STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245346	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Senior Living	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the resident's representative was notified of a new bruise for 1 of 1 resident (R5)who was reviewed for skin injury. Findings include: R25's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated diagnosis of Alzheimer's Disease, Non-Alzheimer's dementia with behavioral disturbance and hemiplegia (complete paralysis on one side of body) and hemiparesis (partial weakness on one side). R2 had severe cognitive impairment with moderate hearing loss and adequate vision. R25 had delirium with symptoms of inattention and disorganized thinking but no behaviors. R25 was dependent on staff for all activities of daily living. R25's plan of care last revised on 4/30/25, indicated R5 had a cognitive impairment as indicated by her diagnosis of Alzheimer's disease and was unable to answer questions. Interventions included allowing R25 time to process information; approach R25 from the front, make eye contact and explain cares before providing them; ask yes and no questions to aid in decision making; monitor for and address signs of pain or discomfort and report to nurse as needed; provide calm, comfortable, homelike environment. On observation 12/30/25 at 8:17 a.m., R25 was lying in bed with lights off. A bed alarm was present. R25 had a bruise to her left temple circular in shape and approximately 3x4 centimeters in size. Color was dark purple. On observation 12/30/25 at 9:55 a.m., R25 was sitting in her Broda chair with a stuffed cat in her lap. The bruise remained present and unchanged on her left temple. When asked if it hurt, R25 did not respond. On interview 12/30/25 at 10:43 a.m., family member (FM)-A stated she had noticed bruises on R25 multiple times on her head and a few times on her arms over the past 6 months. FM-A stated she thinks when the aides are in a hurry, they are sometimes careless. FM-A stated she had witnessed them almost hit R25 in the head with the lift hanger a few times. FM-A stated she became aware of the current bruise when she came to visit and staff never notified her prior to her arrival 2 days later. FM-A added she also had not notified in the past of the bruises (on her arms) she has seen on R25 over the past 6 months. On interview 12/30/25 at 3:58 p.m., nursing assistant (NA)-C brought R25 back from music activity in her Broda (positioning wheelchair) chair. NA-C stated she had worked 12/26/25, evening shift and R25 did not have a bruise on her left temple area. NA-C stated she returned to work 12/28/25, and noticed the bruise and reported it to the nurse. NA-C stated her role was to report changes to the nurse and was unsure what they do with the information once its reported. Facility Incident Report dated 12/28/25 at 4:37 p.m. included when getting resident up noted a 4 cm by 3 cm reddish purple spot on the left side of her face near her eye. Origin is unknown but resident has been known to rub her face. Area appears very dry so lotion was applied. Resident is unable to verbalize any details. On 12/30/25 family, provider, director of nursing and administrator were notified. 12/30/25 monitoring was added to orders until area resolved. Night staff reported that resident sleeps with her left hand under the side of her face and this was confirmed this morning by writer while resident was sleeping in that position. Incident report was completed by director of nursing. A nursing order dated 12/31/2025 at 6:00 a.m., by the director of nursing included 3 cm red area on left side of upper face. Monitor daily until resolved for increase in size. A progress note dated 12/28/25 at 4:37 p.m., by licensed practical (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse (LPN)-B indicated when resident got up noted a 4 cm by 3 cm reddish purple spot on the left side of her face near her eye. Origin is unknown but resident has been known to rub her face. Area appears very dry so lotion was applied. A phone interview 12/31/25 at 12;25 p.m., with NA-D who worked shift prior to discovery of injury indicated R25 slept most of her shift and shift was uneventful and she never noticed a bruise on R25's temple area. Denied ever getting R25 out of bed using the lift but did indicate R25 was turned and repositioned throughout the night but stated R25 always holds onto the grab bar with her hand and to her knowledge R25's face never hit the grab bar on the bed. On interview 1/2/26 at 10:40 a.m., director of nursing (DON) indicated she was notified Tuesday afternoon 12/30/25 regarding R25's bruise and was unaware of this prior. The DON completed an incident report on 12/30/25 and implemented monitoring of the area on 12/31/25. The DON stated she would expect an incident report to be completed at the time of discovery of the injury and also for family to be notified. On interview 1/2/26 at 11:25 a.m., licensed