

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure residents who required assistance during mealtime on a locked dementia unit had a dignified dining experience.</p> <p>Findings include:</p> <p>During observation on 2/24/25 at 5:18 p.m., nursing assistant (NA)-A and NA-N prepared the dining area and residents for a meal. NA-A was passing out desserts and drinks to a table with two residents, and NA-N was approximately ten feet away near the steam table. NA-A stated to NA-N, with two tables of residents in between them, to set-up all the feeders first.</p> <p>During interview on 2/24/25 at 5:38 p.m., NA-N stated they usually served residents who needed assistance last so they could assist them right away, but they had extra help so could assist those who needed help first. NA-N acknowledged NA-A used the term feeders and stated the term was wrong to use and they could have used a better term instead. NA-N stated private information was usually discussed one to one and not across the room but sometimes comments were made from across the room in the memory care area. NA-N stated there were approximately five residents who needed assistance with eating.</p> <p>During interview on 2/27/25 at 10:36 a.m., NA-I stated feeders was a term for babies and did not use the term. NA-I stated residents on the memory care area may not respond to someone who used the term feeders but it may make the residents feel like they were babies.</p> <p>During interview on 2/27/25 at 11:00 a.m., licensed practical nurse (LPN)-E stated the term feeders was not a good one, and the term would make residents feel bad. LPN-E compared the term to how staff used clothing protector instead of bib.</p> <p>During interview on 2/27/25 at 2:43 p.m., the director of nursing (DON) agreed use of the term feeders was not dignified.</p> <p>A provided care sheet dated 2/25/25, identified a total of six residents needed assistance of one with eating.</p> <p>A provided Standards of Care Guidelines dated 7/2019, directed staff to care for residents in a manner which promoted maintenance, dignity, or enhancement of each person's quality of life.</p>

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: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>44656</p> <p>Based on observation, interview and document review, the facility failed to ensure complaint investigations for 2024 and 2025 and any plans of correction in effect with respect to the facility, and posting of notice of availability of such reports were posted in areas of the facility that were prominent and accessible to the public. This had the potential to affect all 155 residents, families and visitors who may have wished to review the information.</p> <p>Findings include:</p> <p>According to the Federal database Automated Survey Processing Environment (ASPEN) in 2024, the facility had in person complaint investigations on 5/1/24, 5/31/24, 6/13/24, 7/12/24, 8/19/24, 10/1/24, 10/30/24, 12/11/24, and 1/15/25. Per ACO deficiencies were issued for 10/1/24.</p> <p>During observation and review on 2/25/25 at 10:31 a.m., a three-ring binder titled Survey Results was posted inside facility entrance in a wire basket 60 inches off the ground.</p> <p>During observation and interview with R42 on 2/25/25 at 10:48 a.m., R42 was wheeling self into facility through entrance door and stated, [survey results binder] is out of reach to anyone who does not have the ability to stand up.</p> <p>During observation and interview with R10 on 2/25/25 at 1:25 p.m., R10 wheeled self into facility through entrance door and stated, No, I can't reach that. I would have to ask someone to get that for me if I wanted to look at it.</p> <p>During observation and interview with R265 on 2/25/25 at 1:39 p.m., R265 wheeled self into facility through entrance door and stated, No I would not be able to reach that binder there. It is too high off the floor.</p> <p>During observation and interview with social serviced director (SSD) on 2/25/25 at 2:29 p.m., SSC stated the survey results binder is, probably not within reach of anyone in a wheelchair unless they ask someone for it.</p> <p>During observation and interview with facility administrator on 2/25/25 at 2:49 p.m., the administrator stated he was responsible for delegating the task of posting the survey results. The administrator stated, probably not when asked if a resident, visitor, or staff in wheelchairs were able to reach and review the survey results. The administrator stated, I don't know why I moved that [wire rack containing the survey results] up. Should be lowered to within reach. During review of the facility's survey results, the administrator stated, I don't see the results of any complaint surveys for 2024 and last month [January 2025]. Should be in there.</p> <p>Facility policy on posting of survey results was requested and not received.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034</p> <p>Based on interview and document review, the facility failed to ensure a resident's advance directives was accurately and consistently documented in the resident's electronic health record (EHR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the residents wishes would be followed in the event of a cardiac arrest. This resulted in immediate jeopardy for 1 of 33 residents (R84) whose code status was not accurately documented and was reviewed for advanced directives.</p> <p>The immediate jeopardy began on [DATE], when the POLST was signed indicating do not resuscitate (DNR) and a physician's order for R84 to have a full code status remained. The immediate jeopardy was identified on [DATE]. The assistant director of nursing (ADON) and director of nursing (DON) were notified of the immediate jeopardy on [DATE], at 7:40 p.m. The immediate jeopardy was removed on [DATE], however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (level D).</p> <p>Findings include:</p> <p>R84's admission Minimum Data Set (MDS) dated [DATE], indicated R84 had intact cognition and had been admitted to the facility on [DATE].</p> <p>R84's Transfer/Admission orders dated [DATE], indicated R84's code status was a full code with the page signed by the provider on [DATE]. The report then indicated a copy of a signed POLST was still needed and this would need to be done by a provider, with the page signed on [DATE].</p> <p>R84's POLST dated [DATE], indicated DNR/allow natural death and was signed by R84 and nurse practitioner (NP)-A on [DATE]. This POLST was found in both the EHR and paper chart with no further POLSTs found.</p> <p>R84's progress note dated:</p> <p>-[DATE] at 3:20 p.m., indicated data was collected for R84's admission by nursing staff and R84's code status was DNR.</p> <p>-[DATE] at 3:17 p.m., indicated R84's advanced directive could be found on her POLST and had the code status was DNR.</p> <p>-[DATE] through [DATE] were reviewed and lacked documentation to support the resident wished to receive CPR if she was found with no pulse and was not breathing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R84's provider note dated [DATE], indicated R84 had recently moved to the facility from her home in the community due to an increased level of care need. The note indicated R84 was a Jehovah's Witness and was excited to talk with another Witness who lived in the building. The note listed R84's code status as DNR. The note indicated R84 was diagnosed with diabetes, a heart arrhythmia (the heart beats with an abnormal rhythm), and obstructive sleep apnea (OSA, repeatedly stopping and starting breathing while sleeping).</p> <p>R84's care plan dated [DATE], indicated R84's code status could be found on her POLST and the goal of the care plan was to have her code status wishes honored. The care plan indicated that code status would be reviewed quarterly and as needed with the resident/resident representative. The care plan indicated R84 followed Jehovah's Witness practices, and the facility would help to coordinate visits with spiritual leaders from the same faith.</p> <p>R84's Care Conference Summary dated [DATE], indicated a care conference was held with R84 attending. The note indicated R84's advance directives were reviewed with her, and no changes were needed to the DNR status.</p> <p>R84's order summary dated [DATE], included an order, code status: full code, that was dated [DATE].</p> <p>R84's EHR banner, printed on [DATE], indicated R84's code status was full code.</p> <p>R84's clinical profile in the EHR, printed on [DATE], indicated R84 was her own representative.</p> <p>During an interview on [DATE] at 4:01 p.m., R84 confirmed she would not want to be resuscitated if she was found with no pulse and was not breathing. R84 stated she was one of Jehovah's Witnesses as part of her religious belief she would want to enter the future world if it was her time and would not want to suffer by being resuscitated.</p> <p>During an interview on [DATE] at 4:09 p.m., licensed practical nurse (LPN)-B stated he was not R84's nurse but if a resident was found pulseless and not breathing, he would look at the POLST in the hard chart to determine if CPR should be initiated.</p> <p>During an interview on [DATE] at 4:37 p.m., LPN-A stated she was R84's nurse this shift and although both the POLST or the EHR banner could be referenced to determine code status, she would reference the EHR banner to see if R84 needed to be resuscitated because it was easier to access. LPN-A stated that R84 was a full code per the EHR banner and the provider order so she would initiate CPR if R84 was found pulseless and not breathing. When asked to review R84's POLST, LPN-A exclaimed ooooh and stated the POLST indicated R84's code status was DNR and believed this was the accurate code status. LPN-A stated she would be worried staff would perform CPR on R84 against her wishes because of the mismatch.