

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Truman Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 North 4th Avenue East Truman, MN 56088	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49336</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that identified R1 had failed to use call light appropriately and/or refusals to use the call light for 1 of 1 (R1) resident reviewed for care plan.</p> <p>Findings include:</p> <p>R1's, 7/07/24 quarterly Minimum Data Set (MDS) identified R1 had severely cognitive impairment, little interest, or pleasure in doing things, and feeling down, depressed, or hopeless for never to 1 day. R1 was dependent on staff with cares and was incontinent with bowel and bladder. R1 had a diagnosis of anxiety and manic depression. R1 had taken antipsychotic and antidepressant on a routine basis.</p> <p>R1's, undated care plan identified R1 had verbal aggression related to her bipolar disorder and the goal was for R1 to have 1 or fewer episodes per week. Staff interventions were to administer medication, analyze places, times, circumstances, triggers and what de-escalate the behaviors. Staff were to understand R1's situation and allow time to express her feelings, provide choices for care and activities and talk to her with care and inform her of what staff were doing.</p> <p>R1's, undated care plan identified there was no mention for R1 to use a call light for assistance.</p> <p>Interview on 8/21/24 at 3:29 p.m. with director of nursing (DON) stated changes to R1's care plan was modified recently and was unsure if the care plan had been implemented in a timely manner.</p> <p>Interview on 8/21/24 at 3:31 p.m., with administrator stated R1's interventions should have been reflected in a timely manner on her care plan.</p> <p>Review of January 2024 Comprehensive Care Plans policy identified the facility would assess residents' goals, preferences, outcomes during admission and before discharge from the facility. The facility would include interdisciplinary team to prepare residents individual care plan that was to reflect resident's needs, interventions, measurable objectives and timeframes identified on the residents comprehensive assessments.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49336</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and document review, the facility failed to complete appropriate assessments and failed to reposition and document that repositioning for 1 of 1 resident (R1).</p> <p>Review of the report filed to the State Agency identified on 8/13/24 at 2:30 p.m., two nursing assistants placed R1 on a bedpan at approximately 12:30 p.m., and was found by staff remaining on the bed pan at approximately 4:15 p.m., when R1 call out to staff notifying them staff had forgotten to return and remove R1 off the bed pan.</p> <p>R1's, 7/07/24 quarterly Minimum Data Set (MDS) identified R1 had severely cognitive impairment, little interest, or pleasure in doing things, and feeling down, depressed, or hopeless for never to 1 day. R1 was dependent on staff with cares and was incontinent with bowel and bladder. R1 had a diagnosis of anxiety and manic depression. R1 had taken antipsychotic and antidepressant on a routine basis.</p> <p>Interview on 8/20/24 at 9:07 a.m., with family member (FM)-A stated she received a phone call from the facility's registered nurse (RN)-A of R1 had been found with a bedpan under her buttocks for hours and was forgotten by the staff and appeared to be upset. She stated RN-A had informed her that there was no excuse for R1 to be left on a bed pan and stated R1 did have her call light within reach. She had her call light next to her. R1 has had good care at the facility and added RN-A had informed her they would implement an action plan to prevent R1 from developing pressure ulcers on her bottom.</p> <p>Interview on 8/20/24 at 10:23 a.m. with R1 stated she did not remember the incident of her being left on a bedpan. When asked if she could press her call light, R1 stated she did not want to, but then stated staff had treated her well here. Asked if resident had any concerns, she stated no. Asked if she had issues with her bottom since the incident, she stated no. Asked her if she had continued to use the bedpan since the incident a week ago, she stated, yes. R1 did not say anything else after being questioned and proceeded to watch television.</p> <p>Interview on 8/20/24 at 10:25 a.m., with social services explained that R1 had no impaired cognition and would verbally communicate her need to the staff. She stated R1 had difficulty forming a relationship with staff when she was admitted to the facility last year and took time to acclimate to staff in the facility. R1's Brief Interview for Mental Status (BIMS) assessment were assigned to a previous employee, who no longer works at the facility and confirmed R1 would need an updated BIMS assessment to be completed.</p> <p>Interview on 8/20/24 at 10:33 a.m., with nursing assistant (NA)-B stated R1 would sometime use her call light and sometimes she would not use her call light. She stated R1 required frequent checks throughout the day even when she used the bedpan and would assist her with personal cares as needed. She stated she was unaware if R1 had displayed behaviors of not using the call light when she needed assistance. She stated handover communication and rounding in the facility had been difficult to implement. She stated she on a few occasions she would punch in for work and was obligated to find nursing staff for handover communication of resident updates. She had clocked out of the facility and went home and had not given report to her colleagues at the end of her shift.