DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0USP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00096

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245271**

2. STATE VENDOR OR MEDICAID NO. (L2) **797948100**

3. NAME AND ADDRESS OF FACILITY
(L3) **PROVIDENCE PLACE**
(L4) **3720 23RD AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55407**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **08/08/2007**

6. DATE OF SURVEY **04/05/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **190** (L18)

13.Total Certified Beds **190** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	190			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 04/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 06/02/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **05/29/1984** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **03/29/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245271

May 19, 2016

Ms. Megan Luukkonen, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, Minnesota 55407

Dear Ms. Luukkonen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 23, 2016 the above facility is certified for:

190 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 190 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118   Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 15, 2016

Ms. Megan Luukkonen, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: Project Number S5271027

Dear Ms. Luukkonen:

On March 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on February 12, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on February 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2016, effective March 23, 2016 and therefore remedies outlined in our letter to you dated March 4, 2016, will not be imposed.

However, as we notified you in our letter of March 4, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 12, 2016.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245271		4/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 03/23/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 03/23/2016	ID Prefix F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 03/23/2016
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 03/23/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 03/23/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 03/23/2016
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 03/23/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 03/23/2016	ID Prefix F0364 Reg. # 483.35(d)(1)-(2) LSC	Correction Completed 03/23/2016
ID Prefix F0497 Reg. # 483.75(e)(8) LSC	Correction Completed 03/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GL/kfd	04/15/2016	28230	4/5/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/12/2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245271	A. Building 01 - MAIN BUILDING 01 B. Wing	4/4/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 03/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 4/15/2016	SIGNATURE OF SURVEYOR 37009	DATE 4/4/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0USP
Facility ID: 00096

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245271**

2. STATE VENDOR OR MEDICAID NO. (L2) **797948100**

3. NAME AND ADDRESS OF FACILITY
(L3) **PROVIDENCE PLACE**
(L4) **3720 23RD AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55407**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **08/08/2007**

6. DATE OF SURVEY **02/12/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **190** (L18)

13. Total Certified Beds **190** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	190			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NE II 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/28/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **05/29/1984** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 03/29/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 4, 2016

Mr. Tyler Donahue, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: Project Number

Dear Mr. Donahue:

On February 12, 2016, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 23, 2016 the following remedy will be imposed:

- Per instance civil money penalty (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician</u>

of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Providence Place is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective May 12, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or

Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This
action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		3/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/14/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide liability notices for 1 of 3 residents (R44) reviewed for liability notices and beneficiary appeal rights. Findings include: R44's Admission Record indicated the resident was admitted to the facility on 10/2/15. A nursing progress note dated 11/4/15, indicated the resident discharged on 11/4/15. While at the facility, R44 received physical and occupational therapy services. R44's Medicare denial date was 10/29/15, according to the Notices of Medicare Non-Coverage (NOMNC) it was noted, however, the resident's responsible party's signature on the form was also dated 10/29/15. A registered nurse (RN)-C stated in an interview on 2/12/16, at 11:12 a.m. she was responsible for issuing denial notices. RN-C explained R44 was not progressing in therapy and was therefore was denied Medicare services for skilled care. R44 was not able to sign the denial notice do to his cognitive deficiency. RN-C explained she received notice from therapy on 10/27/15, that R44's Medicare coverage was ending. She contacted R44's responsible party on 10/28/15, regarding the end of therapy date of 10/29/15. The son signed the NOMNC and dated it 10/29/15. RN-C further verified the guidance from Centers for Medicare Services (CMS)	F 156	F156 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of state and federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to R#44, a verbal notice for non coverage was provided on 10/28/2015 and written notice of non-coverage was provided to his decision maker on 10/29/2015. R#44 discharged from the facility 11/4/2015. 2. Any resident who is currently on a skilled stay and pending discharge will be discussed daily mon-fri at the interdisciplinary meeting. Notices of liability will be completed and signed by the appropriate party with 48 hours advanced notice. 3. The IDT meeting minutes (form) and Guidelines has been revised to include discussion of all pending discharges. All admissions, billing, social service, MDSC and case manager and therapy staff will receive education regarding the process for communicating discharges and beneficiary notices within the required	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3 required no less than a two day notice should have been given when Medicare services were withdrawn. RN-C stated, "I gave him a 24 hour notice, not a 48 hour notice." A progress note written 10/29/15, at 2:23 p.m. indicated RN-C spoke with R44's responsible party regarding NOMNC and last covered day for Medicare services was 10/30/15. The call was place to the son on 10/28/15. The NOMNC was left in the business office for him to sign as well as a copy. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, approved 10/31/11 stated: "A Medicare provider or health plan must give in advance , a completed copy of the NOMNC to beneficiaries/enrollees receiving skilled care--services no later than two days before the termination of services." An interview with the interim director of nursing on 2/12/16,at 11:43 a.m. revealed she expected staff to use the protocol set forth by CMS to provide a 48-our notice so residents would have time to plan for discharge.	F 156	time frames. 4. The administrator and or/designee will audit two residents admitted within the past 30 days each week for one month and then one resident each week for two months to assure there is documentation of appropriate notifications. 5. The data collected will be resented to the QAPI committee by the administrator and/or designee. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any neccesary follow up studies.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 241	1. With respect to R #22, and R# 186:	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 review, the facility failed to ensure appropriate attire was maintained for 2 of 2 residents (R22, R186) who reported missing clothing. Findings include: R22 was interviewed on 2/10/16, at 2:43 p.m. to follow up on concerns regarding various concerns voiced by the resident during a formal interview on 2/8/16, at 2:39 p.m. voiced by the resident. R22 was admitted to the facility in 5/15, and at that time arrived with seven pair of pants, and much of her clothing had since "disappeared." The resident explained she currently had only one pair of pants, and four other pair were "missing." R22 explained that on Saturday morning (2/6/16) she had been informed "I had nothing to wear" with the exception of a shirt. When R22 complained of her missing clothing to the nursing assistant (NA) she reportedly responded, "'It happens.'" The NA then went to look for R22's missing clothing in the laundry and was unable to find any of the resident's pants. The resident stated she was "stuck in the chair with the horrible hospital gown" until noon, when the NA found her a pair of "very ugly" men's pants to wear. "It was humiliating to be defenseless without clothing and having someone looking for something for me to wear...I'm dependent on the staff for help and to take care of me." R22 stated she "gave up wearing bras" as they got lost in the laundry and "nobody cares...I feel better with a bra on." The resident gave the surveyor permission to look in her closet and dressers and the only clothing available was six shirts, two sweaters, shawl, coat, and no pants, and no bras. R22's 1/21/16, Minimum Data Set (MDS) assessment indicated she was cognitively intact	F 241	social services has approached the residents regarding missing clothing items. All items that were not found have been replaced. 2. All feedback forms for the past three months have been reviewed for Missing property. All residents identified with missing items have been followed up and the items found or replaced as able. 3. The system for logging in concerns and action plan results is revised to include a three day time frame. Concerns/forms are brought up daily in the morning idt meeting all staff will receive re-education regarding the missing property guideline and feedback form for reporting missing items by 3/23/16. 4. The director of nursing and/or designee will audit three residents each week for two months for assuring that the resident is dressed in a dignified manner and has appropriate attire available. 5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5	F 241		

and required extensive assistance from staff to dress.

The licensed graduate social worker (LGSW) was interviewed on 2/10/16, at 3:03 p.m.
and stated she did not know much about resident clothing, and had not received a report that R22 was missing pants.