practical nurse (LPN)-B stated she discovered the bruise on R25's temple area on Sunday, 12/28/25. LPN-B stated she was not sure if it was from R25 frequently rubbing that area and she noticed her skin was dry so she applied lotion. LPN-B stated when they laid R25 in the bed, it was noted she put her hands up in the area where the injury was so that likely caused the injury. LPN-B stated she forgot to complete an incident report and forgot to notify the family of the bruise. Facility Notification of Changes policy, undated, included: Circumstances requiring notification includes: Accident resulting in injury or potential to require physician intervention, or circumstances that require a need to alter treatment which may include a new treatment or discontinuation of current treatment. Contact information of the resident's legal representative or family member must be recorded and periodically updated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident medication status was accurately coded in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R21) reviewed for medications, specifically insulin. Findings include:R21's face sheet received on 1/6/26, included diagnosis of type 2 diabetes mellitus (when the body does not produce enough insulin or use it properly).R21's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R21 had diabetes.R21's physician orders included Trulicity (Trulicity is not insulin. It is a glucagon-like peptide-1 (GLP-1) receptor agonist which controls blood sugar by signaling brain to feel full, slowing digestion and stimulating insulin release) subcutaneous solution pen-injector 0.75 mg (milligram) /0.5 ml (milliliters) at bedtime every Wednesday related to type 2 diabetes mellitus. R21's care plan dated 10/14/25, indicated R21 had diabetes type 2 and required medication for control.R21's MDS, Section N indicated the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry was one. During an email exchange on 12/31/25 at 12:47 p.m., the facility MDS coordinator indicated she used a document titled MDS 3.0 Drug Class Index developed by MED-PASS with revised date of 9/25, to guide her when coding MDS assessments. During an interview on 12/31/25 at 1:15 p.m., the administrator was informed of findings and stated she would have expected MDS assessments to be coded accurately. Facility MDS 3.0 Completion policy undated, indicated the responsibility of all sections of the MDS would be assigned. Persons completing part of the assessment must attest to the accuracy of the section they completed. All disciplines shall follow the guidelines in Chapter 3 of the current RAI (Resident Assessment Instrument) Manual for coding each assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a falls care plan for 1 of 1 resident (R5) was updated to include the current interventions. Finding include: R5's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R5 understands and is understood and had intact cognition. R5 was dependent on staff with transfers, and partial to moderate assistance with oral hygiene, independent with eating and requires substantial to maximal assistance with dressing and personal hygiene. R5 uses a manual wheelchair for mobility. R5's diagnoses included high blood pressure, coronary artery disease, renal insufficiency, diabetes mellitus, depression and asthma. R5's plan of care last updated 8/20/25, indicated R5 was at moderate fall risk as evidenced by the most recent Morse Fall Scale score (a fall scale calculator that predicts risk of falling) related to impaired cognitive function which can affect her reasoning. Interventions included R5 had a low bed so she can reach the floor and bariatric size for extra space side to side (4/13/23). R5 had been known to ease herself to the floor to sit. She had stated she prefers to sit on the floor instead of in a recliner. Treat each case as an un-witnessed fall per facility protocol (6/19/25). Contact pharmacy for consult to evaluate medications (1/20/21). For no apparent acute injury, determine and address causative factors of the fall (1/20/21). Monitor every shift for 72 hours and as needed for pain, bruising, change in mental status or new onset confusion, sleepiness, inability to maintain posture, agitation and contact provider as needed (1/20/21). Resident is not to have any blue chucks in her wheelchair seat due to potential for sliding out of wheelchair (5/8/25). On 1/1/26 an order was received from provider for silent bed alarm and plan of care was updated with this information. R5's task list included safety checks to be completed on location and room activity every 2 hours. R1's Comprehensive Care Area Assessment (CAA) dated 12/23/25, included R5 was at risk for falls related to impaired gait and mobility and level of assistance required with transfers. Contributing factors included history of falls, prior to admission, medications that affect level of alertness, weakness and physical performance limited. Morse