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on [DATE] at 5:09 p.m., health unit coordinator (HUC)-A stated when a resident was admitted , she would reference the hospital paperwork or admit orders to determine the code status to enter into the EHR until a POLST was reviewed with the resident and signed by the provider. HUC-A stated she was in charge of uploading POLSTs to the EHR and updating the physician order/EHR banner after reviewing the POLST. HUC-A confirmed R84's EHR banner/provider order did not match R84's most recent POLST. HUC-A stated she thought R84's accurate code status was DNR. HUC-A stated she was unsure how updating the EHR banner/provider order was missed after R84's POLST was completed. HUC-A stated she was supposed to be completing audits every two weeks to ensure resident code status in the EHR matched the POLST. HUC-A stated these audits had not been completed since R84 had been admitted in January as she felt they were pretty short-staffed and did not feel she had time.</p> <p>During an interview on [DATE] at 5:09 p.m., LPN-C stated if a resident was found pulseless and not breathing, she would check their code status on the EHR banner, and if the banner said Full code, she would start CPR.</p> <p>During an interview on [DATE] at 6:19 p.m. with the director of nursing (DON) and the administrator, the DON stated if a resident was found pulseless and not breathing, staff could look at either the POLST or the EHR banner/provider order as they should all match, to determine if CPR should be initiated. The administrator stated that R84's profile or face sheet could be referenced to determine if the resident was her own representative and confirmed that she was. The DON stated that the HUCs were in charge of completing audits to ensure the POLST and the EHR banner/provider order indicating code status, matched. The DON stated as this was an informal process, the frequency of these audits did change based on results and the DON thought audits were being completed monthly. The DON stated the health information system supervisor (HISS) oversaw ensuring these audits were being completed. On [DATE] at 7:27 p.m., the DON stated she had reviewed her emails and confirmed that code status audits were to be completed every two weeks, not monthly, and these were not completed for the floor R84 resided so far this month.</p> <p>During an interview on [DATE] at 6:42 p.m., the HISS stated the HUCs were supposed to complete audits or resident code status every two weeks. HISS stated he and the DON had decided on the audit frequency when the HUC checklist was updated in January and confirmed that audits were to be completed every two weeks to ensure EHR code status accuracy.</p> <p>During an interview on [DATE] at 7:29 p.m., the social services director (SSD) stated social workers reviewed code status wishes with residents at their care conferences and would review the POLST to see if it needed to be updated to honor the resident wishes. The SSD confirmed that R84 had wished to be DNR on her care conference on [DATE] and was her own decision-maker.</p> <p>During an interview on [DATE] at 1:30 p.m., registered nurse (RN)-C, the staff development coordinator stated she had assisted in educating staff members on the advance directive process. RN-C stated either the HUC, if working, or the nurse on duty would be in charge of ensuring when a new POLST was obtained, that the EHR banner/provider order matched the updated POLST.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on [DATE] at 9:42 p.m., NP-A stated that on [DATE], she had a conversation with R84, as she was her own decision-maker, about her wishes in the circumstance that her heart stopped beating and she stopped breathing. NP-A stated R84 indicated she would not want to be resuscitated related to her religious beliefs. NP-A stated that it was important that R84's wishes to allow a natural death were honored as CPR would be a violent death for R84 and R84 had made it clear she did not want a violent death. NP-A stated once she completed a POLST with a resident she would attach it to the resident's hard chart for the HUC to upload but did not go in herself and verify that the provider order matched the updated POLST as she expected the HUC to do this. NP-A stated after the communication error involving R84's code status order being a full code instead of being updated to a DNR, she would now ensure the EHR provider order matched the POLST after she completed a POLST with a resident.</p> <p>The undated HUC Job Description, indicated the HUC would complete daily, weekly, and monthly audits as directed.</p> <p>The HUC Duties Checklist revised on [DATE], indicated POLSTs were to be audited every two weeks, on the first and third Friday of every month.</p> <p>The facility's Advanced Care Planning and POLST policy dated ,d+[DATE], indicated when the need for resuscitation occurred, the physician order, CPR/DNR section of the health care directive, and/or the POLST would be followed. The policy indicated if a resident was admitted with a signed POLST, it would be honored during the initial assessment period and a designated staff member must review the POLST with the resident as soon as possible to ensure its accuracy. The policy indicated the physician would review the POLST with the resident within the 14-day assessment period as part of the comprehensive assessment.</p> <p>The facility's Cardiopulmonary Resuscitation policy dated ,d+[DATE], indicated that if a resident experienced cardiac arrest, facility staff would provide basic life support, including CPR in accordance with the resident's advanced directives.</p> <p>The immediate jeopardy that began on [DATE], was removed on [DATE] when the facility developed and implemented a systematic removal plan. The removal plan was verified through interview and documented review as the facility had corrected R84's code status on the EHR banner/provider order to DNR, completed a facility-wide audit to ensure there were no other code status discrepancies, reviewed related policies and procedures, and provided education for all staff involved in ensuring advance directives were honored on the CPR and POLST policies/procedures and their respective roles in the process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0583</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>44656</p> <p>During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This had the potential to affect all 72 residents of the second and third floor whose personal information was listed on exposed care sheets.</p> <p>Findings include:</p> <p>During continuous observation on 2/24/25 starting at 3:24 p.m., licensed practical nurse (LPN)-A locked the medication cart, closed the laptop screen, and left the medication cart with 2 North nurses' worksheet unattended face up. Information included name, room number, sleep/wake preferences, assistance needed with dressing, grooming bathing, toileting, including continence of bowel and bladder, turning assistance needed, mobility devices, diet, assistance needed with meals, skin integrity issues such as wounds, and personal interests such as puzzles, music, religious services, and reading books.</p> <p>-at 3:31 p.m., two staff members walked past the unattended care sheet.</p> <p>During observation and interview at 3:43 p.m., LPN-A walked back to the medication cart with unattended care sheet and stated, the care sheet should not be left like that because people could look at the private information and care sheet has their [resident] name and it has patient identifying information. HIPAA problem.</p> <p>During continuous observation on 2/25/25 at 8:12 a.m., a medication cart was observed with 2 South nurses' worksheet unattended face up. Information included name, room number, sleep/wake preferences, assistance needed with dressing, grooming bathing, toileting, including continence of bowel and bladder, turning assistance needed, mobility devices, diet, assistance needed with meals, skin integrity issues such as wounds, and personal interests such as puzzles, music, religious services, and reading books.</p> <p>-at 8:14 a.m., a housekeeper pushing a cart walked past the unattended worksheet.</p> <p>-at 8:15 a.m., a resident with wheeled walker walked past the unattended worksheet.</p> <p>-at 8:18 a.m., a staff member walked past the unattended worksheet.</p> <p>-at 8:26 a.m., another staff member walked past the unattended worksheet.</p> <p>During observation and interview at 8:32 a.m., registered nurse (RN)-B walked up to the medication cart with unattended worksheet and stated, [care sheet] should not be left like that because it has private information that should not be seen by anyone except me.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0583</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During interview with director of nursing on 2/27/25 at 10:35 a.m., DON stated the nursing care sheets, should be flipped [sic] over and not visible to unauthorized staff. DON stated, it's a constant battle and facility was leaving reminders around to staff to cover unattended patient identifying information.</p> <p>Facility policy on privacy practices was requested and not received.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925</p> <p>Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene cares (i.e., nail care, showering, facial hair removal, personal cares, dressing assistance) were offered and/or completed for 4 of 6 residents (R62, R37, R112, R64) reviewed for activities of daily living (ADLs) and whom were dependent on staff for such cares.