On 2/11/16, at 9:08 a.m. the director of social services (DSS) explained he had initiated a grievance for R22 on 2/9/16, following a report of missing clothing. The DSS reported the ombudsman had informed him R22 had no clothing over the weekend, and he planned to order clothing for the resident that day. At 10:25 a.m. the DSS said he had followed up with R22 and obtained a list of items she needed. In the meantime, they had found extra clothing in the laundry which was labeled with R22's name. The facility's plan was to replace the resident's missing clothing.

The director of nursing stated in an interview on 2/12/16, at 9:55 a.m. the staff should have reported R22's missing clothing.

The administrator explained on 2/12/16, at 10:05 a.m that approximately three months prior there had been complaints of missing resident clothing. He thought the problem was personal laundry was inadvertently being sent out with the linens to an outside laundry service, when the laundry should have instead been laundered at the facility. He said par of the problem was that some staff were unsure how to pass on such information. The facility's policy was to replace missing items if they were responsible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 R186 (whose room was at the far end of the hallway from the nursing station/elevator) was observed wearing only underwear as he was in wheelchair at the nursing station on 2/12/15, at approximately 1:10 p.m. The registered nurse (RN)-D was heard telling the resident, "Let's go downstairs [to the laundry room] and take a look." While still only wearing underwear, R186 and RN-D got onto the elevator. At 1:21 p.m. R186 explained, "I wear my shorts two to three times in a row and send them to laundry. I was missing eight pair of shorts today," and said he had reported the problem to the LGSW that day. R186 stated, "I don't want to wait another ten weeks for them to replace them like they did the last time when I lost six pair. I had to buy them myself. It bothers me that I had to come out in my underwear, but what am I supposed to do?" R186's 11/28/15, MDS indicated he was cognitively intact. RN-D was approached at 2/12/16, at 1:30 p.m. and immediately stated, "I should have put a blanket on him [R186] instead of letting him go around in his underwear. It is dignity. He had no shorts. We went downstairs and found two pairs of his shorts. He told me six were still missing." The facility's 2/11 Personal Property Loss policy indicated the facility was not responsible for lost or missing items, however, would facilitate the recovery of items whenever possible. "The person reporting the loss should complete a Feedback Form" which was then given to the executive director." The policy delineated a process for looking for the missing items.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 7 The facility's 6/18/14, Promoting Resident Rights and Dignity policy noted each staff member was responsible for protecting and promoting each resident's rights.	F 241		
F 244 SS=F	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation,interview and document review, the facility failed to ensure a system for addressing resident council concerns/grievances was implemented to ensure issues were resolved to residents' satisfaction to the extent possible. This practice had the potential to affect all 170 residents including complaints registered by several residents (R17, R105, R20, R195, R217, R48, R192, R129, R119) who reported un-addressed concerns regarding residents being served cold and inappropriately cooked food, as well as residents (R186, R22) who reported missing clothing. Findings include: SNF [Skilled Nursing Facility] Resident Council Meeting Agenda and Minutes from 8/15 to 1/16 were reviewed. The minutes included Concerns/Issues, Action, Resolution and Date, and Responsible Party. The minutes, however,	F 244	1. With respect to the identified residents: each resident was met with individually and an action plan developed for resolution to concerns. A follow up meeting with each of the identified residents will be conducted to determine level of satisfaction and any further action needed. 2. The previous 6 months of resident council minutes have been reviewed and a plan of action developed for the identified concerns regarding: call lights, food quality, and missing items/laundry. A follow up resident council meeting is scheduled to discuss actions taken, and an continued areas of concern. 3. The system for logging in concerns and action plan results is revised to include a response within a 3 day time frame. Concerns/forms are brought up daily in the morning idt meeting. The	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 8 revealed a lack of documentation showing the facility's actual resolutions to residents' concerns. Examples were as follows: 1) On 8/19/15, Old Business: a) a resident on 2 north reported room trays were late and "luke-warm" and two other residents on 2 north stated nursing assistants (NAs) who served meals need to be "more attentive and They [residents] feel like they are getting ignored." Additional issues included b) staff "still" not knocking c) missing clothing d) bathroom cleaning, and e) music selection during meals. The Action was to follow up with appropriate staff. The Resolution and Date was "Ongoing." New Business included a) salads were "still" being served after the main meal, and b) suggested residents complete anonymous audits related to their dining experience, staff not knocking (continued issue) and residents wanted a suggestion box. No plan of action or responsible party was designated. Although council members suggested residents complete audits, staff completed audits from 8/14/15 to 8/31/15. The audits did not include whether food was served at the proper temperatures. 