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	04/14/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 49338 Based on observation, interview, and document review, the facility failed to comprehensively assess supervision needs and develop individualized person-centered interventions to identify and mitigate risks and hazards for residents when out in the community and upon subsequent return to the facility. This failure resulted in the risk of serious harm, injury, or impairment for 3 of 3 residents (R2, R3, R1) reviewed for safety. The immediate jeopardy began on 2/27/25 when the facility failed to ensure a systematic process of an individualized community safety assessment to identify potential risks or establish prevention strategies to ensure resident safety for R2 who had vascular dementia and required supervision, R3 who had significant current alcoholism with impaired insight, judment, and memory, and R1 who had substance abuse disorder (SUD) with cognitive impairment and mobility limitation. The IJ was identified on 4/10/25. The executive director (ED), director of nursing (DON), assistant executive director, and administrative intern were notified of the immediate jeopardy on 4/10/25 at 5:53 p.m. The immediate jeopardy was removed on 4/11/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R2's hospital discharge summary dated 11/5/24 to 11/8/24, indicated R2's past medical history included, abnormal urination (history of incarceration for public urination), aggressive behavior of child (history of physical fights), anxiety disorder, counseling on substance use and abuse (chemical dependency treatment 8 times), family history of suicide, history of psychiatric hospitalization s, intravenous (IV) drug user, self-mutilation, substance use disorder (SUD) - (history of IV heroin, cocaine and alcohol use), and suicidal behavior (R2 reported history of chronic suicidal ideations since 2005). Hospital course identified R2 had failure to thrive, indicating R2 was reportedly altered, covered in feces, urine and had wandered into a shelter confused, according to the shelter. R2 was discharged to skilled nursing facility. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Nurse Practitioner (NP) visit dated 1/6/25, identified R2 had a Saint [NAME] University Mental Status (SLUMS) score of 23/30 showing moderate dementia. R2 could live in supportive housing, waiting on assisted living facility (ALF) setting which continues to be appropriate based on scoring. Assessment/Plan identified diagnosis of primary moderate vascular dementia with mood disturbance (moderate degree of cognitive impairment due to vascular disease, accompanied by mood changes with symptoms that may include difficulties with problem-solving, slowed thinking, and loss of focus): mood disturbances longstanding depressive disorder, history of homelessness, recommendation for assisted living setting for future housing. R2's ACP visit dated 1/8/25, identified R2's mental status exam indicated short term memory and insight/judgement was impaired and thought content was blocked. R2's treatment recommendations/plan identified R2 would present as someone who would benefit from remaining in a secure structured setting to support best functioning and quality of life. Strategies to support him to maintain his sobriety area warranted including placement considerations given his history and level of cognition. R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 admitted to the facility on [DATE] and identified R2 had moderate cognitive impairment. R2's care plan focus dated 2/21/25, identified R2 had cognitive loss/dementia or alteration in thought processes. Interventions included to cue and supervise as needed and observe/document/report to medical practitioner any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. The care plan lacked evidence of interventions related to safety in the community and did not identify if R2 was safe to be independent in the community or not. R2's progress notes were reviewed in conjunction with facility sign out/sign in forms between 2/27/25 through 4/8/25. Progress notes identified multiple occurrences of R2 leaving the facility without indication that he was supervised. Further identified R2 did not complete the sign-out sheet, notify staff he was leaving, or inform staff of his whereabouts, who he was with/if he had supervision, his expected time of return, and his actual return. R2's progress note dated 2/27/25 at 3:55 a.m., identified R2 was unable to be located, a thorough search of the entire facility including all common areas, rooms, bathrooms, outdoor areas was conducted. A missing person's report made to the police department and the facility DON/supervisor notified. At 4:38 a.m., police came to the facility and gathered more information for R2. At 8:00 a.m., R2 was at the ED with complaints of SOB. ER was assessing and send R2 back to the facility later this morning At 11:10 a.m., R2 returned to the facility via ambulance. The progress notes indicated staff did not know when he was last seen until 3:55 a.m. ; R2 was out of the facility and missing for at least 4 hours before the facility identified R2 was at the hospital. R2's record did not include a comprehensive community safety assessment that would identify individualized interventions for R2's safety in the