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 8/20/24 at 10:45 a.m., with registered nurse (RN)-A stated she received a call from the administrator Tuesday afternoon that R1 had been on her bedpan for hours and had not been checked. She stated she had called LPN-B approximately at 5:30 p.m. and informed her to reposition R1 every hour. She stated she informed LPN-B to update the oncoming night nurse of the incident and document R1's condition throughout the night. She stated she had completed education on the phone with NA-A, NA-B and NA-F and sent the information to the director of nursing (DON). She stated there was a breakdown in communication between the oncoming and off going staff and confirmed the facility had reported the incident. She had modified R1's care plan to include a timer be placed outside her door to alert staff to check on R1 and stated the intervention was to remind staff to check on R1 when she was on the bedpan.</p> <p>Interview on 8/20/24 at 11:45 a.m., licensed nurse (LPN)-A stated she had not seen handover communication implemented for oncoming and off going staff and found it to be challenging for agency staff. She stated facility staff were adamant to give report to agency staff and were left to search for the charge nurse on shift to receive resident updates.</p> <p>Interview on 8/20/24 at 1:45 p.m., with NA-A stated she had started her first day at the facility and was to work independently with residents on the unit. She stated R1 had requested to use a bedpan and she along with NA-D had repositioned and placed R1 on the bedpan. She stated she had checked on R1 minutes later and R1 needed more time on the bedpan. She stated she informed NA-D she would check on R1 before completing her shift and stated she forgot to check on R1. She stated RN-A had called her and informed her that R1 was left on the bedpan and apologized to RN-A and noted she had received training on the phone from RN-A.</p> <p>Interview on 8/20/24 at 1:58 p.m., with LPN-B stated she was informed by NA-E and NA-F that R1 was found on the bedpan and went to R1's room to assess her skin and had found R1's buttock had bruising and an outline of the shape of her bedpan. She stated she had placed a call to RN-A, the administrator, and the director of nursing (DON). She stated RN-A had informed her to reposition R1 every hour and to report the incident to the oncoming nurse to monitor R1's buttocks during the overnight shift.</p> <p>Interview on 8/20/24 at 4:27 p.m., with family member (FM)-A stated the facility did not inform her of a timer placed outside of R1's door and stated if staff was to know the timer had been implemented to notify staff to check on R1 when on the bedpan, there was no problem with the intervention.</p> <p>Interview on 8/20/24 at 4:58 p.m., with NA-C stated R1 required extensive assist with 2 staff for activities of daily living and transfers and had observed R1 used the call light on occasionally. She stated R1's care plan had interventions for to reposition R1 every and could not document it on the Point Click Care (PCC) online medical record, system. She stated the facility would have to modify the entry on PCC for it to show the frequency of when R1 was to be repositioned and had no way to document when R1 was repositioned. She stated on several occasions she had punched in for her shift and had to assist resident with cares when she had not received report from the off going shift. She stated she had no knowledge of those resident care needs during her shift and would expect the facility to have a system in place for handover communication amongst staff.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5:12 p.m., with LPN-B stated nursing assistants was to reposition R1 every 2 hours and were expected to document on PCC when they had completed the task. LPN-B reviewed and attempted to access the documentation on PCC and confirmed she noted repositioning was scheduled every shift and not every 2 hours and confirmed nursing assistants were not able to document the frequency of the task. She stated she was not aware it had been an issue for the staff and was not aware of how to correct it.</p> <p>Interview on 5:18 p.m., with NA-D stated R1 required 2 people to assist her with cares and stated when she utilized PCC, R1's care plan required R1 to be repositioned every 2 hours and confirmed her task were scheduled to complete once a shift on PCC. She stated she would expect communication amongst the nursing team to improve and found it difficult to take care of residents and their needs appropriately when she was not well-informed during handover communication.</p> <p>Interview on 5:28 p.m., with NA-E stated R1 was on a check and change scheduled as stated on PCC. She stated she had assisted R1 along with NA-F approximately at 4:30 p.m., on 8/13/24 and had removed the bedpan from R1 buttocks. She stated R1 appeared upset and had informed the charge nurse to assess R1's skin. She stated she was aware that R1 can use the call light but has not seen R1 use it frequently. NA-E stated she completes handover communication with the oncoming shift staff and would check on residents after her shift report. She confirmed she was not able to chart on residents who had to be repositioned every 2 hours on PCC. She stated the task would only show up to be documented once a shift.</p> <p>Interview on 8/21/24 at 8:09 a.m., with physical therapist stated he had assisted residents at the facility for a period of 11 months. He stated R1 had the capability to use her call light and had seen her use her call light on a few occasions and had informed staff to position the call light next to R1's fingers. He stated he was not aware that R1 had not used her call light and was not aware she had been found on her bedpan for an extended period. He stated given the situation of R1's incident, he stated R1's muscle decline would progress over time and the facility would need to implement additional interventions that would assist R1's communication and mobility needs long term.