2) On 9/16/15, Old Business was noted, with action including follow up with appropriate staff on issues, and inviting the administrator and director of nursing (DON) to the meetings. The Resolution and Date was "Ongoing." New Business: request to know where to find grievance forms, signage by the community book, housekeeping issues (smells, cleaning bathrooms), missing clothing, staff not knocking. Action was to add additional grievance forms, adding requested signage, follow up with housekeeping, and follow up with nursing staff. The Resident's Bill of Rights for right to voice	F 244	leadership team will receive education regarding the procedure for follow up to resident council concerns and action plans for correction. Education will be completed by march 23 2016. 4. The executive director and/or designee will audit the resident council minutes, areas of concern identified and action plans post council. Action plans will be audited to assure satisfactory outcomes as much as possible. 5. The data collected will be presented to the qapi committee by the executive director. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 9 grievances was covered, however, did not indicate whether staff asked the residents whether they felt their grievances were adequately addressed by facility staff. 3) On 10/21/15, Old Business included Resolution for grievance forms and signage was completed. "Completed/ongoing: New Housekeeping Director has been hired and concerns should be resolved. Ongoing: education with staff provided to assist with these concerns." New Business: Call lights still remain a concern, would like name tags visible, cleaning issues including elevator carpet and mold in the shower, food temperature and serving times, council member voting. Action Plan: Continue to educate at unit meetings, all staff reminded regarding name tags, housekeeping is addressing "many issues"-under new management and no mold in bathroom, but was cleaned, dietary manager explained food service delivery process is a team effort with nursing to pass meals. 4) On 11/9/15, Old Business: Resolutions "ongoing education, new housekeeping manager, and shower cleaned. New Business: call light times getting better but some residents felt could still improve. No Action listed. 5) On 12/16/15, Old Business: Call light resolution was "ongoing." New Business: Request to continue education on door knocking, call lights are longer than residents would like, "night shift needs a refresher," want sign as to who is supervisor on each shift. 6) On 1/20/16, Old Business: Continue to discuss knocking at unit meeting, DON explained how call light system works and has been steadily improving over the last few months, DON will find solution and post supervisors' names. Resolution was "Ongoing. "	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 10 In addition, the resident grievance log from 11/20/15 to 1/26/16 also included resident concerns consistent with concerns brought up in resident council meetings such as: 11/20 room cleaning and call lights; 12/3 room cleaning; 12/8, not getting snacks (3N); 12/8 lack of food variety (3N); 12/9 cold food (3N); 12/16 food issue (3N); showers; 12/18 room odors, showers; 12/22 dietary concerns (2N); 12/22 meal concern (3N); and 12/24 "residents" meal concerns; 1/6 call lights and cold food (2N); 1/13 food concerns (2N); and 1/25 dietary concerns (3N). The grievance log noted various staff members reviewed the resident concerns. FOOD AND CALL LIGHTS: Two Feedback Forms revealed concerns consistent with comments made in resident council meetings. 1) On 12/9/15, a resident voiced, "Concerns of cold food delivered to his room." Follow up with the resident on 12/11/15, indicated staff "Explained to resident that room trays are delivered after everyone in the dining room has been served--encouraged resident to eat in dining room. Staff will continue to monitor steam table temperatures to ensure they are correct." 2) On 1/6/16, a staff person reported for a resident on 2N expressed concerns that "Food is cold for all meals" and "Concerns of call light times being too long." The Action Plan was staff encouraged the resident to eat meals in the dining room as room trays were delivered after residents in the dining room have been served. Kitchen staff were to ensure food was served at correct temperatures/steam table at right temperature. The resolution was noted as discussed with the resident on 1/11/16, however, did not include information as to whether the	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 11	F 244		

resident expressed satisfaction regarding the follow up.

