



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 23, 2026

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

RE: CCN: 245346
Cycle Start Date: July 24, 2026

Dear Administrator:

On September 22, 2026, the Minnesota Department of Health completed a revisit 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.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Electronically delivered

September 23, 2026

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

Re: Reinspection Results
Event ID: 2CFB49-H2

Dear Administrator:

On September 22, 2026 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 July 24, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2026

Administrator

Truman Senior Living

400 North 4th Avenue East

Truman, Mn 56088

RE: CCN:245346

Cycle Start Date: July 24, 2026

Dear Administrator:

On July 24, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 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.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

**Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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, 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, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 24, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by January 24, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 2CFB49-H1

Dear Administrator:

The above facility survey was completed on July 24, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules 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, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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.

Sincerely,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245346		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER TRUMAN SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST , TRUMAN, Minnesota, 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
F0000	INITIAL COMMENTS On 7/24/26, 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 complaints were reviewed. H53463448C (3106439) with a deficiency issued at F609 and F689. 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.			F0000			09/01/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult			F0609	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. F609 Plan of Correction Facility Name: Truman Senior Living Regulation Cited: F0609 – Reporting of Alleged Violations (42 CFR § 483.12(c)(1) and § 483.12(c)(4)). Policy Statement It is the policy of Truman Senior Living to comply with all state and federal regulations, including F609 – Reporting of Alleged Violations, to ensure the		09/01/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245346		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
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F0609 SS = D	Continued from page 1 protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure an alleged violation involving neglect were reported to the State Agency within the required timeframe after becoming aware that staff failed to follow a resident's transfer care plan by transferring the resident without the required gait belt for 1 of 1 resident (R1) reviewed for falls. Findings include: R1's face sheet dated 6/24/26, identified diagnoses of Alzheimer's disease (a progressive brain disorder that damages memory), chronic kidney disease (a long-term condition where the kidneys are damaged), osteoporosis (a medical condition where the bones become thin and weak), and diabetes (a condition where your body uses glucose as fuel). R1's quarterly Minimum Data Set (MDS) dated 6/15/26, identified R1 had moderate cognitive impairment, had not behavioral symptoms, no rejection of care, had no impairment on upper or lower extremities, used a walker/wheelchair, partial/moderate assistance for bed mobility, substantial/maximum assistance for transfer, and no falls since admission. R1's mobility focus care plan dated 8/15/25, identified R1 had impaired mobility related to inability to walk independently. Goal to be able to perform activity within physical limits. Interventions as follows: -Ambulation as therapy indicates (dated 8/15/25). -Family requested no use of mechanical lifts at this time. However, if refuses to stand and transfer with two staff, educate resident that lift will be used for both staff and own safety (dated 5/1/26).			F0609	Continued from page 1 health, safety, and welfare of all residents. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or injuries of unknown source are reported promptly to the appropriate officials, including the State Survey Agency, in accordance with regulatory timeframes. Corrective Actions for Residents Affected by the Deficient Practice The following corrective actions will be taken for the resident directly affected: Resident R1 was assessed immediately by the charge nurse on-duty after the witnessed fall. The facility sent R1 to the emergency room via ambulance due to continued knee pain, even though R1 always complains of knee pain. R1 returned to the facility at 11:45 PM the same day with x-rays completed on the pelvis, left knee, and left hip with negative results. The resident's care plan and transfer interventions were reviewed to ensure staff followed the care plan transfer assistance requirements. The facility interdisciplinary committee conducted an investigation and root cause analysis into the witnessed fall. It determined the CNA on duty failed to utilize a gait belt during transfer as the care plan had identified. Education and corrective action were provided to the CNA by the Director of Nursing and Administrator. Administration reviewed the incident to determine whether the event met the threshold for an alleged violation involving neglect and whether immediate reporting to the State Agency was required under federal reporting requirements. The policy and procedure were reviewed and revised to include these types of incidents. Actions to Identify Other Potentially Affected Residents A comprehensive review of all residents with transfer assistance, fall risk, or mobility care plans will be conducted to identify any individuals who may have been affected by a similar failure to follow transfer interventions. The Risk Management and Care Plan will be audited		09/01/2026