</p> <p>Interview on 8/21/24 at 9:34 a.m., with NA-F stated she did not receive handover communication that R1 was placed on a bedpan. She stated she had entered R1's room to get her up for supper and stated R1 appeared upset and said she was left on the bedpan. She stated NA-E had assisted R1 off her bedpan and had informed the nurse. She stated she was informed by LPN-B to reposition R1 hourly and document when she had completed the task. She stated the PCC system did not allow her to chart every hour only once per shift. She stated the facility had no process in place for nursing assistants to document on paper when she had repositioned R1 during her shift. She stated the facility had lacked report sheets to chart residents last bowel movements or toileting schedules.</p> <p>Interview on 8/21/24 at 10:12 a.m., with NA-G stated she was informed of R1's incident on her shift. She stated handover communication at the facility was a challenge when the oncoming shift did not show up to work on time. She stated since R1's incident, the facility had not implemented appropriated handover communication amongst the staff. She stated R1's care plan identified she was to be repositioned every 2 hours and could not document every 2 hours on PCC, when she had repositioned R1. She stated PCC system had been set up for her to document on R1 every shift, instead of every 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 8/21/24 at 10:16 a.m., with LPN-A and LPN-B confirmed the facility had no process in place for nursing assistants to complete handover communication, appropriately. LPN-B stated nursing assistants were expected to access PCC to verify resident updates or talk to the charge nurse on shift.</p> <p>Interview on 8/21/24 at 10:21 a.m., RN-B stated staff were expected to assess and document task interventions that were assigned on PCC for residents and was linked to each resident care plan which collected data from resident assessments. She stated, R1's care plan had interventions for staff to reposition R1 every 2-hours and confirmed PCC was not set up for staff to chart their interventions as reflected on R1's care plan and could not prove staff had completed the task as reflected on R1's care plan.</p> <p>Interview on 8/21/24 at 1:22 p.m., with medical director confirmed the facility had informed her of R1's incident and was aware the facility had implemented interventions for R1. She stated every 2-hour repositioning was appropriate for R1 and would expect the facility to complete accurate documentation of resident interventions when changes are made to reflect improvement of resident care. She agreed therapy services would be appropriate to determine R1's needs that would manage R1's physical mobility impairment.</p> <p>Interview on 8/21/24 at 3:29 p.m., with DON stated her expectations was for R1's assessments and interventions to be reflected accurately on R1's medical record.</p> <p>Review of December 2023 Rounds Shift Report identified the facility would use round shift report during a 24-hour period to ensure continuity of care. The facility staff would complete shift to shift report, that contained confidential information, used for ongoing and on-coming staff to include toileting, repositioning, and observations of resident's condition.</p> <p>Review of 7/2024 Facility Assessment identified the facility would embrace a person-centered care culture, and provide services based on resident's needs, such as, mobility assistance, rehabilitation, incontinence prevention and care, and assistance with activities of daily living. The facility would encourage residents to include their own daily routines and schedules and would be added on residents individualized care plans. Lastly, the facility would communicate to providers and staff expectations of care delivery and clinical reasoning to promote high-quality care for residents.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>49336</p> <p>Based on interview and record review, facility failed to ensure 1 of 1 nursing assistant (NA)-C was deemed competent upon hire or yearly thereafter to provide care to residents.</p> <p>Findings include:</p> <p>Review of NA-C's employee file identified a hire date of 6/03/24.</p> <p>Review of NA-C timesheets identified she had worked at the facility on 6/16, 6/17, 6/19, 6/20, 6/21, 6/24, 6/25, 6/27, 6/28, 6/29, 6/30, 7/01, 7/02, 7/03, 7/05, 7/06, 7/07, 7/08, 7/09, 7/11, 7/12, 7/13, 8/05, 8/06, 8/07, 8/08, 8/09, 8/10, 8/11, 8/12, 8/14, 8/15 and 8/16/24.</p> <p>Review of NA-C, 5/08/24 Relias (online training program) identified she had completed a clinical assessment training. The facility did not provide facility specific competencies for NA-C upon hire.</p> <p>Interview on 8/21/24 at 3:31 p.m., with administrator and director of nursing agreed competency training should be given to all employees to reflect current knowledge of the facility's resident specific needs and services.</p> <p>Review of January 2024 Orientation policy identified the facility would provide department orientation plan that would reflect the skills and competencies of each employee before contact with residents. Secondly, the facility department checklist would be used to document training and competency evaluations during the employee's orientation until the employee had demonstrated competency and skills to meet residents needs.</p> <p>Review of July 2024 Facility Assessment identified the facility would utilize an action plan to complete assessments of residents needs to determine staffing services. In addition, the facility would provide, contract staff and training for those staff according to the specific care area needs of the residents.</p>		