community and/or ability to be unsupervised while out of the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's progress note dated 3/3/25 at 2:55 p.m., per report R2 last seen at 12:25 p.m. R2 had left the facility. At 3:44 p.m., writer began petition for guardianship for R2. At 4:21 p.m., R2 had not returned to the facility, did not sign out when he departed at 12:25 p.m. At 8:53 p.m., R2 had not returned to the facility yet, last seen at 12:25 p.m., call placed to family with concerns of whereabouts. According to family they have no idea of R2's location. Calls placed to hospitals with no admission record for R2. At 10:50 p.m., R2 had not yet returned to the facility, oncoming night shift nurse updated to call police if not returned to facility by midnight. On 3/4/25 at 12:15 p.m., R2 had not returned yet to the facility .a call placed to 911 about 12:15 a.m., to report R2 as missing. Police arrived at the facility around 12:55 a.m., gathered all necessary information about R2 missing. On 3/4/25 at 5:45 a.m., R2 was found lying in bed (at the facility) at this time. R2's progress notes identified R2 was gone for 17 hours and 15 minutes and R2's whereabouts were unknown. R2's occupational therapy (OT) encounter note dated 3/14/25, identified R2 had a SLUMS assessment completed that he scored a 19/30 (score under 20 identified cognitive impairment or potential dementia). Most of R2's points were lost on recall of objects. R2 engaged in community outing involving indoor and outdoor ambulation, wheelchair management (pushes w/c in front of him like a walker), uneven surfaces, dressing, toileting (both independent), money management, social interaction, managing both his device and hot coffee (he did without spilling or burning himself) and general community safety. R2 was educated about therapy trying to get him out of memory care and into a more appropriate setting. Plan: continue functional cognitive assessments and functional mobility. R2's progress note dated 3/14/25 at 11:16 a.m., met with R2 discussed sign out policy when leaving facility and calling if not making it back timely, R2 agreed, writer will assist with ordering a free cellphone. At 9:22 p. m., day shift nurse reported that R2 went outside to smoke. He signed out at approximately 5:30 p.m. However, R2 had not returned, writer called R2's family left message informed shift supervisor. Supervisor stated to wait until midnight if R2 does not return by then will report as a missing person. At 1:12 a.m., R2 did not return to facility, missing person report filed .At 6:26 a.m., two police officers came to the facility, all necessary information given. On 3/15/25 at 9:33 a.m., hospital emergency room called and stated R2 was being admitted for respiratory difficulty .At 8:35 p.m., R2 returned to the facility via ambulance. R2's progress notes indicated he was missing and whereabouts unknown for approximately 15 hours. R2's progress note dated 3/17/25 at 12:45 p.m. staff seen R2 at bus stop, R2 stated he was going to the store via a bus and intended to be back by dinner time. At 5:57 p.m., received phone call from metro transit police said R2 was lost and unable to go back. R2 will be sent back. At 6:31 p.m., R2 was sent back by metro transit police, was found on [NAME] Avenue/[NAME] Avenue southbound bus stop shelter waiting for a bus. R2 was alert and oriented x 2, denied alcoholic drink, R2 stated he checked out before he left, writer unable to find where R2 signed. Progress note dated 3/18/25 at 12:45 p.m., writer applied for an assurance wireless phone for R2 should arrive within 7-10 business days. R2's progrss notes identified R2 was gone for approximately 5.5 hours whereabouts unknown, and identified R2 was lost and unable to make his way back to the facility and the police brought him back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's progress notes dated 3/28/25 at 1:39 a.m., R2 was not in room for scheduled inhaler for COPD. At 2:02 a.m., writer got report from previous shift that R2 had not been seen in the facility since this morning. Writer checked around facility and not available. Writer called 911 and filed a missing person report with police. They will send police out as soon as possible. Writer called family and left message. At 2:50 a.m., police stopped at the facility requesting information regarding R2. Police stated to call and let them know when R2 returns so they can take him off the missing person report. At 10:33 a.m., identified R2 was on LOA. At 2:15 p.m., identified R2 returned to the unit between 1:00 p.m., and 1:30 p.m., R2 went to bed and was sleeping, message left with family that R2 was back. At 2:27 p.m., writer educated R2 on the importance of signing out, R2 stated, okay . R2's progress note identified on 3/28/25, R2 was missing for approximately 12 hours and his whereabouts unknown. -On 4/4/25 at 7:09 p.m., identified R2 was not in the facility until dinner time and med pass time. Tried to contact him through cell phone but did not answer, will continue to follow up. At 11:47 p.m., R2 was not in the facility, called and left voice message incoming nurse updated. On 4/5/25 at 1:12 a.m., writer called R2's phone again and phone went to voicemail left message for call back. Called and filed a missing person report with police. Stated they would send officers to come to the facility, called family, left voicemail. At 1:30 a.m., police called to inform they will be sending an officer to the facility. At 6:00 a.m., police stopped by to see if R2 was back. At 3:02 p.m., R2 has not returned to the facility, family notified. On 4/6/25 at 12:08 a.m., R2 has not returned to the facility. At 6:42 a.m., R2 did not return to the facility will update incoming nurse. At 12:42 p.m., nurse received a call form the hospital regarding R2's admission due to COPD exacerbation and pneumonia will be arriving back to the facility with medications after 1:00 p.m. At 1:45 p.m., R2 returned from the hospital to the facility at 1:40 p.m., Temperature was 99.1, pulse 105, oxygen saturations 94% on room air and blood pressure was 112/67, no complaints of pain or discomfort. R2's After Visit Summary (AVS) dated 4/5/25 to 4/6/25 identified R2 was in the hospital for treatment of COPD exacerbation. Summary included The patient presented to the ED due to new onset shortness of breath and mild cough over the past two days. R2 reported he was out of his as needed inhaler and R2 is most likely experiencing exacerbation of COPD due to lack of medication with a possible component of community acquired pneumonia. R2 was discharged with medications to treat this and will have an upcoming appointment with pulmonology on 6/3/25. R2's medical record identified R2 was gone from facility from 4/4/25 at approximately 7:00 p.m., and returned to facility on 4/6/25 at 1:45 p.m., gone for approximately 42 hours and 45 minutes. R2 was hospitalized from 4/5/25 at 3:11 p.m., and discharged from the hospital on 4/6/25 at 12:58 p.m., accounting for approximately 22 hours of hospitalization , with 22 hours of R2 missing and whereabouts unaccounted for. R2's progress notes dated 4/8/25 at 12:25 a.m., per PM nurse R2 was last seen around noon (on 4/7/25) on the floor .R2 not on the floor/room. R2's personal cell phone was left in his room. At midnight a call was placed to police and hospital, was not found, filed missing person report. Night supervisor was updated. At 4:27 a.m., two police officers followed up on missing person report .At 9:03 a.m., R2 returned to the facility, writer had conversation with R2 regarding the importance of signing out and ensuring he has his cell phone with them to keep the facility updated. R2 was in agreement. R2s progress notes identified R2 was gone from facility from 4/7/25 at approximately 12:00 p.m., and returned to facility on 4/8/25 at 9:03 a.m., gone for approximately 21 hours with whereabouts unknown. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/9/25 at 12:38 p.m., registered nurse (RN)-A stated all residents can leave the building anytime they want unless they reside on the secured unit. RN-A further stated all they must do is sign in/out on the sign out book. RN-A indicated they would not notice a resident was gone unless they went to go give their medications and could not find them. RN-A stated if a resident was not back by midnight, and we could not get a hold of them we would file a missing person's report with the police and document in the nurse's progress notes. During an interview on 4/9/25 at 4:28 p.m., OT-A stated a resident's cognition will be assessed on admission, the social worker would first screen a resident to get a snapshot of their cognition by performing a Brief Interview for Mental Status (BIMS) assessment. OT-A stated this was used to assess for delirium and was not a true show of cognition. OT-A stated the SLUMS exam is a brief screening test for detecting mild cognitive impairment and dementia and assess for orientation, short term memory, calculation and language-verbal fluency. OT-A indicated if the SLUMS score is less than 20 it can indicate dementia and require further cognitive testing. OT-A stated she assessed R2's SLUMS on 3/13/25 and he scored a 19 out of 30 indicating dementia. OT-A stated the Cognitive Performance Test (CPT) assesses a person's cognitive abilities, like memory, attention, and reasoning, through various tasks and questions without being able to the cue the individual. OT-A stated the CPT assessment can be used to diagnose cognitive impairments like dementia and guides interventions and support for persons with cognitive challenges. OT-A indicated the CPT assessment takes about an hour to complete so rarely was utilized in the long-term care setting as it was unrealistic. OT-A was unable to articulate what staff at the facility would be responsible to assess a resident's safety in the community. OT-A identified R2 did not have a CPT assessment, stated she did assess R2 while he was in the community on 3/14/25, and completed a SLUMS assessment with a score of 19/30 that indicated cognitive impairment but was unable to articulate if R2 was able to be safe in the community independently while residing at the facility. OT-A stated R2's short-term memory was not intact and if she was doing a discharge to home assessment on R2, he would require supervision. During a phone interview on 4/10/25 at 8:29 a.m., when asking nurse practitioner (NP)-A if the facility was responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address the risk. NP-A stated he was not involved in the process in the identifying and assessing the resident's risk for leaving the facility and the development of associated safety interventions. NP-A