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F0609 SS = D	Continued from page 2 -Per therapy: Encourage to continue with stand pivots using four wheeled walker (4WW) to all seated surfaces. Will need moderate assist of one. Cue her to lean forward. Lift from gait belt and her pant line. Do not pull from front. She can walk distances with 4WW, and gait belt applied (dated 5/1/26). R1’s fall incident report dated 7/17/26 at 4:30 p.m., identified R1 was found on the floor partially lying on her back with her knees slightly bent. R1 was crying and stating her left knee was hurting. Witness statement from nursing assistant (NA)-A identified that during a transfer to wheelchair with walker from the recliner, without a gait belt, R1 was lifted by the waistband when her knees gave out and she fell to the floor. During an interview on 7/24/26 at 4:19 p.m., nursing assistant (NA)-A stated she had assisted R1 during a transfer on 7/17/26 and did not use a gait belt during the transfer at the time R1 fell. NA-A explained she had moved R1 and placed a gait belt on R1 prior to calling the nurse to come and assess R1, because she was “afraid she was going to get in trouble.” During a phone interview on 7/24/26 at 1:57 p.m., licensed practical nurse (LPN)-A stated she had been the nurse working at the time of R1’s fall on 7/17/26. After R1 had fallen she completed a full assessment of R1, who was having pain in her left knee. R1 was picked up off the floor and was later sent to the emergency room for evaluation but did not have any fractures and was sent back to the facility. LPN-A stated she had received a phone call from family to inform her they had reviewed camera footage at the time of the fall and identified that NA-A had not used a gait belt at the time of R1’s fall. During a follow up phone interview on 7/24/26 at 4:59 p.m., LPN-A did not recall if she had notified the DON or administrator of R1’s care plan not being followed at the time of the fall. During an interview on 7/24/26 at 2:14p.m., director of nursing (DON) stated she had not been aware until 7/19/26 that following R1's fall that occurred on 7/17/26 that a gait belt had not been used at the time of R1's fall. DON explained this had not been reported to the SA and the facility just began their investigation of the fall but should have reported this to the SA as well. During an interview on 7/24/26 at 2:20 p.m., administrator stated after the facility had discovered			F0609	Continued from page 2 to identify any additional instances in which required transfer devices or safety measures were not used. Any additional concerns identified through the review will be immediately investigated and reported in accordance with facility policy and applicable state and federal requirements. Measures to Ensure the Deficient Practice Does Not Recur Education was provided to the nursing department staff on Resident Safety/Gait Belts and Kardex and care plan training beginning on 7/19/2026. Education was provided to employees on F609 Reporting of Alleged Violations and Guidance for Reporting of Alleged Violations, followed by a competency quiz. Nursing department education and training will be completed regarding: Resident transfer safety and Gait Belts, Adherence and location of care plans, Point Click Care (PCC) CNA Kardex task information and Communications, What constitutes a resident change in condition, Recognition of neglect concerns, Reporting requirements for alleged violations, and required timeframes for reporting to the State Agency. Facility policies and procedures related to: Compliance with Reporting of Abuse/Neglect/Exploitation Alleged neglect reporting timelines to include the Vulnerable Adult Reporting crosswalk criteria, and Guidance for Reporting Alleged Violations, Falls Prevention Program Policy, Falls Interventions List, Accidents and Supervision, Safe Resident Handling/Transfers, and the Use of the Gait Belt will be reviewed and revised as		09/01/2026

