

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/24/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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). -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 (continued on next page)		

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. 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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk due to having falls in the last six months, had impaired gait, overestimates or forgets limits. R4's admission Minimum Data Set (MDS) dated [DATE], 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 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 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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		