stated that all residents that do not reside on the locked unit are able to come and go into the community from the facility and would require the resident to put the date and time they are signing out, where they are going and what time the expected return is. NP-A further stated they cannot stop residents from coming and going as it is their right, stated, this is not a prison. During an interview on 4/10/25 at 9:20 a.m., the medical director stated the process for a resident to leave the facility was all the residents that did not reside on the locked unit use a sign in and sign out process. Medical director stated, we are not a prison, we cannot stop someone from coming and going unless they are in a locked unit. Medical director further stated if a resident was their own decision maker we are assuming they have capacity to go safely in the community unsupervised. Medical director further stated the BIMS assessment was not comprehensive in determining a resident's cognition and to determine true cognition it would be a combination of cognitive tests that include a CPT, SLUMS and the [NAME] Cognitive Level Screen (ACLS) assessment. Staff did not routinely assess cognition upon admission unless warranted. Medical Director was unable to articulate a facility process of how a resident was comprehensively assessed to be safe independently in the community. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 4/10/25 at 10:51 a.m., licensed psychologist (LP)-A stated she performed a SLUMS assessment indicating R2 had cognitive impairment with short term memory impairment. LP-A stated residents with cognition concerns should be comprehensively assessed to be independent in the community several factors would need to be assessed to include cognition, diagnoses, capacity to create a contract and follow through, etc .then IDT should discuss this to put a safety plan in place for each resident. During an interview on 4/10/25 at 11:16 a.m., when asking director of nursing (DON), if the facility was responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address the risk. DON explained the OT would be the professional to assess a resident to see if they would be safe to be in the community independently unsupervised. DON verified the OT that assessed R2 on 3/14/25, did not clearly state if R2 was safe to be independent in the community unsupervised. DON indicated their current process for a resident to leave the facility was if the resident did not reside on the locked unit the resident would utilize the sign in and sign out sheet located at each wing. The resident should write the time they leave and an expected return time along with where they are going. DON verified that residents do not always use the sign and sign out sheets and was unable to articulate what interventions the facility has in place to keep residents requiring supervision in the community safe. If a resident was missing, the staff call family and the resident to try and identify the resident's whereabouts and are to wait until midnight and call the police to file a missing person's report and notify myself, the family and the supervisor. DON stated she received a report this morning that R2 went missing yesterday sometime and had not yet returned to the facility, a missing person's report was filed with the police at midnight, and she did not have any more information on R2. During an observation and interview on 4/14/25, at 9:48 a.m., R2 was observed dressed and lying in bed in his room. R2 stated he currently didn't feel good and has the sniffles, further stated he was put on the locked unit because he was smoking in his room, rules are rules, don't bother me none. R2 stated he didn't come here to make friends and tried to stay to himself. R2 stated he was waiting to get out of here and get his own place. R2 stated he had been to the ED and hospital a few times recently due to his mental health. R2 did not wish to speak with surveyor any further and asked surveyor to leave. R3 R3's quarterly MDS dated [DATE], indicated R3 admitted to the facility on ,d+[DATE]. R3 was cognitively intact with a BIMS score of 15, was independent with activities of daily living and mobility, and utilized a wheelchair. R3's diagnosis report indicated R3 had diagnoses including alcohol [ETOH] abuse with withdrawal, alcohol dependence, alcoholic hepatitis (liver inflammation due to excessive ETOH consumption), alcoholic polyneuropathy (nerve damage from excess ETOH consumption), liver cirrhosis (scarring of the liver), opioid abuse, unspecified psychosis, major depressive disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, adjustment disorder with disturbance of conduct, muscle weakness, unsteadiness on feet, history of falling, repeated falls. R3's psychiatry note dated 12/20/24, indicated she had diagnoses including generalized anxiety disorder, alcohol use disorder, major depressive disorder, and opioid use disorder. Her mental status examination included her insight, judgment, memory, and concentration are quite impaired. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's physician orders included naltrexone hydrochloride (HCl) 50 mg daily for substance use disorder (dated 2/14/25). R3's care plan focus revised 3/25/25, identified she had limited physical mobility with fall risk related to ETOH abuse and noted she was independent with ambulation and utilized a wheelchair as needed. Interventions included: independent with bed mobility (dated 11/29/23), utilizes wheelchair as needed independently (dated 3/25/25), independent with toileting (dated 4/5/24), and independent with transfers (dated 4/5/24). R3's care plan focus revised 3/25/25, identified she had suspected/actual illicit drug/ETOH use and previously declined treatment services but had started to talk with the LADC. Interventions dated 4/5/24 included: Doctor updated regarding actual/suspected abuse, hold all mood altering or all sedative medication when ETOH or marijuana use suspected; Ensure safety and observe for withdrawal symptoms; and a list of symptoms of a drug overdose including alcohol poisoning. R3's care plan did not identify the symptoms of alcohol withdrawal or identify her supervision needs in the community or related interventions for her safety in the community and upon subsequent return to the facility. R3's physician note dated 1/8/25, indicated she had alcohol use disorder with recurrent episodes of alcohol use. She was most recently hospitalized [DATE] after being found intoxicated and her blood alcohol level was 0.33. R3's progress notes dated 1/9/25, 1/12/25, 1/13/25, 1/14/25, 2/8/25, and 2/9/25 indicated R3 was intoxicated and medications were refused and/or held. The notes did not indicate the provider was notified or identify what ongoing monitoring and interventions were implemented. R3's progress notes dated 2/10/25, indicated R3 was intoxicated, medications were held, vital signs taken, and provider was notified. R3 later request transport to the hospital because she wasn't feeling well and reported vomiting all day. R3's hospital notes between 2/11/25 through 2/13/25 identified R3 had a history of alcohol abuse and admitted to the hospital on 2/10/25 with nausea and vomiting. R3's principal diagnosis was alcoholic ketosis (buildup of acid in the blood caused by heavy alcohol use often in conjunction with poor nutrition) and she initially presented with tachycardia (elevated heart rate) to the 120's, hypertensive (elevated blood pressure) to 180's/100's, with numerous abnormal lab values. A hospital Social Work Initial Assessment indicated R3 reports she uses the w/c when at the facility, does not use an assistive device when she leaves the facility. She leaves the facility independently, usually via a cab ride she independently arranges. Patient reports her typical outing includes stops at Target and a liquor store. A progress note by hospitalist included R3 reported the nursing home don't really monitor where she goes so she regularly walks down to the bar on the corner of the street and drinks. R3's progress note dated 2/13/25, indicated R3 returned from the hospital. R3's record did not identify the concerns in hospital documentation, including lack of assistive device when leaving the facility and purchase/consumption of alcohol while in the community, were addressed. Further, did not indicate that her need for supervision in the community was assessed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's progress notes dated 2/25/25, indicated R3 was extremely intoxicated and found sleeping on the floor next to her bed with partially consumed bottles of alcohol at 3:00 a.m. Assessment and vital signs completed, assisted back to bed, and staff kept monitoring her situation with intervention of lowering her bed to the floor to prevent injuries in case she decided to get out of bed. The provider notification section of the note was blank and did not indicate the provider was notified. Further, progress notes indicated R3 remained intoxicated throughout the day, did not eat breakfast or lunch, refused all morning and afternoon medications, and refused assessment and vital signs. R3's progress note dated 2/25/25 at 8:55 p.m., indicated nurse went to get R3 from front desk, R3 was intoxicated, R3 stated she fell while downtown and hit her head while trying to get on a bus. R3 refused vitals, neurological checks performed, provider notified. Additional progress note at 10:58 p.m., indicated R3 sustained a bruise and head hematoma from the fall, identified contributing factor of R3 was not using her wheelchair, and noted care plan and care sheets were reviewed with no changes indicated. It was not evident in R3's record that her supervision needs were assessed or interventions were developed to ensure her safety in the community after she fell and sustained a head injury while intoxicated in the community. R3's record reviewed between 2/26/25 through 4/10/25 identified although R3 continued to be intoxicated almost daily, R3's record did not include a comprehensive assessments and/or monitoring of withdrawal symptoms nor assessments and/or monitoring of R3's medical condition while she intoxicated, nor safety interventions including the level of supervision while R3 was intoxicated inside the facility. Further there was no indication a monitoring system was developed to prevent and/or identify if/when R3 brought or had alcohol in room and not evident interventions were developed to keep R3 safe and other residents safe that may inadvertently have access to R3's alcohol. Additionally, R3's records did not include a comprehensive community safety assessment, despite R3's patterned history of leaving the