During an interview on 2/8/16, at 8:26 a.m. with the dietary manager (DM) he explained two staff had called in and he apologized that he was rushing around the kitchen to help the other staff on duty. The DM stated meals times for all floors were 8:00 a.m. 12:00 p.m. and 6:00 p.m.

Continuous dining observations on 2N were conducted on 2/8/16, from 12:09 p.m. to 12:37 p.m. Twenty-five residents were seated in the dining room waiting for the noon meal to be served. A cart containing salad ingredients was near the serving door by the kitchenette. At 12:17 p.m. a NA began asking residents whether they wanted a salad. At 12:26 p.m. the NA continued serving salads when the doors opened into the kitchenette to indicate the main meal was ready to be served. The first plate of food was served at 12:37 p.m. Forty-five minutes later at 12:48 p.m. a resident room tray was delivered to a resident.

R17 reported on 2/8/16, at 12:24 p.m. food was often served late. The meat was often tough and she had recently been served slimy mushrooms.

R105 reported on 2/8/16, at 12:30 p.m. he did not like the food. He said he had been served half-cooked hamburgers and burnt eggs.

R20 reported on 2/8/16, at 12:30 p.m. the food was often served lukewarm and she preferred hot food. When she requested the food be reheated, it was often not microwaved until it was hot.

R195 stated during an interview on 2/8/16, at 3:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 12 p.m. he ate his meals in his room. He did not eat the noon meal that day because it arrived late, was cold and was not what he had ordered. "The meatloaf was awful and I wanted corn not green beans." Then R195 pointed to the monthly menu "here see it states corn today not green beans." R195 stated that something needed to be done about the food and had requested to speak to the DM, but instead another dietary staff person was sent. In a follow up interview on 2/11/16, at 4:36 p.m. R195 described the food as "Always cold and always late. The eggs are cold and my milk was frozen." R195 explained that at a care conference four weeks ago he asked for the DM to come to his room to discuss food issues. "Just this morning my breakfast order was taken before 8:00 a.m. and delivered to me at 8:25 a.m. "I have my daughter bring in food because it's always chicken...no fresh fruit like bananas...everything comes in a can." R217 stated in an interview on 2/9/16, at 12:55 p.m. that the food and the snacks served at the facility were a "failure" and 7 of 10 items on the menu in one week tasted "awful." R217 described the food as "horrible...no seasoning...mushy...lack of variety." R217 reportedly routinely attended resident council meetings, and said food issues were always brought up by residents at the meetings, and she personally spoke up about ongoing food concerns. The dietary manager had attended some of the meetings, and residents were told there were plans for new menus, but nothing had changed since last fall and they just kept rotating the same menus. When asked why the residents could not get more variety, the DM said the menu items were "seasonal." R217 explained broccoli was served "constantly," and although she used	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 13 to like it, she no longer did. That day she had specifically requested the alternate vegetable so she would not be served broccoli, however, then was served broccoli regardless of her request. R217 stated that today she purposely asked for the second option for the meal so that she would not get broccoli and she was then served broccoli anyway. Vegetables were served kind of "mushy" and foods were often either "undercooked or overcooked." That day the resident was served "a veal patty that was undercooked--pink in the middle--almost cold." R217 stated she ate meals in her room and her food was nearly constantly served cold. Although mealtime was scheduled to begin at 12:00 p.m. she received her meal between 12:30 and 12:50 p.m. and room trays were the last to be delivered. When R217 heard other residents complain chicken was served undercooked and pink in the middle, they were told by the DM to have their food reheated in the microwave. R217 requested her food be reheated "once," but staff did not return in a timely manner. When she was served the wrong beverage, the staff never returned with the proper one. When she was given pureed peaches instead of her regular diet, the nursing assistant just walked away and did bring her the correct diet. R217 reported food often was served on paper plates due to dishwasher being broken, and the paper plates did not keep the food warm. Approximately half the time food was not delivered to her room with both the bottom plate warmer and the cover that was supposed to help keep the food warm. At 6:20 p.m. R217 reported she was served a hamburger patty on a bun with mustard and ketchup packets, but nothing else. In addition, the resident expressed concerns snacks were not being passed to residents, rather were left at the nursing station. R217	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 14	F 244		

