STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	3720 23rd Avenue South Minneapolis, MN 55407

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interviews and record review, the facility failed to ensure staff had not taken unauthorized pictures without consent for 1 of 4 residents (R4) reviewed for abuse. This had the potential for mental abuse using a reasonable person concept. Findings include: R4's quarterly Minimal Data Set (MDS) dated [DATE], indicated R4's diagnoses included paranoid schizophrenia, schizoaffective disorder bipolar type, and R4 had moderately impaired cognition. R4's Vulnerable Adult Evaluation dated 6/26/24, identified R4 had physical limitations which made him susceptible to abuse due to R4 required assistance with cares and activities of daily living (ADLs). Further, R4 was identified to have cognitive deficits which made R4 susceptible to abuse due to changes in cognition related to diagnoses of paranoid schizophrenia and unspecified symptoms and signs involving cognitive functions and awareness. R4's care plan dated 6/21/24, indicated R4 had a diagnosis of schizoaffective disorder bipolar type with paranoia and R4 had a history of refusing cares, showers, changing clothes, and meals. R4 had a history of making statements like Maybe I should just kill myself and Maybe I should just go to heaven when he was feeling frustrated but denied having a plan to hurt himself. Further, R4's care plan identified R4 had an ADL self-care performance deficit exhibited by R4 refusing to change clothes and be assisted with routine hygiene and would refuse to allow staff to wash his jacket, or clothing until he decided that they were dirty enough to clean, refused to allow wheelchair to be washed, wears long and unshaven facial hair, and did not change socks. R4 had a history of the following behaviors: refused to change clothing despite being dirty/soiled, refuse to be toileted, transferred, changed. Often found sleeping in wheelchair and would become angry if staff encouraged to go to room to lay down, R4 was often observed leaning over side of wheelchair sleeping and refuse to lay down and would become verbally and physically abusive with attempt to move him or assist him to lay down. Review of email sent by the ED on 9/30/24 at 5:32 p.m., revealed there was a text message conversation sent from COTA-A which contained a behind view of R4, who was wearing a blue top, sitting in his wheelchair, and leaning over to the right side. This text message had a date of 9/9/24, and the picture did not reveal R4's face. The text message sent by COTA-A to R1. There was no context to the picture. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 11:20 a.m., ED stated COTA-A was a contracted therapy staff and they were aware of the two pictures, who he identified as R4, on 9/24/24. ED stated R4 was mentally ill, resistive to cares, and would stay up late and sleep odd hours in his wheelchair in the hallway. ED indicated COTA-a was a contracted therapy staff and R4 was not receiving therapy services, so ED was not sure why COTA-A would have taken a picture of R4 other than passing by him in the hallway. Further, ED stated R4 appeared to be sleeping in the two pictures COTA-A took. ED stated after seeing the pictures of R4 he was frustrated and confirmed he did not ask COTA-A why she took the picture. On 10/1/24 at 12:09 p.m., assistant executive director (AED) stated he was aware of the pictures of R4 sent by COTA-A, and stated it was inappropriate as it violated the facility policy. Further, the AED stated R4 would not be happy unauthorized pictures were sent of him. On 10/1/24 at 12:15 p.m., guardian (G)-A stated R4 had impaired cognition and if he was upset, he would let staff know. G-A stated she was not aware unauthorized pictures were sent of R4, and stated R4 would be pissed off and angry if he knew. G-A asked surveyor not to speak with R4 about the incident as R4 would then become paranoid and fixated on it as that was part of his diagnoses. Interview with COTA-A was unsuccessful. Review of facility policy titled Personal Phones, Communication Devices, and Cameras in the Workplace revised 7/1/24, indicated any use of a cell phone or other communication device must not be in the presence of a resident or client and personal cameras or devices with photo capability must never be used on facility premises to take pictures without prior approval and are limited to that specific use approved. Review of facility policy titled Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting revised 10/22, indicated all adult residents living or receiving services in the facility are vulnerable and come under the protection of the Vulnerable Adult Act (VAA) and it's the policy to ensure the resident was free from abuse, neglect, mistreatment. Further, the policy an occupational therapist as a licensed health professional. The facility policy also defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It would include verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental abuse included but was not limited to humiliation, harassment, and threats of punishment or deprivation. Technology abuse was defined as unauthorized photographs or videos of a resident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and record review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for 2 of 4 residents (R1 and R4) reviewed involving 1 of 1 contracted staff (certified occupational therapy assistant (COTA)-A)). Findings include: R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1's diagnoses included anxiety disorder, major depressive disorder, paranoid personality disorder and R1 was cognitively intact. R4's quarterly MDS dated [DATE], indicated R4's diagnoses included paranoid schizophrenia, schizoaffective disorder bipolar type, and R4 had moderately impaired cognition. Review of facility report to the State Agency dated 9/24/24, indicated R1 who was no longer a resident at the facility, reported consensual sexual relations and a consensual relationship with COTA-A. On 10/1/24 at 11:20 a.m., executive director (ED) stated as part of the investigation for R1's allegation, two therapy staff were interviewed; however no facility floor staff were interviewed regarding R1 and COTA-A. ED stated while investigating R1's allegation, ED discovered text messages from COTA-A to R1 which contained two pictures of R4. Further, ED stated the pictures of R4 sent by COTA were not addressed, and ED stated the therapy department was trained related to abuse which wouldn't cover the electronic piece, we haven't done anything directly with that. On 10/1/24 at 12:09 p.m., assistant executive director (AED) stated facility staff were not interviewed regarding R1 and COTA as it did not seem essential to the interview since R1 was fixated on the laundry room and there were no staff down in the laundry room at the time of the allegation and it would not be abnormal for therapy staff to assist a resident off the unit. Further, AED also confirmed the pictures of R4 on COTA-A's phone were not investigated or addressed. Review of facility policy titled Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting revised on 10/22, indicated employees would report findings, verbally and immediately to their supervisor, the supervisor would then immediately report to the administrator and director of nursing. The administrator or designee would initiate an investigation and any findings would be acted upon immediately by the administrator. The policy lacked staff direction on what was expected to be included as part of the investigation.