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F0609 SS = D	Continued from page 3 NA-A had not followed R1's care plan at the time of her fall on 7/17/26 by not using a gait belt to maintain resident safety, this should have been reported to the SA, however, had not been reported. Review of the facility's Abuse, Neglect, and Exploitation Policy dated 7/2026, identified the facility will have written procedures to assist staff in identifying the different types of abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. Possible indicators of abuse include, but not limited to: -Resident, staff, or family report of abuse. -Physical marks such as bruises or patterned appearance such as a handprint, belt or ring mark on a resident's body. -Physical injury of a resident of unknown source. -Resident theft of property or missing property. -Verbal abuse or a resident observed. -Physical abuse or a resident observed. -Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning, and repositioning. Reporting/Response: The facility will have written policies that include: Reporting all alleged violations to the administrator, state agency, adult protective services, and all other required agencies with specified timeframes: Immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involve abuse or resulted in serious bodily injury, or; Not later than 24 hours if the events that caused do not involve abuse and do not result in serious bodily injury.			F0609	Continued from page 3 needed to ensure alignment with current regulatory requirements. Ongoing reminders, supervision, and auditing tools will be implemented to reinforce compliance with transfer assistance requirements and mandatory reporting expectations. Monitoring to Ensure Effective Implementation of Actions The Administrator, Director of Nursing, or designee will utilize the Abuse Prevention Audit tool with random staff members from all disciplines to ensure staff knowledge regarding reporting of alleged violations. The Abuse Prevention Audit will be conducted weekly for three months to ensure required interventions are being followed and reported appropriately. Audit results will be reviewed during the monthly QAPI meeting. The QAPI committee will evaluate audit trends, staff compliance, and any repeat concerns to determine whether additional interventions or continued monitoring are necessary. Person Responsible for Maintaining Compliance The Director of Nursing and/or designee will oversee implementation of this Plan of Correction and ensure ongoing compliance related to F609. Completion Date: 9/01/2026		09/01/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			F0689	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.		09/01/2026

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F0689 SS = D	Continued from page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure use of the correct sling was used according to manufacture instructions for a total body mechanical lift 1 of 1 resident (R2) reviewed for safe transfers involving mechanical lifts. In addition the facility failed to complete a comprehensive fall investigation analysis to identify root cause/causal factors to prevent and/or reduce the risk of falls and/or falls with major injury for 1 of 3 residents (R4) reviewed for falls. Findings include R2’s face sheet dated 7/24/26, identified diagnoses of dementia, heart failure, spinal stenosis (narrowing of the spaces within the spine). R2’s quarterly Minimum Data Set (MDS) dated 5/28/26, identified R2 had severe cognitive impairment, no behaviors, no rejection of cares, used a wheelchair, dependent for all transfers, and had no falls since admission/or prior assessment. R2’s mobility focus care plan dated 4/13/23, identified R2 had a potential for a decline in mobility related to lack of motivation, obesity, heart failure, anxiety, major depressive disorder and chronic pain. Goal to maintain ability to hold her feet up when propelling in wheelchair. Interventions as follows: -Transfer using full body mechanical lift using large sling. During an observation and interview on 7/24/26 at 10:00 a.m., nursing assistant (NA)-C explained the facility had multiple total body mechanical lifts and stored the slings in the storage room. Upon entering the storage room, it was observed to have multiple different manufacture slings hanging on hooks. NA-C stated some of the full body mechanical lift slings they have in storage are from when people come from the hospital and we just keep the slings “in case we need a sling for emergencies”, such as if the correct sling is being laundered. NA-C further explained the slings from the hospital are not the correct manufacture lifts the facility uses and could potentially put a resident at risk for falling out of the			F0689	Continued from page 4 F689 — Plan of Correction Facility Name: Truman Senior Living Regulation Cited: F689 — Free of Accident Hazards/Supervision/Devices Policy Statement It is the policy of Truman Senior Living to comply with all state and federal regulations, including F689, to ensure the health, safety, and welfare of all residents. The facility will ensure that residents requiring mechanical lifts are transferred using the correct sling per the manufacturer's instructions and that falls are thoroughly investigated to determine root causes and contributing factors so that future incidents may be prevented and/or reduced. Corrective Actions for Residents Affected by the Deficient Practice The following corrective actions will be taken for residents directly affected: Resident R2 Resident R2 was assessed immediately after the deficient transfer practice was identified. Staff were instructed to use the correct sling for the total body mechanical lift in accordance with the manufacturer’s instructions. The resident’s transfer care plan and lift instructions were reviewed and updated as needed to identify the correct sling type and transfer method clearly. Nursing staff were reeducated on the appropriate machine and corresponding sling size to the correct lift equipment. Resident R4 The fall incident for Resident R4 was reviewed immediately. A comprehensive fall investigation was completed, including review of the event circumstances, resident status, environmental factors, witness statements, and contributing causes. The care plan was updated as needed to address identified risk factors and interventions intended to reduce the likelihood of recurrence.		09/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245346		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER TRUMAN SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST , TRUMAN, Minnesota, 56088			
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F0689 SS = D	Continued from page 5 lift if they are used during a transfer. During an observation and interview on 7/24/26 at 10:08 a.m., NA-B came out of R2’s room and was propelling a Direct Supply Atlas Lift out of the room. Hospice NA-A was in R2’s room making her bed. R2 was in her wheelchair with a tan sling with burgundy edges underneath her. NA-A stated R2 had just been transferred using the Direct Supply Atlas Lift, however, they had used an incorrect manufacture sling during the transfer. NA-A explained R2 should have been used the sling designed for the specific lift, however, they sometimes “just grab whatever sling is available.” During an interview on 7/24/26 at 10:14 a.m., NA-B stated R2 was in the incorrect manufacture sling for the total body mechanical lift that was used for her transfer and should have been the sling designed for the lift. According to the Direct Supply Atlas Floor Lift manufacture owner’s manual dated 7/2016 indicated that only slings and accessories designed for use with Direct Supply resident lifts should be used. Use of other manufacturers’ components or accessories may compromise the operation of this resident lift. During an interview on 7/24/26 at 11:40 a.m., director of nursing (DON) stated during a resident transfer using a full body mechanical lift only the correct manufacture sling should be used to match the lift that is being used and if staff use the incorrect manufacture sling this could cause the resident to fall out of the sling. Review of the facility's Safe Patient Handling/Transfers Policy dated 2/26, identified the sling designed for the lift is utilized with that specific lift. R4’s face sheet dated 7/24/26, identified diagnoses of disease of the spinal cord and neuromuscular dysfunction (a wide group of conditions that impair the function of voluntary muscles). R4’s baseline care plan dated 7/13/26, identified R4 was not a fall risk. Although R4’s baseline care plan identified R4 was not a fall risk, review of R4’s record did not identify a fall risk assessment had been completed on 7/13/26. R4’s Morse Fall Scale (a tool used to determine a fall risk) dated 7/14/26, identified R4 as a high fall risk due to having falls in the last six months, had			F0689	Continued from page 5 Additional monitoring, supervision, and fall-prevention interventions were implemented based on the findings. Actions to Identify Other Potentially Affected Residents A comprehensive review of all residents using mechanical lifts will be conducted to identify any individuals potentially affected by the same deficiency. This review will include: Verification that the correct sling type is identified for each resident requiring a mechanical lift Observation of staff performing transfers to ensure correct sling use and adherence to manufacturer instructions A review of all residents with a history of falls will be completed to determine whether fall investigations were comprehensive and whether root cause analysis was completed. This review will include: Audit of fall investigation reports. Review of post-fall assessments and care plan revisions. Verification that root cause and causal factors were identified and addressed. Identification of any residents who may require additional fall interventions or increased monitoring. Measures to Ensure the Deficient Practice Does Not Recur The facility purchased additional Hoyer slings for both manufacturers of the lift equipment used within the facility to ensure there are extra slings available. The hospital slings that were being utilized at the time of survey that were not compatible with the current Hoyer equipment were removed from the floor by the Environmental Services Director. The use of gait belts was added to the CNA and agency orientation packets. The Director of Nursing educated the hospice RN and requested that hospice CNA education be provided.		09/01/2026