</p> <p>Findings include:</p> <p>R62</p> <p>R62's annual MDS, dated [DATE], identified R62 had intact cognition and had multiple medical conditions including progressive neurological disease, multiple sclerosis (MS), and malnutrition. Further, the MDS identified R62 demonstrated no rejection of care behaviors and required substantial/maximal assistance with personal hygiene cares.</p> <p>R62's most recent Body Audit 11-15-V8, dated 2/21/25, identified R62 had a bed bath completed and listed a section which read, Nails. The section had questions to be answered by staff about what, if any, cares were completed. This identified R62's fingernails were clean and trimmed, and R62 had allowed the care to be completed.</p> <p>However, on 2/24/25 at 12:51 p.m., R62 was observed lying in bed while in his room. R62 was dressed in a hospital-style gown and had a bedside table pulled over himself at waist level with an opened can of Dr. Pepper on top. R62 had visibly long, soiled fingernails present on both hands with his left hand having black-colored debris around each nail fold (where skin meets nail), and several nails being multiple millimeters (mm) in length. R62 was asked about his nails and looked at them, then expressed aloud, I want them cleaned. R62 stated he was unsure when his nails were last clipped but expressed he got a weekly bed bath. R62 reiterated he wanted his nails clipped and cleaned when asked.</p> <p>R62's care plan, printed 2/26/25, identified all of R62's actual or potential problem statements along with corresponding interventions for them. The care plan identified R62 had an ADL self-care deficit and was on hospice care. The care plan outlined R62 preferred to have a bed bath twice weekly and directed, PERSONAL HYGIENE: Requires substantial/maximal assistance of 1 staff to complete. The care plan lacked any information on R62's nails, including any identified length preference, or evidence R62 refused nail care to be completed.</p> <p>On 2/26/25 at 9:33 a.m., R62 was again observed in bed. R62's nails remained long on both hands, however, the debris which had been present on 2/24/25 (two days prior) appeared lessened. R62 was again asked about his nail length and responded aloud, They could take care of it [clip them].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Following, on 2/26/25 at 9:34 a.m., nursing assistant (NA)-B was interviewed and stated R62 needed total help with cares. NA-B explained the unit had a bathing schedule but NA-B stated they had not helped him with bathing recently. NA-B stated they were unsure where nail care, if offered and refused, would be documented adding aloud, I don't know. NA-B then observed R62's fingernails and described them as long and kinda dirty, adding further, It needs work. NA-B stated R62's wife visited a few times each week and also, at times, would clip them and clean them.</p> <p>R62's medical record was reviewed and lacked evidence R62 had been offered or had his nails clipped and/or cleaned since 2/21/25, despite having visibly long and soiled nails on both hands which was verified by staff observation.</p> <p>On 2/26/25 at 9:38 a.m., licensed practical nurse (LPN)-D was interviewed, and stated R62 was total care and on hospice services. LPN-D stated they had noticed R62 seemed to be refusing more cares more recently and observed R62's fingernails at the request of the surveyor. LPN-D stated R62 had been eating chocolate and that was the reason for them to appear soiled, and expressed they believed hospice had just clipped them the week prior. However, LPN-D acknowledged their appearance and expressed aloud, They look like they need to be trimmed. LPN-D stated nail care should be completed with baths adding and PRN [as needed]. LPN-D verified if nails were long, they could be clipped whenever needed. LPN-D continued and explained another NA had noticed them long the day prior, however, was unable to locate a clippers to address them. LPN-D then stated they felt R62's nails were not extremely long for him and thought they were looking fine on Monday [2/24/25; also when observed by the surveyor]. LPN-D stated nail care wasn't charted by the NA staff but staff should look at everybody, everyday. LPN-D stated nails should be kept clean and trimmed so they [resident] don't scratch themselves.</p> <p>Later, on 2/26/25 at 10:17 a.m., LPN-D approached the surveyor and expressed nail care was charted in the completed Body Audit forms and, again, reiterated someone had clipped them the week prior to their recall. However, LPN-D stated they had just clipped R62's nails prior, and he allowed some of the nails to be addressed. R62's corresponding progress note, dated 2/26/25 at 10:07 a.m., identified text which read, [R]esident allowed staff to cut nails on left hand and refused nails to be cut on the left [sic] hand.</p> <p>On 2/26/25 at 1:14 p.m., the assistant director of nursing (ADON) was interviewed. ADON explained nail care should be completed on bath days or when needed. ADON stated the NA should be checking nails with provision of cares and addressing it then, if needed, adding aloud such was part of the daily cares. ADON stated if R62 consumed chocolate regularly causing his nails to be soiled, then they could also outlined such within his care plan. ADON stated nails should be kept trimmed and clean as someone could scratch themselves or cause infection. ADON added, Dignity is number one [reason].</p> <p>A facility' provided Standards Of Care Guidelines policy, dated 7/2019, identified a section labeled, Care of Body, which directed bathing should be completed as scheduled along with, G. Assure fingernails are kept clean.</p> <p>48299</p> <p>R37</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R37's annual Minimum Data Set (MDS) dated [DATE], indicated R37 had moderately impaired cognition, delusions, verbal behavioral symptoms directed towards others and not directed towards others, and did not reject cares. The MDS indicated diagnoses which included dementia, anxiety, depression, bipolar disease, and psychotic disorder. The MDS indicated R37 required partial and/or moderate assistance with shower and/or bathing self and setup or clean-up assistance with personal hygiene, which included shaving.</p> <p>R37's care plan printed 2/25/25, indicated R37 required assistance with bathing and was setup/clean-up assistance for personal hygiene. R37's care plan lacked information regarding R37's preference on chin hair and did not indicate R37 refused cares, besides wearing hearing aids appropriately.</p> <p>During observation and interview on 2/25/25 at 2:14 p.m., R37 had approximately 10 gray and brown colored hairs on their chin and stated I do not like it about the hair on their chin.</p> <p>During observation on 2/26/25 at 11:00 a.m., R37's chin hair remained the same.</p> <p>During observation on 2/27/25 at 10:27 a.m., R37's chin hair remained the same.</p> <p>R112</p> <p>R112's quarterly MDS dated [DATE], indicated R112 had short and long-term memory problems, severely impaired cognitive skills for daily decision making, inattention, and disorganized thinking. The MDS indicated R112 had verbal behavioral symptoms directed toward others and not directed toward others and rejected cares daily. The MDS indicated R112 had Alzheimer's disease, dementia, depression, and post-polio syndrome (condition which can affect people who have had polio and causes gradual muscle weakness and muscle loss). The MDS indicated R37 had impairment to both lower extremities, used a wheelchair, and was dependent on staff for shower/bathing self and required substantial/maximal assistance with personal hygiene.</p> <p>R112's care plan printed 2/27/25, indicated R112 required assistance with personal hygiene and showers/bathing. The care plan indicated R112 refused cares, showers, and yelled and swore at staff when they attempted to change R112's clothing or visibly soiled brief. The care plan directed staff to provide redirection when R112 had behaviors. The care plan lacked direction or preferences about R112's facial hair.</p> <p>R112's electronic medical record recorded R112 had a shower on 2/13/25, and lacked documentation of R112's chin hair. R112's record further lacked information on whether R112 had a shower or any refusals of shower or chin hair removal after 2/13/25.</p> <p>During observation on 2/24/25 at 5:08 p.m., R112 was in their wheelchair and had a thick amount of multiple chin hairs. R112 was not interviewable.</p> <p>During observation on 2/25/25 at 8:26 a.m., R112's chin hairs were unchanged. A second interview was attempted, and R112 was not interviewable.</p> <p>During observation on 2/27/25 at 10:26 a.m., R112's chin hairs were unchanged.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 2/27/25 at 10:42 a.m., nursing assistant (NA)-I stated if staff saw chin hair on female residents, they took care of it since most residents were not able to shave themselves in the memory care area. NA-I stated they reapproached, reassured, and asked another staff person to help if a resident refused care. NA-I stated they reported to the nurse if reapproaching and reassuring did not work. NA-I stated they did not work with R37 often and had never shaved R37. NA-I confirmed R37's chin hair and stated staff should document if R37 refused shaving when showered, and R37 did not refuse cares. NA-I stated R112 did not refuse cares but had behaviors of yelling and screaming while staff assisted with cares. NA-I stated staff can shave R112 and did not work with R112 this morning. NA-I confirmed R112's chin hair, and stated staff could shave R112.</p> <p>During interview on 2/27/25 at 11:12 a.m., licensed practical nurse (LPN)-E stated staff documented in resident's medical record if a shower was refused, and staff were to shave female residents' chin hair when noticed. LPN-E confirmed R112's chin hair and stated R112 tried to kick and hit staff away when they helped with cares. LPN-E confirmed R37's chin hair and stated LPN-E did not notice the chin hair from a distance away and did not think R37 would refuse to shave.</p> <p>During interview on 2/27/25 at 12:55 p.m., NA-H stated they reapproached residents who refused care one or two times, asked another coworker to try, and then told the nurse. NA-H stated the facility had an electric shaver and blade they used for shaving. NA-H stated R112 refused cares, screamed and yelled at staff. NA-H stated they tried to shave R112 yesterday, and R112 refused. NA-H was not sure why R112 refused and stated cares depended on R112's mood. NA-H confirmed R37 had a shower yesterday and stated staff were supposed to shave residents on their shower day. NA-H stated R37 refused cares some days.</p> <p>During interview on 2/27/25 at 1:28 p.m., registered nurse (RN)-E stated they documented in resident's body audits if they refused shower or shaving. RN-E confirmed R112 did not have a documented body audit or documentation R112 refused shaving after 2/13/25. RN-E stated R37 had a body audit documented on 2/26/25, and did not indicate if R37 refused shaving.</p> <p>During observation and interview on 2/27/25 at 1:49 p.m., R112 did not have chin hairs. NA-G stated R112 yelled during cares but was cooperative. NA-G stated R112 tried to push their hand away, and then R112 allowed NA-G to shave them. NA-G stated R112 allowed cares if staff started the cares and did not approach R112 from the front or explain the cares to R112.</p> <p>During joint interview on 2/27/25 at 2:14 p.m. with the director of nursing (DON) and assistant director of nursing (ADON), the DON expected staff to give residents showers weekly and shave female chin hair. The DON expected staff to document refusals, and care planned those who refused cares or shaving of chin hairs. The ADON stated staff followed R112 while R112 wheeled self in wheelchair and R112 refused cares. The ADON expected staff to reapproach R112 when cares refused. The DON expected staff to document if R37 refused to shave chin hair when showered, and residents needed to look clean and presentable.</p> <p>A facility provided Standards of Care Guidelines policy dated 7/2019, identified a section labeled, Care of Body, which directed bathing should be completed as scheduled along with, E. Female residents should be assisted as needed with shaving.</p> <p>51567</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R64</p> <p>R64's Minimum Data Set (MDS) dated [DATE], indicated moderate impaired cognition, diagnoses of dementia, schizoaffective disorder, bipolar and received antipsychotics on a routine basis. R64 needed substantial/maximal assistance with toileting hygiene and self-cares, and had no documented rejection of cares.</p> <p>R64's care plan printed 2/27/25, indicated a self-care deficit and he was to be dressed and groomed according to personal preference daily as conditions allows. R64 required partial/moderate assist of one with upper and lower body dressing and supervision/touching assistance of one for personal hygiene. R64 preferred showers at 3:00 p.m., and required assist of one to wash/dry. Nursing assistants were to provide sponge bath on days shower cannot be tolerated, and observe and report changes in skin conditions. Nurse was to provide nail care. Furthermore, the care plan indicated R64 was continent of bowel and bladder, and independent with toileting and hygiene.</p> <p>R64's progress notes dated 2/6/25, indicated resident received a shower, but did not require nail care.</p> <p>R64's progress notes dated 2/7/25, indicated resident walked out of the dining room to the carpeted area, pulled down his pants, and defecated on the floor. When staff intervened, R64 asked where the bathroom was.</p> <p>R64's progress notes skin audit dated 2/13/25, indicated R64 was showered, and that nails were clean and trimmed. Nail care was not needed.</p> <p>R64's nursing assistant task documentation lacked evidence of shower, sponge bath, or nail care from 2/14/25, through 2/26/25.</p> <p>R64's progress notes with nurse practitioner (NP)-A dated 2/19/25 indicated, writer also noticed pretty long nails and offered to trim, but patient declined.</p> <p>R64's progress notes skin audit dated 2/20/25, indicated resident was not given a shower and that nails were clean and trimmed, and nail care was not needed.</p> <p>R64's progress notes dated 2/26/25, indicated that registered nurse (RN)-D offered to trim nails, but resident refused nail care and resident would be added to the podiatry list.</p> <p>R64's Toileting task documentation dated 2/26/25, indicated he needed extensive assistance for bladder incontinence twice, at 3:02 a.m. and 12:46 p.m. No other toileting was documented this day.</p> <p>On 2/25/25 at 9:48 a.m., R64 was observed on the couch in the commons area with television turned on. His sweatshirt hood was pulled up, and he appeared to have full facial hair, and ungroomed nails one inch long with debris under the thumb and several fingernails on both hands. His long- sleeved blue hooded sweatshirt had wet or stained areas, his grey sweatpants had tears on the bottom, and his shoes were off and placed under table. R64 wore blue gripper socks and paced from the couch to the hallway.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/25/25 at 11:54 a.m., R64 was observed seated at the lunch table. His left leg was wet from groin to knee.</p> <p>On 2/25/25 at 1:07 p.m., R64 continued to pace unit, sweatpants continued to have darkened areas down his left leg. R64 smelled of urine. Staff were present around R64, but did not offer to toilet or assist R64.</p> <p>On 2/25/25 at 1:20 p.m., R64 was observed to lay/sit on couch. His right blue gripper sock had a hole in heel the size of a [NAME].</p> <p>On 2/25/25 at 2:13 p.m., R64 continued to pace the unit.</p> <p>During interview on 2/25/25 at 2:18 p.m., RN-D verified R64's bath day was Thursday afternoon., and had not noticed R64's torn sock.</p> <p>On 2/26/25 at 7:12 a.m., R64 was dressed in the same gray sweatpants tears on bottom of pant legs and a long sleeve, navy hooded sweatshirt as the previous day. His fingernails remained as previously described.</p> <p>On 2/26/25 at 11:22 a.m., R64 observed to be dressed in same outfit. No personal cares were documented.</p> <p>During interview on 2/26/25 at 11:35 a.m., with RN-D stated nursing assistants should be charting refused for nail care or not needed. She stated she would talk with the primary nurse this afternoon regarding nail care, and will also attempt to offer nail care after lunch.</p> <p>On 02/26/25 at 11:54 a.m., R64 was observed at lunch table wearing the same clothing and his left leg appeared wet.</p> <p>On 2/26/25 at 1:11 p.m., R64 was observed back on the couch after lunch wearing the same clothes and smelling of urine. The pant leg appeared almost dry, and his fingernails were approximate one inch long.</p> <p>During interview on 2/26/25 at 1:28 p.m., (NA)-F stated R64 was given a bath yesterday 2/25/25, however, nail care was not offered because it was not his regular bath day. NA-F stated, not gonna [sic] offer all the things as this shower was extra. NA-F verified that he changed R64's briefs this morning right before breakfast. NA-F stated the resident had a large bowel movement and was incontinent, put his hands up wide, and stated boom. NA-F verified that R64 didn't get his clothes changed every day because he refused, and he didn't have many clothes or allow for dressing. NA-F verified the shower was not documented. When asked what should be done if a resident refused to change clothes, NA-F stated there was nothing they could do about that. NA-F verified that he did not report R64 had been in the same clothes from 2/25-2/26 to the nurse, and stated nail care would be done on Thursday evenings by the nurse.</p> <p>During interview on 2/26/25 at 1:31 p.m., RN-D stated she was not aware a shower was given on 2/25, and confirmed R64 was dressed in the same clothing and had a urine odor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 2/26/25 at 1:47 p.m., assistant director of nursing (ADON) stated the expectation was that staff change residents' clothes if they were soiled or had an odor. If the resident would not allow clothes to be changed the staff member should re-approach. If it was a laundry issue the staff should talk with social work, and if the resident lacked clothing they would get the family involved. If a resident refused to change clothes, the staff member should get someone else to try and maybe there was a reason the resident didn't want that person offering to help. If the resident could not make the decision, it was the staff's responsibility to change them out of odorous and dirty clothes, and to explain to the resident the risk/benefits of being in soiled clothes if they refused. If the nursing assistant could not get the resident in clean clothes, next step is to talk to the nurse who could also get the family involved. It is the expectation that nursing assistant will ask the resident if they want a shower on designated bath day, and if the resident refused or was not available to receive a shower on designated day, the staff member would offer the shower at the next opportunity. Nail care should be offered with every shower and if resident refused nail care it should be documented as refused. If shower or nail care was completed it was also expected to be documented.</p> <p>On 2/27/25 at 8:18 a.m., R64 was observed to be seated at dining room table in flannel pajama pants, a blue shirt, and blue grip socks. At 10:10 a.m., R64 was seated at the couch. Fingernails continues to appear approximately one inch long with brown colored substance under more than half of the fingernails. No odor was present.</p> <p>Policy-Standard of Care Guidelines dated July 2019 directed, on page two under Care of Body- Part A. Cleanliness-bath/showers as scheduled. This includes body, nails ears, hair. Nails are to be trimmed weekly or more often as needed. Part G. Assure fingernails are kept clean.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925</p> <p>Based on observation, interview, and document review, the facility failed to ensure developed skin conditions were identified, assessed and acted upon in a timely manner to promote healing and reduce the risk of complication (i.e., infection, worsening) for 2 of 2 residents (R103, R158) reviewed who had skin impairments.</p> <p>Findings include:</p> <p>R103</p> <p>R103's admission Minimum Data Set (MDS), dated [DATE], identified R103 had intact cognition, demonstrated no delusional thinking, and was dependent on staff for dressing and bed mobility. Further, the MDS identified R103 had several medical complications including cancer and diabetes mellitus, but had no current skin impairments (i.e., ulcers, surgical wounds, lesions on the foot).</p> <p>R103's care plan, printed 2/25/25, outlined all of R103's identified potential or actual problems along with corresponding interventions. The care plan outlined R103 had a self-care deficit and needed assistance with lower body dressing, bathing, and bed mobility; R103 had a history of false accusations against the staff along with exaggerated statements (i.e., they left me in bed for 10 days); and R103 was at risk for actual skin impairments due to her impaired mobility, incontinence and diabetes mellitus. The care plan directed to keep her linens dry and wrinkle free along with, Skin Observation, and, Observe skin during cares. Report any changes to nurse.</p> <p>On 2/24/25 at 1:22 p.m., R103 was observed lying in bed while in her room. R103 was interviewed and expressed multiple concerns about her care while at the nursing home. R103 stated she had dry skin on her feet which wasn't being addressed adding aloud, I think they need to be looked at. R103's feet were observed and both feet had visibly dry, flaking and, at times, cracked skin on the soles of the feet extending up towards the ankle. R103 stated her feet were sore and that she had asked staff about them several weeks ago but there was little response from them adding, They feign interest and move on to something else. R103 stated there was no active treatment being done to them to her knowledge (i.e., lotion, medicated ointment) and reiterated she felt they needed to be addressed.</p> <p>R103's most recent Body Audit 11-15-V8, dated 2/19/25, identified R103 received a shower and had no skin impairments identified. R103's heels were recorded as, a. Firm.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 2/25/25 at 2:12 p.m., nursing assistant (NA)-C stated they had worked with R103 multiple times and explained R103 often, if not always, refused to get up from the bed. NA-C stated R103 only wanted female caregivers and the cares completed for her were mostly briefs [change] and the meals. NA-C explained staff did reposition her, at times, but it required always two people due to R103 having pain and needing so much assistance with turning. NA-C verified they had helped R103 with morning cares that day (2/25/25), however, when asked about the dry skin on her feet, NA-C responded they had not looked at them. NA-C stated nobody had told them about R103's feet being dry or needing lotion, and verified they only applied lotion when she [R103] ask. NA-C stated R103 had never asked them personally to apply lotion and reiterated they did not check the skin on her feet with morning cares adding aloud, No. NA-C stated the nurses were responsible to check the skin on the feet.</p> <p>R103's Treatment Administration Record (TAR), dated 2/2025, identified all of R103's current treatments ordered along with spaces for staff to record their administration or refusals. The TAR lacked any treatments or monitoring of R103's developed skin condition.</p> <p>On 2/25/25 at 2:19 p.m., licensed practical nurse (LPN)-D was interviewed. LPN-D stated they worked full-time during the week but had only once or twice I think seen R103's feet. LPN-D observed R103's feet and verified their condition but added aloud they were not dry like that last time they had seen them. LPN-D stated skin, including on the feet, should be checked weekly on bath day. LPN-D stated R103's care plan intervention to monitor skin during cares should include checking her feet adding aloud, It should, yes. LPN-D stated the medical record would have any assessed skin condition or subsequent interventions for them would be most likely in the Body Audit forms. LPN-D reiterated they had not seen her feet dry like that prior and expressed they were unsure how long they had been in such condition. LPN-D stated nobody had reported R103's feet skin condition to them, however, if they had then it would have been looked at and orders for treatment obtained. LPN-D reviewed R103's medical record, including TAR, and verified no active treatments or monitoring on R103's feet were being done. LPN-D stated they would update the medical provider and get an order for it. LPN-D stated they were unsure why a shower had been recorded (Body Audit 02/25/25) as R103 remained mostly in bed; however, expressed it was important to ensure a skin condition was acted upon timely as R103 was bariatric and had more possibilities for breakdown.</p> <p>R103's medical record was reviewed and lacked evidence R103's dry skin on her feet had been identified or acted upon until 2/25/25 despite R103 saying the condition had been present for several weeks, nor despite the care plan directing staff to check R103's skin with cares and direct care staff saying this had not been completed.</p> <p>On 2/26/25 at 1:03 p.m., the assistant director of nursing (ADON) was interviewed. ADON stated skin should be inspected daily while the NA is doing cares. If something abnormal was spotted, then it should be reported to the nurse. ADON stated R103 would, at times, refuse cares but acknowledged staff should look at everybody's skin with cares. ADON stated this was important to do as a skin condition could deteriorate and cause infection adding, So much worse things that can happen.</p> <p>51567</p> <p>R158</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R158's admission Minimum Dat Set (MDS) dated [DATE], identified R158 was cognitively intact and was diagnosed with diabetes mellitus. R158 was observed for one deep tissue injury in evolution and identified as at risk for pressure ulcers.</p> <p>R158's orders from 1/17/25, indicated nursing to complete a body audit every bath day and feet should be assessed weekly for skin integrity.</p> <p>R158's care plan revised on 1/28/25, included a diabetes focus area and instructed staff to observe feet daily for open areas, sores, pressure areas, blisters, edema or redness. The care plan also included R158 had a potential and actual impairment to skin integrity related to recent surgery and left heel deep tissue wound. The care plan indicated nursing assistants will keep linens dry, and wrinkle free, observe skin every shift and report changes to the nurse. Nurses were directed to perform weekly skin inspections and as needed.</p> <p>R158's Body Audit 11-15-V8 form included the following:</p> <p>2/7/25- R158 received a bed bath, documented alterations in skin integrity of a left heel pressure and right thigh (front) o/a healing.</p> <p>2/14/25- No Body Audit available.</p> <p>2/21/25- R158 received a shower, documented alterations in skin integrity of a left heel pressure injury. The audit lacked documentation regarding right thigh or right foot.</p> <p>2/28/25 R158 received a shower, documented alterations in skin integrity of a right thigh with an open lesion. The audit lacked documentation regarding an area on the right foot.</p> <p>R158's nursing assistant skin observation task documentation indicated R158 had no skin concerns from 2/15/25 through 2/25/25.</p> <p>During observation and interview on 2/24/25 at 7:20 p.m., R158 stated she had a painful area on the bottom of her right foot and an open area on her right thigh, and she rubbed a prescribed skin barrier cream on her right thigh routinely. The tube was cut in half, open to air, and stored in an exam glove. R158 stated she self-administered the cream without hand hygiene and kept the cream on her side table. R158 stated staff was aware of the open area on the right thigh, but hadn't looked at the right foot.</p> <p>During interview on 2/25/25 1:41 p.m., R158 stated registered nurse (RN)-D was in her room and assessed her left toes that caused discomfort but overlooked the bottom of the right foot. RN-D was asked to return to the room by R158. When asked if there were any skin concerns RN-D touched the left toes. RN-D was not aware R158 felt discomfort on the bottom of the right foot or aware of the open area on her right thigh. RN-D assessed and measured both areas and announced the next step was to notify the nurse practitioner (NP)-B for treatment orders. RN-D informed R158 not to use the cream on her side table and tossed the cream in the trash can. RN-D verified there were no foot cushions or wedges to float heels for positioning and no orders stating to do so.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R158's progress notes from 2/25/25 at 2:00 p.m., indicated skin on the bottom of the right foot was slightly raised with a firm area that measured 1.5 centimeter (cm) long by 0.5 cm wide. R158 reported sensation on the bottom of the right foot. The note indicated a second area on top of the right thigh measured 0.5 cm and was described as a round, dry scab. R158 reported applying her own personal white cream that was discarded by the nurse. A message was left for the nurse practitioner with information regarding the skin concerns.</p> <p>During observation and interview on 2/26/25 at 7:46 a.m., RN-D entered R158's room and assessed her right foot, applied cream to the right thigh, and explained the cream to be a skin barrier. A cushion was observed in the corner of the room. RN-D verified it was for positioning, unopened and brand new. At 8:03 a.m., R158 asked RN-D to put a pillow under her right leg to elevate her foot off the bed. RN-D was not aware of any floating heels or wedges that were care planned for this resident, and confirmed NP-B had not entered orders regarding the two areas identified on 2/25/25.</p> <p>During interview on 2/26/25 at 8:17 a.m., nursing assistant (NA)-O stated they checked on R158 at 8:00 a.m. and offered to reposition and change resident. R158 refused because the night shift repositioned her before they went home. NA-O stated they understood what pressure relieving support devices were and why they were important but had not performed any cares for the resident, and was not aware of any skin concerns or positioning devices care planned for R158.</p> <p>During observation and interview on 2/26/25 at 11:37 a.m., R158's sheets were straightened, she was visibly repositioned with head of bed approximately at 75 degrees, and pillows were positioned under both feet.</p> <p>During interview on 2/27/25 at 10:08 a.m., RN-D stated only nurses did skin checks, not the nursing assistants.</p> <p>During interview at 2/27/25 at 10:12 a.m., nursing assistant NA-P stated they were in R158's room a few times to offer morning cares and a bedding change, but R158 refused. NA-P confirmed they repositioned R158 today, moved her shoulder, and gave her a boost up in bed. NA-P stated, she rubbed lotion on both her feet because they were dry and sore. NA-P stated, she was not aware of any skin concerns or positioning care planned for R158 and would not provide cares differently for any of the assigned residents. NA-P further explained the care sheet indicated treatment plans and verified she was not aware of any skin concerns with R158. NA-P stated, R158 didn't have any skin concerns, only a callus on the bottom of her foot. R158 complained of dry skin, and no painful areas.</p> <p>During interview on 2/27/25 at 10:30 a.m., RN-D pointed to R158's right foot and stated, this would be concerning. RN-D verified no assessments or notes pertaining to the right foot were documented prior to 2/25/25. RN-D verified with R158 her right foot has been hurting for over a week. R158 stated she couldn't see the bottom, and no one has looked at her foot. The open area on her right thigh has been present since she arrived at the facility. RN-D verified a verbal order was taken for both the right foot and right thigh.</p> <p>During interview on 2/27/25 at 10:45 a.m., staff development, registered nurse (RN)-C stated, nursing assistants were trained to notice changes with residents and report those changes back to the nurse. The cares provided were not based on the resident's diagnosis. RN-C confirmed if a nursing assistant rubbed lotion on a resident's foot with a sore area, it should be reported to the nurse and documented on their skin observation task sheet.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R158's Progress Notes from 2/27/25 at 2:13 p.m., indicated a skin concern on the bottom of the right foot was pink, intact, and firm and had a pink area noted underneath. A small round area on top of the right thigh was cleansed with wound cleanser and no drainage was noted. Bacitracin and dressing applied to a shallow area.</p> <p>R158's orders transcribed from verbal order at 2/27/25 at 4:00 p.m., indicated right foot, monitor area twice a day and call nurse practitioner if area opens or changes.</p> <p>R158's orders transcribed 2/28/25 at 8:00 a.m., indicated right thigh wound care. Area should be cleansed with wound cleanser and apply bacitracin ointment, cover with a border dressing.</p> <p>R158's progress notes from 2/28/25 at 9:33 p.m., indicated resident received a shower and had no skin issues documented on the feet or thigh.</p> <p>Skin Management Program Policy, revised 9/22 indicated that body audits completed upon admission and weekly by licensed staff, preferable on bath day and as needed (PRN) for changes in skin integrity. Comprehensive skin and positioning evaluation completed upon admission quarterly, annually and with changes in condition. Interventions included daily skin observations with cares.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to implement planned fall interventions for 1 of 2 residents (R125) reviewed for falls.</p> <p>Findings include:</p> <p>R125's quarterly Minimum Data Set (MDS) dated [DATE], identified R125 had moderately impaired cognition and had diagnoses which included cancer, hip fracture, other fracture, personal history of traumatic brain injury, and history of falling. The MDS indicated R125 required substantial and/or maximal assistance with toileting hygiene and transfers. The MDS indicated R125 had two or more falls with no injury since prior assessment.</p> <p>R125's care plan printed 2/24/25, indicated R125 had limited physical mobility with fall risk related to history of falls, and falls were anticipated related to impulsivity, cognition, multiple attempts to self-transfer, and incontinence. Interventions included auto-locking brakes to wheelchair, gripper socks or shoes on at all times, keep wheelchair at bedside when in bed, and identified R125's mobility and transfer needs.</p> <p>R125's nursing assistant care plan sheet updated 2/25/25, indicated R125 was a fall risk and required bilateral grab bars, auto lock brakes, gripper socks, and lock and keep wheelchair at bedside.</p> <p>Review of R125's most recent fall progress notes from 12/1/24 to 2/25/25, identified the following:</p> <p>-12/16/24 at 12:09 p.m., indicated R125 was found sitting on floor in room next to wheelchair with no sign of injuries.</p> <p>-12/17/24 at 8:22 a.m., indicated a Post Fall Data Collection for fall on 12/16/24 at 12:00 a.m. R125 was found on the floor in their room next to transfer surface with no apparent injury. R125 attempted to self-transfer prior to the fall. Intervention: keep mobility device at bedside.</p> <p>-12/19/24 at 7:49 p.m., indicated R125 was found on floor in their room, and R125 stated they attempted to self-transfer and the floor was slippery. The bed was lowered to the lowest position, R125 was reminded to use call light for assistance, and the call light was placed within reach.</p> <p>-12/19/24 at 7:51 p.m., indicated a Post Fall Data Collection for fall on 12/19/24 at 6:45 p.m R125 was found on floor in their room next to transfer surface with wheelchair and/or bed brakes unlocked and no apparent injury. R125 did not activate call light and attempted to self-transfer prior to fall. Intervention: keep mobility device at bedside.</p> <p>-12/21/24 at 11:59 a.m., indicated a Post Fall Data Collection for fall on 12/21/24 at 8:45 a.m R125 was found on floor in their room next to transfer surface with no apparent injury. R125 rolled and/or slid out of bed prior to the fall. Intervention: bed adjusted to appropriate height.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-12/21/24 at 12:22 p.m., indicated R125 was found on floor lying on their right side in the room by bedside. R125 stated they attempted to self-transfer and lost balance. Bed was in lowest position, call light was within reach, and resident re-educated to use call light for help.</p> <p>-12/26/24 at 8:53 p.m., indicated R125 was found sitting on the floor hanging onto their wheelchair with no apparent injury. Intervention: continue customer rounds.</p> <p>-12/26/24 at 8:56 p.m., indicated a Post Fall Data Collection for fall on 12/26/24 at 5:30 p.m R125 was observed on floor in their room with no apparent injury and attempted to self-transfer prior to fall. Intervention: Other fall intervention: [nursing assistant] care plan sheets were reviewed and no changes indicated.</p> <p>-1/13/25 at 5:31 p.m., indicated R125 was found sitting on the floor next to their wheelchair around 4:59 pm with no injury. R125 attempted to self-transfer to wheelchair.</p> <p>-1/13/25 at 5:38 p.m., indicated a Post Fall Data Collection for fall on 1/13/25 at 4:59 AM. R125 was observed on floor in their room next to transfer surface. R125 did not activate call light, had socks on, and was not wearing proper footwear. R125 attempted to self-transfer prior to fall. Intervention: Other fall intervention: [nursing assistant] care plan sheets were reviewed and no changes indicated.</p> <p>-2/23/25 at 12:15 a.m., indicated a Post Fall Data Collection for fall on 2/23/25 at 12:15 a.m R125 was found on floor at bedside, had bare feet, and had an abrasion (scrapes and scratches) and a laceration (deep cut). R125 was incontinent of urine when assessed following the fall, and attempted to self-transfer and rolled and/or slid out of bed. Intervention: bed adjusted to appropriate height and gripper socks or shoes at all times.</p> <p>-2/23/25 at 2:22 a.m., indicated R125 was found sitting on the floor by bedside and wheelchair and was holding onto the grab bar. R125 had a laceration by their eyebrow and right elbow. Intervention: 72 hour post fall vital signs and neurological exam (tests to monitor mental status, motor function, sensory function, reflexes, and coordination), gripper socks on, monitor eyebrow and elbow daily for signs and/or symptoms of any complication.</p> <p>During observation on 2/25/25 at 12:51 p.m., R125 was in their wheelchair near the dining area. R125 had on gripper socks, and the wheelchair did not appear to have anti-rollback brakes.</p> <p>During observation on 2/25/25 at 2:08 p.m., R125's wheelchair was not next to their bed and across the room out of reach, facing towards their dresser. R125's wheelchair did not appear to have anti-rollback brakes.</p> <p>During observation on 2/25/25 at 2:26 p.m., R125's wheelchair was in the same position.</p> <p>During observation on 2/25/25 at 2:55 p.m. to 2:56 p.m., R125's wheelchair was in the same position, and a nursing assistant walked by R125's room.</p> <p>During observation on 2/25/25 at 3:06 p.m., R125's wheelchair was in the same position.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 2/25/25 at 3:15 p.m., trained medication assistant (TMA)-A stated they notified the nurse when a resident fell , and the nurse completed documentation about the fall. TMA-A stated they monitored everyone for falls in the memory care area. TMA-A stated R125 was a fall risk and tried to self-transfer to use the bathroom by themselves, and fall interventions for R125 included to assist R125 to bed after lunch, check on R125, and ask if R125 needed to use the bathroom. TMA-A stated fall interventions were listed on care plan sheets. TMA-A entered R125's room, and R125 was standing up next to their bed with their back towards the bedside table and hands holding onto the bedside table. R125 had gripper socks on and shoes of a soft material. One of the shoes was not connected at a seam. TMA-A moved the wheelchair, which was next to the dresser, assisted R125 to sit in their wheelchair, and offered R125 to use the restroom. TMA-A assisted R125 to the hallway where other residents were, and R125's shoes remained on. TMA-A verified the wheelchair placement away from the bed and by the dresser and stated they kept the wheelchair away from the bed so R125 was not tempted to self-transfer.</p> <p>During observation and interview on 2/25/25 at 3:42 p.m., nursing assistant (NA)-J stated they pulled the emergency light, put a pillow under the resident's head, and called for help when they found a resident on the floor. NA-J stated they know residents' fall interventions by the paper care plan and report from nursing staff. NA-J stated they had checked on R125 around 2:50 p.m., and R125 was in bed. NA-J stated R125 was a fall risk, attempted to self-transfer, and staff were supposed to keep the wheelchair at bedside. NA-J was not sure if R125 had auto-lock brakes on their wheelchair or not. NA-J brought R125 to their room to check for auto-lock brakes with R125's permission. NA-J and TMA-A applied a gait belt to R125, assisted R125 to stand, unlocked the wheelchair, and pushed the wheelchair backwards. NA-J confirmed R125's wheelchair did not have auto-lock brakes and assisted R125 back into their wheelchair.</p> <p>During interview and document review on 2/25/25 at 4:03 p.m., licensed practical nurse (LPN)-E stated they documented about falls and fall interventions in the electronic medical records' Risk Management. LPN-E stated they checked residents for injuries, movement abilities, and vitals when a resident was found on the floor. LPN-E stated they called the doctor, family, supervisor, and DON. Staff collected information about what happened prior to the fall and created interventions. Nurses then continued taking vitals and neurological checks if needed. LPN-E stated they knew about fall interventions from their morning and evening meetings and reviewing documentation about falls. LPN-E stated managers and sometimes they health unit coordinator updated the care plans with fall interventions. LPN-E reviewed a care plan sheet updated 2/21/25, and indicated R125 as a fall risk with interventions which included bilateral grab bars, auto lock brakes, gripper socks, and lock and keep wheelchair at bedside. LPN-E confirmed R125's wheelchair did not have auto-lock brakes.</p> <p>During observation on 2/26/25 at 7:35 a.m., R125's wheelchair was out of reach from the bed.</p> <p>During observation and interview on 2/26/25 at 7:41 a.m., LPN-E exited R125's room, and the wheelchair was now by R125's bed. LPN-E confirmed they moved the wheelchair to R125's bedside and stated staff forgot to keep the wheelchair at bedside.</p> <p>During interview on 2/27/25 at 2:26 p.m., the director of nursing (DON) reviewed fall interventions from the Risk Management documents. The DON expected staff to follow R125's care planned fall interventions, which included keeping R125's wheelchair at bedside when in bed and auto-locking brakes to wheelchair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	A provided Adverse Event policy dated 2/2021, indicated falls were reviewed to ensure correct interventions occurred.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure assessed and ordered nutritional supplement interventions were followed for 1 of 1 resident (R18) reviewed for weight loss.</p> <p>Findings include:</p> <p>R18's annual Minimum Data Set (MDS) dated [DATE], identified R18 had severe cognitive impairment and required supervision or touching assistance with eating. R18 had diagnoses which included dementia, peripheral vascular disease, chronic viral hepatitis C, chronic obstructive pulmonary disease, dysphagia, constipation, hemiplegia (partial or total loss of voluntary movement on one side of the body) or hemiparesis (weakness on one side of the body), multiple sclerosis (chronic, autoimmune disease which affects the brain and spinal cord), and schizophrenia. The MDS identified R18 weighed 146 pounds, had sustained no substantial weight loss or weight gain in the previous six months, and had a mechanically altered diet.</p> <p>R18's comprehensive Nutritional assessment dated [DATE], indicated R18's weight was 145.8 pounds, had a check next to <5% [less than five percent] weight change in 30 days, <7.5% in 90 days or < 10% within 180 days, and indicated sign [significant] weight loss noted at 90 days (-12.8# [pounds], -8%) in the description for Interventions for unexpected/unintentional weight change.</p> <p>R18's Nutrition Progress Note dated 2/5/25 at 1:24 p.m., indicated the following:</p> <p>Weight (2/3): 137.6#; 30 days (1/6): 146.2# (-8.6#, -5.8%); 180 days (8/1):158.3# (-20.7#, -13%); height: 64 inches; BMI:23.6. Sign weight loss noted at 30 and 180 days. Intake: 50-100%. Res [Resident] receives weekly weights and a fortified diet. Fortified food at meals to help maintain/ gain weight. Res food will have increased calorie and protein during meals by providing liquid butter/oils, cream, milks, and gravy. RD [registered dietician] recommends magic cup BID r/t [twice a day related to] sign weight loss RD updated [nurse practitioner] r/t weight loss. RD will continue to monitor weights, intakes, labs, and skin.</p> <p>R18's care plan printed 2/26/25, indicated R18 had a potential nutritional problem. The care plan indicated several interventions which included evaluate weight changes, determine percentage lost/gained and follow facility protocol for weight loss, observe fluid intake, observe/document/report to medical practitioner as needed for signs/symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss defined as 3 pounds in one week, greater than 5% in one month, greater than 7.5% in three months, or greater than 10% in six months, use of nose cup and scoop plate, fortified diet, observe weight per protocol or as ordered and record, registered dietician to evaluate and make diet change recommendations PRN (as needed), supervision during meals, etc.</p> <p>R18's orders printed 2/26/25, indicated the following:</p> <p>-8/27/24, regular diet, pureed texture, nectar consistency.</p> <p>-10/1/24, weight weekly for nutritional risk per registered dietician in the morning every Monday.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-10/9/24, registered dietician recommends fortified diet for recent weight loss.</p> <p>-2/5/25, magic cup supplement two times a day for routine signs of weight loss per dietician.</p> <p>During breakfast observation on 2/26/25 at 8:22 a.m., R18 was up and dressed at the breakfast table. R18 had oatmeal, pureed breakfast items, and nosey cups with thickened liquids. Throughout breakfast observation, no supplement was given to R18.</p> <p>During observation on 2/26/25 at 9:47 a.m., R18 was in the television room and was not drinking anything.</p> <p>During observation on 2/26/25 at 11:50 a.m., R18 had a chocolate pudding cup before a pureed meal was provided to them.</p> <p>During interview and document review on 2/26/25 at 12:02 p.m., registered nurse (RN)-F stated R18 did not have any scheduled supplements. RN-F checked R18's medication and treatment administration record and a documentation field which directed staff to give R18 a magic cup was marked as given. RN-F stated R18 usually received a magic cup in the morning with breakfast, and nursing staff usually delivered the magic cup to R18. When asked about whether R18 received their magic cup this morning, RN-F stated R18 must have gotten the supplement but was not sure. RN-F stated the nursing assistants knew about R18's supplement and usually provided the supplement to R18 at breakfast.</p> <p>During interview on 2/26/25 at 12:26 p.m., dietary aide (DA)-A stated they brought supplements from the main kitchen to the second-floor refrigerator in the dining area. DA-A stated the supplements brought up this morning were still in the refrigerator.</p> <p>During interview on 2/26/25 at 12:30 p.m., nursing assistant (NA)-H stated nursing assistants sometimes gave residents their supplements in the morning or as desserts. NA-H did not give any magic cups to residents during their shift thus far.</p> <p>During a joint interview on 2/26/25 at 12:33 p.m., NA-Q and NA-R stated supplements came from the kitchen, and nursing assistants gave supplements to residents if the supplement was labeled with the residents' name. NA-Q and NA-R stated they did not give any residents magic cups during their shift thus far.</p> <p>During interview on 2/26/25 at 12:34 p.m., DA-A stated they did not see any magic cups in the main kitchen so only brought up ensure, boost, and pudding this morning. DA-A stated no one had asked them about a magic cup so far during their shift.</p> <p>During interview on 2/27/25 at 11:05 a.m., licensed practical nurse (LPN)-E stated nurses gave residents supplements according to the orders written by the dietician. LPN-E stated the kitchen refrigerator had supplements labeled with residents' names and which shift the supplement should be given. LPN-E stated they had to go downstairs to the main kitchen when a resident's supplement was not in the second-floor refrigerator.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 2/27/25 at 2:55 p.m., the director of nursing (DON) expected staff to give residents their ordered supplements or document if resident refused. DON expected nurses to ensure residents got their supplement, since they were the ones to sign the supplement as given. DON stated weight loss and not meeting nutritional needs were a risk when residents did not get their supplements as ordered.</p> <p>A provided Weight Monitoring and Nutrition-at-Risk policy dated 6/2023, indicated residents with undesired downward trends in their weight were monitored until the resident's condition resolved or stabilized and immediate interventions were implemented by the facility, as appropriate, to prevent further decline. The policy gave examples of interventions, which included supplements.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33925</p> <p>Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were consistently implemented in accordance with Centers for Disease Control (CDC) recommendations to reduce the risk of infection for 2 of 3 residents (R38, R25); and failed to ensure appropriate hand hygiene was completed during provision of personal care for 1 of 4 residents (R25) whose cares were observed.</p> <p>Findings include:</p> <p>EBP:</p> <p>A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care.</p> <p>R38's care plan, printed 2/26/25, identified all of R38's actual or potential problems along with interventions to help R38 meet established goals of care. The care plan outlined, [R38] has indwelling medical device requiring precautions - tube feeding - requiring enhanced barrier precautions. This had a date listed, 04/12/2024. The care plan directed further, Requires enhanced [sic] barrier precautions.</p> <p>On 2/26/25 at approximately 7:15 a.m., R38's double room was observed from the hallway which had an orange-colored sign posted under the name plate which read, [STOP SIGN] Enhanced Barrier Precautions [STOP SIGN] . Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assistance with toileting . The signage was provided from the CDC, and underneath was a hard plastic cart with gowns and other PPE supplies inside. R38 was observed laying in bed but had visible tube feeding equipment at the bedside.</p> <p>Following, on 2/26/25 at 7:32 a.m., R38's room door was opened and nursing assistant (NA)-D and NA-E were inside the room; however, neither of them had a gown on as directed by the signage. NA-D was at R38's bedside and had R38 turned onto her right side as a mechanical lift sling was positioned underneath of her. NA-D stated they had just changed her and pointed to a soiled incontinence brief inside the small trash can next to her dresser. NA-D stated aloud, We change her. NA-D was then assisted to transfer using the mechanical lift to her wheelchair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 7:41 a.m., NA-D was questioned by the surveyor on the posted signage outside R38's double room which directed precautions should be used. NA-D observed the signage and expressed aloud, It's for neither of them [R38 or her roommate]. NA-D stated if either of the residents needed the precautions, then they would have been wearing them. However, a few minutes later NA-D excused themselves from R38's room and was heard in the hallway asking other staff members about the posted signage for R38's room. Following, clinical support specialist (CSS)-A entered the room and verified R38 as being on EBP adding staff should be using a gown and PPE anytime they are giving direct care. CSS-A explained R38 had a feeding tube which inserted into her skin and EBP were used with any tubes like such. NA-D and NA-E then both left the room and donned a disposable gown to finish the cares for R38.</p> <p>On 2/26/25 at 10:27 a.m., registered nurse (RN)-C was interviewed and verified they were the campus' infection preventionist. RN-C stated education with direct care staff had started the year prior for EBP and continued on an ongoing basis. RN-C verified any residents with catheter, chronic wounds, or feeding tubes should have EBP used with direct, personal cares. RN-C verified R38 required EBP during cares due to her feeding tube adding R38 was pretty vulnerable. RN-C stated use of EBP was important to help protect her [R38] from getting an multi-drug resistant organism.</p> <p>48299</p> <p>R25's care plan printed 2/24/25, indicated R25 had a wound which required EBP.</p> <p>During observation on 2/24/25 at 3:35 p.m., nursing assistant (NA)-A had gloves on and registered nurse (RN)-F had no personal protective equipment on to use a full lift to transfer R25 from their wheelchair to bed. RN-F exited the room after the transfer. NA-A continued to wear the same gloves, opened R25's incontinent product, and performed peri-cares to clean bowel movement from R25. NA-A tucked the soiled brief and bed protector under R25, moved the wipes on R25's bed, and wiped R25 again. NA-A adjusted R25's clean brief, placed the incontinent spray product and incontinent wipes on R25's bedside table, removed gloves, did not perform hand hygiene, and applied new gloves. NA-A tucked i R25's clean incontinent product under them, assisted R25 to turn right, grabbed the soiled incontinent product and bed protector, threw away, and secured the clean incontinent product on R25. NA-A removed gloves, did not perform hand hygiene, and applied a clean bed protector under R25. NA-A pulled up R25's blankets and left R25's room. NA-A threw the soiled trash from R25's room into the soiled utility room and went to the clean utility room to wash their hands.</p> <p>During observation and interview on 2/24/25 at 3:49 p.m., NA-A stated they washed their hands in the clean utility room because bins were in the way of the sink in the dirty utility room. NA-A confirmed they changed their gloves during peri-cares but did not perform hand hygiene between glove changes. NA-A stated there was hand sanitizer to use, but got a reaction from the alcohol in the hand sanitizer so they washed their hands instead. NA-A observed the sign and PPE cart outside of R25's room. NA-A stated neither R25 or their roommate were on enhanced barrier precautions and the sign and cart should be removed. NA-A stated the enhanced barrier precautions were for previously for R25's roommate but had since been cleared. The sign on R25's door indicated enhanced barrier precautions and directed staff to clean their hands before entering and when leaving the room. Further, the sign directed staff to wear gloves and gown for high-contact cares, which included transferring, changing linens, and changing briefs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Providence Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 2/27/25 at 9:00 a.m., the RN-C confirmed R25 was on enhanced barrier precautions for a wound and expected staff to wear gloves and gowns for any direct care as listed on the sign outside resident's room. RN-C expected staff to change their gloves and perform hand hygiene after dirty tasks and before clean tasks to reduce the risk of infection and cross-contamination when hand hygiene was missed.</p> <p>A provided Hand Hygiene Practice Guideline and Procedure dated 10/13/17, directed staff to complete handwashing after changing diapers. The policy directed staff to complete hand washing before applying gloves and after removing gloves and to change gloves between cares to prevent cross-contamination.</p> <p>A facility' provided PPE Selection and Use policy, dated 9/2023, identified general guidelines to follow for PPE use along with various procedures to apply and remove the equipment. The policy included, Enhanced Barrier Precautions: Gloves and gown prior to high contact care, change PPE before caring for another resident .[EBP] fall between standard and contact precautions . These may apply to wounds or indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy) regardless of MDRO colonization. These precautions are used during high contact resident care activities such as dressing, bathing, transfers, hygiene, incontinence care, device or wound care.</p>		