facility, consuming alcohol while away, then returning intoxicated. R3's record did not include interventions that would prevent and/or mitigate R3's risks of serious injury or even death while in the community. Examples from the record include but are not limited to: R3's progress notes dated 2/26/25, 2/27/25, 3/1/25, 3/4/25, 3/5/25, and 3/11/25, indicated R3 was intoxicated and medications were refused and/or held. On 3/4/25, alcohol was also found in R3's room and she was verbally abusive towards staff and refused cares. R3's progress notes dated 3/12/25, indicated R3 was intoxicated, verbally aggressive to staff, and medications were refused and/or held. Note at 1:27 p.m., indicated she was sent to the hospital per provider order. Note at 8:06 p.m., indicated she was sent to the hospital for evaluation of a suspected gastrointestinal bleed after being found in her room intoxicated with black stool smeared in the bathroom. She returned to the facility at 6:30 p.m. and was still intoxicated, medications were held. R3's emergency department (ED) After Visit Summary dated 3/12/25, indicated R3 was seen for an alcohol problem and blood in stool with diagnosis of alcoholic intoxication with complication. R3's nurse practitioner note dated 3/14/25, indicated she was seen for evaluation following intoxication and concern for a gastrointestinal bleed two days ago. R3 continues to drink, had a blood alcohol level of 0.36, and she states that her last drink was several weeks ago but this is not accurate. (continued on next page)

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	04/14/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's progress note dated 3/18/25, indicated R3's functional status abilities varied related to alcohol use. When intoxicated, she required supervision/touching assistance of one staff member for bed mobility, transfers, and ambulation for safety. When intoxicated, she required limited assistance of one staff member with toileting tasks and colostomy management. She was able to make her needs known but staff were to anticipate her needs as appropriate when intoxicated. R3's care plan did not identify individualized interventions that reflected the increased need for assistance when intoxicated. R3's Comprehensive Nursing Data Collection assessment dated [DATE], identified R3 was vulnerable to self-abuse described as alcohol abuse, susceptible to abuse from others described as vulnerable adult, susceptible to abuse others, and had verbal behavioral symptoms directed at others described as a history of verbal aggression when intoxicated. The assessment identified R3 had alcohol use daily and history of substance/cannabis abuse was marked as never. The assessment failed to identify R3's diagnosed history of opioid abuse. The Data Collection included an elopement assessment with each 'yes' answer assigned one point and a score of 4 or greater indicating potential for elopement. R3 had an elopement risk score of 3 indicating no elopement risk. The questions exhibits pacing or agitated behavior and has a diagnosis or OBS, dementia, psychosis, Alzheimer's, or other psychiatric diagnosis, were marked no. The assessment failed to identify R3's agitated behaviors where documented in provider and progress noted between 1/8/25 through 3/18/25, and further failed to identify R3's psychiatric diagnoses of unspecified psychosis, major depressive disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and adjustment disorder with disturbance of conduct. If the assessment identified these areas accurately, R3's score would have been 4 or greater, identifying her as an elopement risk. R3's progress notes dated 3/22/25 and 3/23/25, indicated R3 was intoxicated and medications were refused and/or held. Progress note dated 3/28/25, indicated R3 left the facility to go to the mall, walked out, and refused to sign out. Later returned in good condition. R3's progress notes did not identify how long R3 was out of the facility and/or when R3 returned. R3's progress notes dated 3/29/25, indicated she was missing from the unit at 8:00 a.m. and remained missing at 2:00 p.m. with supervisor to follow up. Note at 6:14 p.m., identified person in the community called the facility and stated resident was drunk and needed to be picked up, provided address, staff notified police. At 9:15 p.m. police dropped R3 off at the facility. She was intoxicated, non-compliant with cares, refused vital signs and assessment, and provider was notified. R3's record did not identify assessment of R3's supervision needs after she was found intoxicated in the community and returned to the facility by police. Further, did not identify what interventions were put in place to mitigate related risk while in the community and upon her return. Progress note dated 3/30/25, indicated R3 was intoxicated the whole overnight shift and called emergency services at 6:00 a.m. and was taken to the hospital while still intoxicated. There was no assessment or indication why R2 was sent to the hospital. R3's ED After Visit Summary dated 3/30/25, indicated R3 was seen for an alcohol problem with diagnosis of alcohol intoxication delirium with moderate or severe use disorder. Progress notes dated 3/30/25, indicated R3 returned from the hospital around 12:00 p.m. R3 then requested a cab be called for a shopping trip, refused to sign