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F0689 SS = D	Continued from page 6 impaired gait, overestimates or forgets limits. R4's admission Minimum Data Set (MDS) dated 7/19/26, identified R4 had moderate cognitive impairment, had no behaviors or rejection of cares, had impairment on one side of lower extremities, dependent with bed mobility/transfers, had no falls in last month prior to admission, and had two or more falls since admission with no injury. R4's unwitnessed fall incident report dated 7/13/26 at 7:00 p.m., identified R4 was found on the floor by his dresser. R4 had been observed 15 minutes prior to the fall. R4 stated he was trying to get in his chair. Immediate intervention of assisted off the floor and added an alarm to bed and recliner. R4's unwitnessed fall incident report dated 7/16/26 at 4:20 a.m., identified R4 was found lying on the floor in front of his dresser. R4 had removed his catheter and found near residents' recliner. R4's unwitnessed fall incident report dated 7/16/26 at 11:50 p.m., identified R4 was found on the floor next to his bed after his bed alarm went off. Predisposing physiological factors of being confused and incontinent. Other factors of being confused and believes he is able to walk and unable to redirect. Immediate action was taken to the dining room with nursing staff. R4's fall focus care plan dated 7/17/26 (revised 4 days after the initial fall on 7/13/26), identified R4 had an actual fall related to self-transferring or poor cognition, poor balance, poor communication/comprehension. Goal to not sustain a major injury. Interventions as follows: -Electric sensor placed next to bed to alert staff when getting out of bed (dated 7/17/26 -Fall mat next to bed (dated 7/17/26). -Provide a lipped-edge mattress on the bed for safety (dated 7/17/26). -Provide a low bed for safety (dated 7/17/26). -Provide activities that promote exercise and strength building where possible (dated 7/17/26). -Resident does not always follow the care plan. Staff to catch and assist when resident is seen not following the care plan (dated 7/17/26).			F0689	Continued from page 6 Staff Education and Training All nursing staff involved in resident transfers will be educated on proper mechanical lift use, including: Reviewing the resident-specific transfer plan before each transfer and where to locate this information in PointClickCare. Selecting the correct sling per manufacturer instructions and vendor-specified equipment. During the nurses' meeting on 8/6/2026, the nurses were educated and/or reeducated on the following: Completing the post-fall assessment; Complete and incident report; Reviewing the resident's care plan to determine if it was followed at the time of the incident; Reviewing the care plan and updating it as needed post-fall; Notifying providers and family; Document all assessments and actions; Obtain witness statements in the case of an injury is determined; Complete the post-fall huddle Education will be completed by 9/01/2026. Facility policies and procedures related to: Compliance with Reporting of Abuse/Neglect/Exploitation Alleged neglect reporting timelines to include the Vulnerable Adult Reporting crosswalk criteria, and Guidance for Reporting Alleged Violations, Falls Prevention Program Policy, Falls Interventions List, Accidents and Supervision, Safe Resident Handling/Transfers, and the		09/01/2026

