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	04/30/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on observation, interview, and document review, the facility failed to develop and implement an individualized behavioral health care plan utilizing recommendations from professional psychological services to support sobriety efforts for 2 of 2 residents (R2 and R3) reviewed for behavioral health needs. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, cardiac-respiratory issues, COPD, depression, and dementia. The MDS indicated no mood or behavior issues, R2 was independent with mobility, activities of daily living (ADL)'s, and had troubles with breathing with exertions. R2's Care Plan revised on 4/16/25, indicated R2 had cognitive loss/dementia or alteration in thought process's ability, judgement and decision making. The Care Plan further indicated R2 had major depression and received services in-house from the psycho-geriatric team, and staff were to observe behavior and attempt to determine pattern, frequency, intensity and triggers, recommendations per psych, use support, validate his distress, listen to him, help him problem solve. The care plan further indicated he does not endorse drinking or smoking much of the time and would be a good time to support sobriety and even smoking cessation. Therapy completed a community assessment which indicated R2 could be independent when leaving the facility. A Facility Reported Incident indicated on 4/21/25, R2 signed himself out at the facility and did not return at the intended return time. Police notified and Minnesota Department of Health report was submitted. R2 was assessed to be independent while out in the community and was transported to the hospital from the community. The hospital reported R2 was short of breath and returned the following day. (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Associated Clinic of Psychology (ACP) visit note dated 4/15/25, indicated R2 was seen for continued services to maintain and improve the client's current level of functioning. The note indicated R2 had low mood related to his current living situation and expressed a desire for a more independent living setting. He indicated having a roommate and lack of privacy as negatively impacting his mood. R2 denied any urges to relapse and emphasized the importance of maintaining sobriety and anxiety linked to both his wish to move and his COPD. The note also indicated he reflects on chronic depressive thinking and defines as a loner with low motivation for activity or social engagement. In addition, the note indicated motivation towards sobriety seemed strong. The provider treatment and recommendations/Plan indicated: Continue current psychological treatment intervention plan and interventions in place. Continue supportive and solution-focused therapy. Explore coping strategies for current living situations and reinforce strengths. Monitor mood and anxiety symptoms, encourage engagement in meaningful activities. R2 is hopeful to explore alternative living environments, is open to the idea of Assisted Living facilities. R2 does not recall any discharge planning happening but also presents with cognitive deficits. R2's Activity Progress Note dated 1/29/25, indicated a recreation/wellness interview was completed on R2, work history indicated R2 worked at 3 M, socialization described as enjoyed visiting with others during leisure activities with meals, activity involvement preference is individual. During observation and interview on 4/28/25 at 1:41 p.m., R2 was observed to be lying in his bed watching TV. He stated he takes the city bus and goes out and had been hospitalized a few times while being out due being short of breath. R2 stated he had a cell phone and calls 911 when that happens. R2 stated he did not want to talk today and asked surveyor to leave his room. During interview on 4/30/25 at 12:45 p.m., community life coordinator (CLC)-A stated she leaves it up to R2 to attend activities and for him to request materials for reading. R2 had participated in history group and a party they had in the past. CALC-A stated she could reach out to him since there is a history group on Sundays and invite him, and on Tuesday mornings they have newspaper readings he might be interested in. CLC-A stated R2 might enjoy outdoor visits since he smokes, and leisure materials such as a CD player, library card, and puzzles since he worked at 3 M. CLC-A was not aware of recommendation made by ACP. During interview on 4/29/25 at 2:30 p.m., director of social services (DSS) stated R2 goes out once or twice a week and will drink. DSS stated R2 will sign himself out but will not tell us where he is going, adding he usually will go to a friend's house or to the store. The DSS stated he also has been admitted to the hospital while out due to his COPD. In addition, the DSS indicated awareness R2 was seen by ACP services but unaware he was interested in remaining sober, motivated by and discussed alternative placement options, or the recommendation for engagement in meaningful activities. The DSS stated social services is responsible for reading the ACP recommendations and had no comment why they were not read or implemented to assist with R2 sobriety and treatment goals. R3's quarterly MDS dated [DATE], indicated R3 was cognitively intact, had anemia, diabetes mellitus, anxiety, and depression disorder. The MDS further indicated R3 had no behaviors, used a wheelchair to ambulated, was independent with ADL's and had one fall since admission. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Care Plan revised on 4/13/25, indicated R3 had substance use disorder related to alcohol, staff were to encourage frequent contact with family/friends that do not encourage substance use, encourage to stay in room, hold mood altering sedative medications, observe and report to medical reactionary any signs/symptoms of withdrawal. The Care Plan further indicated R3 needed supervision when leaving the facility related to severe cognitive impairment. In addition the Care Plan indicated R3 refused to see in house psychiatrist, recites psych services as needed, staff should encourage resident to work on breathing when coping, along with drinking water/coffee, and taking her medications, and keep herself busy. To help stop herself from drinking, R3 enjoys music, this could be an encouragement for staff to direct her when upset to self soothe, could benefit from visits from the Chaplin, and observe for behavior and attempt to determine pattern, frequency, intensity and triggers. A Facility Reported Incident dated 4/15/25, indicated R3 left facility without signing out and with no supervision. Facility followed missing persons procedure, contacted police, R3 was found intoxicated and was sent to the hospital and returned to the facility on [DATE]. An After Visit Summary dated 4/17/25, indicated R3 was seen in the Emergency Department (ED) for altered mental status, and intoxication secondary to ethyl alcohol poisoning. A legal hold was placed on the patient due to their inability to care for self which represented a danger to self in addition to their chemical dependency status that is in question due to intoxication. and was discharged on [DATE]. R3's ACP visit summary dated 4/16/25, indicated R3 was seen for continued services to maintain and improve the client's current level of functioning, continued treatment needed to reduce or control of symptoms and prevent relapse. The summary indicated R3 had short term memory impairment, impaired judgement, and impaired thought. The session documentation indicated R3 was found in her room, nicely groomed, and dressed in her bed with her room cluttered and disorganized. In addition, the note indicated she spoke spontaneously about her brother calling her and wanting her to go to detox and how she did not agree with him, but did indicate she liked that he called her and was trying to call him again, but he had not returned her calls. In addition, the note indicated how R3 indicated she had depression and loneliness that caused her to drink, and admitted to drinking three days a week and would like to maintain her sobriety. R3 stated her parents were alcoholics and she drank all her life. In addition, R3 stated she would like a private room to keep her busy, in addition she admits to being lonely since her son moved out. The Summary Treatment Recommendations/Plan indicated to: Continue current psychological treatment plan and intervention in place. In addition, a private room may be worth considering for her to keep her room well organized and wanting to keep herself well groomed. She did see the psychiatrist which is a sign she might be more open to local help. Staff could help R3 find strategies to help keep her busy, such as self-care and keeping her room organized and going out. R3 does not like being disconnected with her son, helping him identify ways to support his mother and referring him to the community-based resources can be of a value as appropriate. When she is drinking, staff striving to have a harm reduction plan and staff helping her feel care for and supported may help. R3 may benefit from a safety plan which this psychologist agreed to meet with her more regularly if she wants to work on sobriety and improved health. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/29/25 at 11:00 a.m., DDS stated R3 will talk to the licensed drug and alcohol counselor (LADC) they had come to the facility but R3 would not sign onto the program he had to offer to assist with quitting drinking. The DDS stated R3 does not have a behavioral contract in place at the facility and was unaware ACP was willing to assist with a safety plan for R3, and had no comment as to the reason the recommendations were not followed through with. The DSS stated she was aware R3 had alcohol in her room and had been drinking in her room and residents have rights and we can't just search their rooms due to their rights in the facility, and the only way we could remove the bottle of alcohol is if it is visible and they allow us to remove it. During interview on 4/30/25 at 11:20 a.m., psychologist with doctorial (PsyD) from ACP stated she was willing to assist a harm reduction program for R3, which would be a contract that would indicate she would be a very important person in the community and would indicate how we would want to support R3's sobriety, and she would sign and agree for the facility to search her room for alcohol, explaining to her it is a facility policy which sometimes would be another reason or way to reduce her drinking, since she had been known to drink in her room. In addition, the PsyD stated when she saw R3, things R3 stated to cause her to drink were loneliness and depression and made recommendations for the facility to help with those feelings. Safety for Residents with Substance Use Disorder policy implemented April 2025, indicated Care Planning interventions will address risks by providing appropriate diversions for residents and encouraging residents to seek out facility staff to discuss their plan of care, including discharge planning, rather than leaving to seek out substances which could endanger the resident's health and/or safety. The policy further indicated the facility will make an effort to prevent substance use which may include providing substance use treatment services, medication-assisted treatment, alcoholic/narcotic anonymous meetings, working with the resident and family, if appropriate, to address goals related to their stay in the nursing home, and increased monitoring and supervision.