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	05/23/2025

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 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** 49616 Based on interview and record review the facility failed to include in the care plan interventions for safe eating and swallowing for 1 of 2 residents (R1) reviewed for quality of care and treatment. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified diagnoses of unspecified tremor (involuntary movement), absence of other parts of the digestive tract (removal or absence of part of the digestive tract which could be stomach, intestines or other components), and dysphagia oropharyngeal phase (swallowing disorder occurs in the mouth and throat affecting the ability to swallow both liquids and solids). R1 had cognition impairment. R1 required set up assistance with meals. R1 did not have difficulty with coughing or choking during meals or when swallowing medications. R1's care plan dated 1/16/25, identified a self-care performance deficit with an intervention labeled eating: set up. R1's physician order dated 1/16/25, identified regular textured diet with thin liquids. R1's progress note dated 2/14/25, included R1 had difficulty swallowing medications whole this morning. Choking and coughing when taking medications but able to clear independently. R1 stated this had happened before but more often lately. Nurse practitioner notified and orders for speech therapy (ST) recommended. R1's physician order dated 2/14/25, identified orders for ST to evaluate and treat for diagnosis of choking/coughing with medication administration. R1's progress note dated 2/14/25 at 12:50 p.m., directed R1 was seen by ST with recommendations to crush medications and put in applesauce or pudding. Nurse practitioner notified and order received to crush medications. Family notified of medications being crushed now. R1's physician order dated 2/14/25, directed to crush medications. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's ST evaluation and plan of treatment dated 2/14/25, identified R1 should be in an upright position for all meals, remain upright for at least 30 minutes after all meals, eat and drink slowly, small bites, small sips, chew foods thoroughly, alternating bites and sips. To facilitate safety and efficiency, it is recommended R1 use the following strategies during oral intake: chin tuck and effortful swallow. R1's progress note dated 3/1/25, included R1 was on a regular diet, regular textured food, regular liquids. R1 can feed self with no chewing/swallowing problems noted. R1's progress note dated 4/20/25, included R1 and son were educated on proper positioning and eating in the dining room with peers for safety and to monitor in case of choking episode. R1 did not say much to the education but son verbalized understanding. R1's record review of the care plan did not include the addition of ST recommendations, that medications should be crushed and placed in applesauce or pudding, nor that R1 was a choking risk. During a phone interview on 5/20/25 at 1:27 p.m., family member (FM)-A stated the facility knew that R1 was a choke risk and had difficulty swallowing. One of the nurses gave FM-A and R1 education that she was to be upright while eating. R1 was on a regular diet and regular liquids. During an interview on 5/23/25 at 8:37 a.m., licensed practical nurse (LPN)-A stated she was working with R1 on 2/14/25, and R1 just could not swallow her pills. LPN-A crushed the pills and put them in pudding and R1 did not have difficulty swallowing that. LPN-A received an order from the nurse practitioner for ST to evaluate and treat. On 4/20/25, FM-A was with R1 in her room and it was right before a meal. R1 had requested to lay down. LPN-A educated FM-A and R1 that it was best to eat in a completely upright position and with other residents. During an interview on 5/23/25 at 10:07 a.m., speech language pathologist (SLP)-A stated R1 did good with eating food but complained that she felt like the food was stuck in her throat. SLP-A encouraged consistent cueing which included chew food well, do a liquid wash. SLP-A gave recommendations to be upright for all meals and 30 minutes afterwards, eat and drink slowly, small sips and bites, alternate between sips and bites. During an interview on 5/23/25 at 2:30 p.m., assistant director of nursing (ADON) reviewed R1's care plan and verified that ST recommendations of remaining upright position for all meals, remain upright for at least 30 minutes after all meals, eat and drink slowly, small bites, small sips, chew foods thoroughly, alternating bites and sips. To facilitate safety and efficiency, it is recommended R1 use the following strategies during oral intake: chin tuck and effortful swallow were not in the care plan. The expectation is that all recommendations from therapies would be included immediately in the care plan and the nursing assistant care guide.