at 12:40 p.m., R2 was observed sitting in her wheelchair at the dining room table with nasal cannula oxygen tubing in her nose that was connected to a portable liquid oxygen tank on the back of the wheelchair. The tank control knob on the regulator was set to 2 LPM, but the tank was in the red zone, indicating no oxygen was being delivered to R2. NA-A was assisting R2 with eating and observed that the portable oxygen tank was turned off and not delivering any oxygen to R2. NA-A turned valve on the regulator counterclockwise which allowed for oxygen delivery. NA-A told NA-B that she had not turned	21520	3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator will ensure that the facility policies and procedures are consistent with the requirements stated in the regulations for this deficiency. The Administrator will educate the Director of Nursing on roles of direct staff regarding oxygen use and what is within their scope of practice. The Director of Nursing Services conducted an in-service education program with the assistance of our oxygen and respiratory supply vendor Northwest Respiratory that was held on 3/28/2024. The education that was provided, addressed, but was not limited to, the roles of oxygen administration according to scope of practice, who any problems with oxygen or resident condition should be relayed to immediately, the significance of providing appropriate oxygen concentrators, tanks, and supplies to a resident requiring supplemental oxygen. Direct care staff attended in person and those that were not in attendance for the in-person training will complete the written vendor oxygen training and competency test with opportunity for Q&A with DON. The Director of Nursing Services and/or designee and the nursing management team will review each resident with oxygen to ensure the presence of an oxygen concentrator, etank, and necessary supplies as ordered or for immediate use if needed.	

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 _____	03/19/2024

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
21520	Continued From page 6 R2's [oxygen] tank on when she got her up [out of bed]. NA-B replied she had turned it on but must have bumped it and shut it off at some time. R2's O2 levels were unknown at that time but R2 did not demonstrate any symptoms of respiratory distress. During an interview on 3/19/24 at 1:25 p.m., NA-B indicated she had helped NA-A assist R2 out of bed just prior to lunch but could not remember what time. NA-B stated she had turned R2's O2 tank on but "may have bumped it and turned it off accidentally" when moving her. Further stated she was unsure how long portable O2 tanks last but guessed about 5 hours. During an interview on 3/19/24 at 2:01 p.m., NA-A verified R2's O2 tank was not turned on at 12:40 p.m. and she had turned it on at that time. Further stated she did not know how long the portable tanks last but was dependent on what the liter flow rate was set to. During an interview on 3/19/24 at 5:00 p.m., NA-C indicated she did not recall getting any training on the use of O2 at this facility. Further indicated portable oxygen tanks were checked when putting them on a resident and then at least once a shift. During an interview on 3/19/24 at 5:07 p.m., LPN-A indicated the portable O2 tanks last depending on the amount of oxygen being delivered and guessed about 4-5 hours but was not sure. During an interview on 3/19/24 at 2:05 p.m., the Northwest Respiratory Senior Representative (NRSR) indicated if a portable O2 tank was in the red zone, it was not delivering any O2 to the	21520	Care plans were updated for R1, R2, and third identified resident, with current provider's oxygen order and marked to pull over to the Kardex to address oxygen dependence and to include goals of treatment and associate interventions. All residents that start on oxygen or admit to our facility on oxygen will be assessed for complete orders and be care planned accordingly. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Audit tools will be used to ensure deficient practice is corrected. They will be completed, reviewed and corrections made as needed. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that R1 and R2 have their oxygen on as ordered, have proper respiratory assessments and monitoring by licensed staff. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that resident dependent on supplemental oxygen will have their oxygen on as ordered, have proper respiratory assessments and monitoring by licensed staff. The Director of Nursing Services (DON), or designee, will complete random weekly	

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 _____	03/19/2024

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
21520	Continued From page 7 resident and the tank needed to be changed immediately. NRSR explained the duration of the portable O2 tank was dependent on the size of the tank and the amount of O2 [LPM] flow that was given. Further indicated there was no recent record of any training provided to the facility's staff. During an interview on 3/19/24 at 3:10 p.m., the director of nursing (DON) indicated awareness of the two incidents of O2 portable tanks not delivering oxygen and further explained the expectation of staff was to check the O2 tanks at every contact with the resident to assure they were working (delivering O2). The staff were to refer to the physician's orders or the Kardex for direction. Then verified that oxygen use was not addressed on the Kardex. On the spot training was in process and a more formal training was being scheduled. Review of facility policy titled Oxygen administration, revised October 2010, directed staff to review the care plan and check the mask, tank, etc. to be sure they are in good working order and securely fastened. The policy lacked direction on which staff were allowed to assist with O2, how often to check for proper working order, how to determine when to replace a tank, and implementing a respiratory care plan and interventions required. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies for oxygen administration. The director of nursing or designee could develop a system to educate staff about oxgyen administration. The quality assurance committee could monitor to ensure compliance.	21520	audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that direct care staff are working within their scope regarding oxygen use for residents. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that oxygen concentrators, etanks and supplies are maintained in a clean and operable condition and are available for immediate use if necessary. The Director of Nursing Services (DON), or designee, will complete random weekly audits for four (4) consecutive weeks and then one time a month for 4 months to ensure that care plans and Kardex remain updated to reflect the oxygen problem, goal, and interventions for current and future residents with oxygen needs/orders. The plan of correction for F695 will be integrated into our QAPI program. QAPI program members will review the completed audits every week. Audits will end when QAPI determines significant compliance is met. Audit reviews will be presented to QAA quarterly. QAA members will identify any trends or patterns and make recommendations to revise the Plan of Correction as needed. The plan of correction will be reported to the QAA on 4/29/2024. The above corrective action measures will	

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 _____	03/19/2024

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
21520	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty One (21) days	21520	be completed on or before 4/15/2024.	