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F0689 SS = D	Continued from page 7 Review of R4's record from 7/13/26 through 7/24/26 did not identify a root cause analysis had been completed for R4's falls that occurred on 7/13/26 nor 7/16/26. During an interview on 7/24/26 at 4:36 p.m., DON stated R4's baseline care plan initiated on 7/13/26 had not identified R4 as a fall risk, however, when a fall risk assessment had been completed on 7/14/26 that identified R4 as a high risk for falls, his care plan should have been revised to add fall prevention interventions to mitigate the risk of falls and this was not added until 7/17/16 following three falls in the facility. DON further explained R4's falls had not had a comprehensive root cause analysis completed for any of the falls that have occurred since 7/13/26 and should have been done shortly after each fall to assist the facility in determining the appropriate fall prevention interventions to mitigate the risk of future falls. Review of the facility's Fall Prevention Program Policy dated 2/26, identified each resident of the skilled nursing facility will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -The facility utilizes a standardized risk assessment for determining a resident's fall risk. The risk assessment categorizes resident's risk according to low, medium, or high risk. -Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. -The nurse will indicate on the care plan the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. -High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program. Indicate fall risk on care plan. Place Fall Prevention Indicator (such as star, color coded sticker) on the name plate to resident's room. Place Fall Prevention Indicator on resident's wheelchair. Implement interventions from Low/Moderate Risk Protocols.			F0689	Continued from page 7 Use of the Gait Belt was reviewed and revised as needed to ensure alignment with current regulatory requirements. The fall investigation policy will require analysis of: Resident condition Environmental hazards Staffing/supervision issues Medication factors Equipment issues Other contributing causes Tools and Job Aids Transfer equipment guides and sling reference tools are available to nursing staff in the Safe Patient Handling education binder at the central nurses station. Sling-specific vendor equipment and sizing reference tools were placed at all three CNA stations. Fall investigation checklists were updated to ensure all required elements of root cause review are addressed. Monitoring to Ensure Effective Implementation of Actions The Director of Nursing or designee will audit 100% of residents using mechanical lifts weekly for 12 weeks to ensure the correct sling is identified and used according to manufacturer instructions. The Director of Nursing or designee will audit 100% of fall investigations weekly for 12 weeks to ensure they include comprehensive root cause analysis and follow-up interventions. Results of these audits will be reviewed during monthly QAPI meetings. The QAPI committee will evaluate audit findings, identify trends, and determine whether further corrective action, education, or extended monitoring is necessary. Person Responsible to Maintain Compliance		09/01/2026