Fall risk last completed on 1/1/26, included a R5 was a moderate fall risk. Fall risk assessments completed 12/19/25, 9/28/25, 7/27/25, 6/20/25, 5/8/254/19/25, and 3/31/25 post falls and also quarterly. Score remained consistent with moderate fall risk. On 3/31/25 and 4/1/25, a fall occurred and the intervention was to lay resident in bed when she was sleeping. The care plan did not include this as an intervention to prevent falls. On 5/8/25, a fall occurred ant the interventions was to not have any blue chucks (absorbent pads) in her wheelchair. This was included in the plan of care. Second intervention of anti-roll back brakes was requested and medical supply company was contacted. Due to R5's use of oxygen facility was told they cannot be installed on her chair. A GradA-aide (prevents the wheelchair from rolling backwards while also maintaining forward movement) was used instead to prevent rolling backwards of chair. This was not included on the plan of care. On 5/30/25, a fall occurred and the intervention was to reattempt therapy which R5 refused. This was not included in plan of care. On 7/26/25 and 7/28/25, a fall occurred and the intervention was that resident was to be monitored and staff to allow R5 to sleep as long as she wants in the morning. This was not included on the plan of care. On 8/29/25 and 9/28/25 R5 had a fall and staff was re-educated on safety for R5. On 12/13/25 R5 had a fall and staff was re-educated on lying resident down but resident had been refusing to lay down this evening when the fall occurred. This was not included on the plan of care. On 12/19/25 R5 fell out of her wheelchair and had a large hematoma on left side of forehead. Attempted therapy but unable to pick up on caseload at this time as R5's abilities had not changed. On observation 12/30/25 at 11:35 a.m., R5 was in her wheelchair in the dining room with oxygen on at 1L nasal cannula. R5 had device on back of chair to prevent wheelchair from rolling backwards. R5 had a low bed in her room. R5 had a light green bruise above left eye on her forehead. R5 denied any pain in the bruised area. On (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/30/25 at 2:55 p.m., R5 remained in her wheelchair at the nurse's station. On 12/31/25 at 7:08 a.m., R5 remained in her bed with lights off. Door was slightly ajar, bed was in low position and R5 was on her left side. On 12/31/25 at 7:59 a.m., R5 remained in her bed with lights off in room but was now lying on her back. On 12/31/25 at 9:59 a.m., nursing assistant (NA)-A stated she had checked on R5 a few times but she hasn't wanted to get up yet this morning. NA-A stated R5 repositions herself in the bed and is able to move side to side without assistance. NA-A stated R5 was impulsive and uncooperative at times. NA-A stated for interventions to prevent falls they checked on R5 frequently and R5 had a low bed so if she tries to get up, she would not get hurt. On 12/31/25 at 11:30 a.m., R5 was sitting in her wheelchair in the dining room with her oxygen on. On interview 1/2/26, licensed practical nurse (LPN)-A stated yesterday 1/1/26, R5 was found on the floor by her bed with no apparent injury. Provider was notified and ordered a bed alarm to be implemented. LPN-A stated the alarm is only for when she is in bed. LPN-A stated they keep a close eye on R5 throughout the day and she tends to hang out by the nurses station desk. LPN-A stated R5 does have sleep issues and sometimes sleeps all day and other days she is up and around the nurses station all day and night. LPN-A stated she had seen R5 fall asleep while sitting in her wheelchair a lot. On interview 1/2/26 at 10:00 a.m., nursing assistant (NA)-B stated they tend to keep R5 by the nurses station whenever she is in her wheelchair. NA-B stated R5 had times where she is anxious and other times where she won't cooperate with staff. NA-B indicated for interventions to prevent falls they checked on R5 frequently when she is in bed. On interview 1/2/26 at 10:11 a.m., the director of nursing (DON) stated that even though some interventions were not on the plan of care such as close observation, it was listed on the tasks and was being completed. When questioned about brakes on the wheelchair, attempting to get R5 to lay down if falling asleep in wheelchair, and staff to allow R5 to sleep and not wake her, the DON stated they were not on the task list and also confirmed they were not on the plan of care. Facility Fall Risk Assessment (undated) policy included: The risk assessment will contain the following components: Identify environmental hazards and individual risks, including the need for supervisionEvaluate and analyze hazards and risks. An At Risk for Falls care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly. The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals and current standards of practice in order to reduce the risk of an accident. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice.