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	06/29/2026

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 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** Based on interview and record review, the facility failed to develop, implement, monitor, and revise individualized interventions to address alcohol-related behaviors for 2 of 2 residents (R1 and R2) reviewed for behavioral health services. Findings include:R2R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had moderate cognitive impairment and no behaviors or rejection of care. R2's diagnoses included non-Alzheimer's dementia, anxiety, and depression. R2 was independent with his wheelchair and most activities of daily living. R2's used antidepressant medication.R2's community life care plan focus revised 4/30/25, indicated R2 self-directed leisure pursuits. R2's substance abuse care plan focus revised 8/12/25, indicated R2 drank alcohol and occasionally used cocaine. R2 was agreeable to work with LADC (licensed alcohol and drug counselor). R2's antidepressant medication care plan focus revised 2/7/26, indicated R2 had history of suicidal ideations and feelings of sadness, low self-esteem, tearfulness, withdrawal from cares/activity, ineffective coping, and feeling lonely/isolated related to depression and substance abuse mood disorder. Interventions and dates included:-4/11/25; approach every three months to discuss treatment options.-4/16/25; therapy community assessment indicates resident can be independent when leaving the facility. SLUMS score indicated concern for cognitive impairment. BIMS score indicated moderate cognitive impairment.-4/30/25; R2's preferences included cards, smoking, cooking, music, going on walks, news channels, discovery and history channels, and encouraging R2 to participate in Well-Fit program's group exercises and/or individual cardio.-5/8/25; observe behavior and attempt to determine pattern, frequency, intensity, and triggers. Offer aromatherapy. Report to nurse ongoing signs/symptoms of depression. Staff to conduct room checks to ensure resident is not smoking in his room. Encourage out of room activities that promote physical activity.-5/14/25; remind R2 of group programs, provide word puzzles, word searches, and pens/pencils.-9/6/25; agreed to find housing. Remain in structured safe setting such as facility to support quality of life and best functioning. Validate, listen, help problem solve, and offer reassurance when R2 expressed distress. Support sobriety and smoking cessation. Encourage meaningful activities. R2 enjoyed socializing.-10/27/25; attempt non-pharmacological interventions.-11/5/25; maintain supervision of peer interactions on the unit. If substance abuse or boundary concerns were suspected, room searches to remove substances may be appropriate to reduce harm to self and others.R2's Associated Clinic of Psychology note dated 2/26/26, identified interventions to explore ambivalence, set harm-reduction goals, cognitive restructuring for urges/boredom, and problem-solving for high-risk situations. Treatment recommendations included continued need for behavioral/environmental structure due to cognitive deficits and ongoing alcohol abuse.R2's Psychiatric Progress Note dated 4/10/26, identified R2 continues to drink regularly from the best I can tell here.R2's provider note signed 5/16/26, identified R2 reported consumption of vodka and beer approximately once a week.R2's provider note signed 5/23/26, identified R2 had recently consumed one bottle of vodka, and R2 stated the occurrence was a one-time event.R2's progress notes on 5/28/26 at 8:43 p.m., 6/3/26 at 4:30 p.m., and 6/4/26 at 5:22 p.m., indicated R2 had slurred speech (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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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	feelings. The facility representatives reviewed no R1 activity recommendations plan despite the interventions in which R1 struggled to identify and initiate activities to improve mood and would benefit from being invited to attend things. The facility representatives stated R1 spent time outside the facility and directed his own activities. R1's activities were reviewed at quarterly care conferences, and activities were tracked by the community of life team. Facility representatives stated African American Survivor Services and LASD were confidential services unless R1 was willing to share information. The staff were educated they could call African American Survivor Services 24/7 if a resident showed signs/symptoms of intoxication or having a hard time and could take residents on outings and car rides. The team reviewed the intervention to utilize coping skills and stated they could only specify trigger or coping skills if R1 shared with the facility staff. The team helped R1 focus on meetings for the week related to substance use and encouraged him to participate. During continued interview, R2's care plan and behavioral services were reviewed. The team verified there were no changes in R2's care plan after the 6/10/26 incident. The team stated R2 was offered LASD and ACP visits and other group meetings. R2 was not open to most services offered besides African American Survivor Services. The African American Survivor Services organizer met with residents at the facility twice a week, but the meeting notes were confidential and not viewable to the facility. The team verified the care plan did not specify R2's triggers for alcohol use and stated asking R2 about his drinking triggers could be a trigger itself. Staff were to monitor R2 for signs/symptoms of substance use, and R2 was not willing to share his triggers with the facility. The team verified R2's records did not indicate his target behaviors or non-pharmacological interventions for behaviors. The team stated they have a PIP (Personal improvement plan) to look at psychotropic medications, target behaviors, and nonpharmacological interventions. The management team expected staff to notify them immediately of events such as the one which occurred between R1 and R2 on 6/10/26, because immediate follow-up for residents was important to promote the best possible psychosocial wellbeing.R1's Mood and Behavior Review assessment dated [DATE], identified R1 used antipsychotic and antidepressant medication. R1 had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. The assessment did not fill in the area to indicate review of current target behaviors and resident specific interventions. The assessment indicated redirection was generally effective for R1's mood and behaviors.R1's Care Conference Summary Resident Profile dated 5/21/26, identified a care conference occurred on 6/3/26 and Community Life section was not filled in. The Care Conference Summary's signature and date section was blank.The facility did not provide activity tracking for R1 from the community of life team.The facility did not provide a recent care conference summary for R2 or activity tracking for R2 from the community of life team.The facility Behavioral Health Services policy dated 4/1/26, indicated a resident care plan will have person-centered, evidence-based, trauma-informed interventions. The policy directed the facility to provide meaningful activities to promote engagement and positive, meaningful relationships. The policy directed the facility to review and revise the care plan as needed, such as when interventions were not effective or when the resident experienced a change of condition.