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F0689 SS = D	Continued from page 8 Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. Provide additional interventions as directed by the residents' assessment, including but not limited to: Assistive devices. Increased frequency of rounds Medication regimen review Low bed Alternate call system access Scheduled ambulation or toileting assistance Family/caregiver or resident education Therapy services referral -When any resident experiences a fall, the facility will: Assess the resident; Complete a post-fall assessment; Complete an incident report; Notify physician and family; Review the resident's care plan and update as indicated; Document all assessments and actions; Obtain witness statements in the case of injury.			F0689	Continued from page 8 The Director of Nursing will oversee implementation and ongoing compliance with this Plan of Correction, with support from the Administrator and all nursing staff. Completion Date: 9/01/2026		09/01/2026

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20000	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 7/24/26, a standard abbreviated 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, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H53463448C (3106439) with a licensing order issued at 830.			20000			09/01/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 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. 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.	20000		09/01/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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	20830	CORRECTED	09/01/2026	

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20830	Continued from page 2 physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure use of the correct sling was used according to manufacture instructions for a total body mechanical lift 1 of 1 resident (R2) reviewed for safe transfers involving mechanical lifts. In addition the facility failed to complete a comprehensive fall investigation analysis to identify root cause/causal factors to prevent and/or reduce the risk of falls and/or falls with major injury for 1 of 3 residents (R4) reviewed for falls. Findings include R2's face sheet dated 7/24/26, identified diagnoses of dementia, heart failure, spinal stenosis (narrowing of the spaces within the spine). R2's quarterly Minimum Data Set (MDS) dated 5/28/26, identified R2 had severe cognitive impairment, no behaviors, no rejection of cares, used a wheelchair, dependent for all transfers, and had no falls since admission/or prior assessment. R2's mobility focus care plan dated 4/13/23, identified R2 had a potential for a decline in mobility related to lack of motivation, obesity, heart failure, anxiety, major depressive disorder and chronic pain. Goal to maintain ability to hold her feet up when propelling in wheelchair. Interventions as follows: -Transfer using full body mechanical lift using large sling. During an observation and interview on 7/24/26 at 10:00 a.m., nursing assistant (NA)-C explained the facility had multiple total body mechanical lifts and stored the slings in the storage room. Upon entering the storage room, it was observed to have multiple different manufacture slings hanging on hooks. NA-C stated some of the full body mechanical lift slings they have in storage are from when people come from the hospital and we just keep the slings "in case we need a sling for emergencies", such as if the correct sling is being laundered. NA-C further explained the slings from the hospital are not the correct manufacture lifts the facility uses and could potentially put a resident at risk for falling out of the lift if they are used during a transfer.			20830			09/01/2026

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20830	Continued from page 3 During an observation and interview on 7/24/26 at 10:08 a.m., NA-B came out of R2’s room and was propelling a Direct Supply Atlas Lift out of the room. Hospice NA-A was in R2’s room making her bed. R2 was in her wheelchair with a tan sling with burgundy edges underneath her. NA-A stated R2 had just been transferred using the Direct Supply Atlas Lift, however, they had used an incorrect manufacture sling during the transfer. NA-A explained R2 should have been used the sling designed for the specific lift, however, they sometimes “just grab whatever sling is available.” During an interview on 7/24/26 at 10:14 a.m., NA-B stated R2 was in the incorrect manufacture sling for the total body mechanical lift that was used for her transfer and should have been the sling designed for the lift. According to the Direct Supply Atlas Floor Lift manufacture owner’s manual dated 7/2016 indicated that only slings and accessories designed for use with Direct Supply resident lifts should be used. Use of other manufacturers’ components or accessories may compromise the operation of this resident lift. During an interview on 7/24/26 at 11:40 a.m., director of nursing (DON) stated during a resident transfer using a full body mechanical lift only the correct manufacture sling should be used to match the lift that is being used and if staff use the incorrect manufacture sling this could cause the resident to fall out of the sling. Review of the facility's Safe Patient Handling/Transfers Policy dated 2/26, identified the sling designed for the lift is utilized with that specific lift. R4’s face sheet dated 7/24/26, identified diagnoses of disease of the spinal cord and neuromuscular dysfunction (a wide group of conditions that impair the function of voluntary muscles). R4’s baseline care plan dated 7/13/26, identified R4 was not a fall risk. Although R4’s baseline care plan identified R4 was not a fall risk, review of R4’s record did not identify a fall risk assessment had been completed on 7/13/26. R4’s Morse Fall Scale (a tool used to determine a fall risk) dated 7/14/26, identified R4 as a high fall risk due to having falls in the last six months, had impaired gait, overestimates or forgets limits.			20830			09/01/2026

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NAME OF PROVIDER OR SUPPLIER TRUMAN SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST , TRUMAN, Minnesota, 56088			
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20830	Continued from page 4 R4's admission Minimum Data Set (MDS) dated 7/19/26, identified R4 had moderate cognitive impairment, had no behaviors or rejection of cares, had impairment on one side of lower extremities, dependent with bed mobility/transfers, had no falls in last month prior to admission, and had two or more falls since admission with no injury. R4's unwitnessed fall incident report dated 7/13/26 at 7:00 p.m., identified R4 was found on the floor by his dresser. R4 had been observed 15 minutes prior to the fall. R4 stated he was trying to get in his chair. Immediate intervention of assisted off the floor and added an alarm to bed and recliner. R4's unwitnessed fall incident report dated 7/16/26 at 4:20 a.m., identified R4 was found lying on the floor in front of his dresser. R4 had removed his catheter and found near residents' recliner. R4's unwitnessed fall incident report dated 7/16/26 at 11:50 p.m., identified R4 was found on the floor next to his bed after his bed alarm went off. Predisposing physiological factors of being confused and incontinent. Other factors of being confused and believes he is able to walk and unable to redirect. Immediate action was taken to the dining room with nursing staff. R4's fall focus care plan dated 7/17/26 (revised 4 days after the initial fall on 7/13/26), identified R4 had an actual fall related to self-transferring or poor cognition, poor balance, poor communication/comprehension. Goal to not sustain a major injury. Interventions as follows: -Electric sensor placed next to bed to alert staff when getting out of bed (dated 7/17/26 -Fall mat next to bed (dated 7/17/26). -Provide a lipped-edge mattress on the bed for safety (dated 7/17/26). -Provide a low bed for safety (dated 7/17/26). -Provide activities that promote exercise and strength building where possible (dated 7/17/26). -Resident does not always follow the care plan. Staff to catch and assist when resident is seen not following the care plan (dated 7/17/26). Review of R4's record from 7/13/26 through 7/24/26 did not identify a root cause analysis had			20830			09/01/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER TRUMAN SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH 4TH AVENUE EAST , TRUMAN, Minnesota, 56088			
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20830	Continued from page 5 been completed for R4's falls that occurred on 7/13/26 nor 7/16/26. During an interview on 7/24/26 at 4:36 p.m., DON stated R4's baseline care plan initiated on 7/13/26 had not identified R4 as a fall risk, however, when a fall risk assessment had been completed on 7/14/26 that identified R4 as a high risk for falls, his care plan should have been revised to add fall prevention interventions to mitigate the risk of falls and this was not added until 7/17/16 following three falls in the facility. DON further explained R4's falls had not had a comprehensive root cause analysis completed for any of the falls that have occurred since 7/13/26 and should have been done shortly after each fall to assist the facility in determining the appropriate fall prevention interventions to mitigate the risk of future falls. Review of the facility's Fall Prevention Program Policy dated 2/26, identified each resident of the skilled nursing facility will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -The facility utilizes a standardized risk assessment for determining a resident's fall risk. The risk assessment categorizes resident's risk according to low, medium, or high risk. -Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. -The nurse will indicate on the care plan the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. -High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program. Indicate fall risk on care plan. Place Fall Prevention Indicator (such as star, color coded sticker) on the name plate to resident's room. Place Fall Prevention Indicator on resident's wheelchair. Implement interventions from Low/Moderate Risk Protocols. Provide interventions that address unique risk			20830			09/01/2026

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20830	Continued from page 6 factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. Provide additional interventions as directed by the residents' assessment, including but not limited to: Assistive devices. Increased frequency of rounds Medication regimen review Low bed Alternate call system access Scheduled ambulation or toileting assistance Family/caregiver or resident education Therapy services referral -When any resident experiences a fall, the facility will: Assess the resident; Complete a post-fall assessment; Complete an incident report; Notify physician and family; Review the resident's care plan and update as indicated; Document all assessments and actions; Obtain witness statements in the case of injury. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			09/01/2026