reported ongoing concerns with food had been brought up to staff and "is not being followed up on here and keeps getting mentioned at every resident council meeting." R217's quarterly Minimum Data Set dated 12/14/15, revealed the resident was cognitively intact.

R48 reported in an interview on 2/9/16, at approximately 1:00 p.m. she consistently attended resident council meetings. R48 explained she preferred to eat her meals in her room, but "the food that is being served is cold and always late." A follow up interview on 2/11/16, at 4:26 p.m. R48 stated yesterday her dinner meal tray was delivered to her at 6:45 p.m. "cold and late." R48 explained that she had spoken to the DM about the food quality and his reply was, "'It not his fault--the nursing assistant has to get it to you on time.'" She went on to say if she asked to have her food re-heated the staff "gets upset, so I don't ask because I don't want to get hollered at or then they give me an attitude. I just eat the cold food but I pay a lot of money to live here. Why can't I get a good meal?" R48 stated other residents suggested more choices like lasagna, Frito pie and creamed tuna over toast/rice. The DM just tells the residents they have to make sure all residents can eat the food, "so we never get it."

R192 said on 2/10/16, at 12:05 p.m. dinner was regularly served late, often a half hour. Regarding reportedly being served very mushy vegetables R192 stated, "ish."

R129 reported on 2/10/16, at 12:11 p.m. the food tasted "terrible," was cold, mushy, and sometimes undercooked. In addition, meals were regularly served a half hour after the scheduled time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 15	F 244		

F 244

Continued From page 15

R119 said on 2/10/16, at 12:15 p.m. the food tasted terrible, was often cold and was often served late.

During an interview on 2/10/16, at approximately 11:55 a.m. the DM stated he had heard of complaints about milk being always spoiled from R195. The DM stated the facility went through milk so fast that it didn't even get close to the expiration date on the container. The DM explained he was on vacation the previous week, and this was the first time he heard R195 wanted to speak to him, and had not yet done so. The DM verified a dietary staff person had spoken to R195 about food issues, mainly about spoiled milk.

LAUNDRY:

R186 was observed wearing only underwear as he was in wheelchair at the nursing station on 2/12/16, at approximately 1:10 p.m. At 1:21 p.m. R186 explained, "I was missing eight pair of shorts today...I don't want to wait another ten weeks for them to replace them like they did the last time when I lost six pair. I had to buy them myself. It bothers me that I had to come out in my underwear, but what am I supposed to do?"

R22 reported on 2/10/16, at 2:43 p.m. that on 2/6/16 she had been informed "I had nothing to wear" with the exception of a shirt. When R22 complained of her missing clothing to the nursing assistant (NA) she reportedly responded, "'It happens.'" The NA then went to look for R22's missing clothing in the laundry and was unable to find any of the resident's pants. R22 also stated she "gave up wearing bras" as they got lost in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 16	F 244		

laundry and "nobody cares...I feel better with a bra on." The resident gave the surveyor permission to look in her closet and dressers and the only clothing available was six shirts, two sweaters, shawl, coat, and no pants and no bras.

The administrator explained on 2/12/16, at 10:05 a.m that approximately three months prior there had been complaints of missing resident clothing. He thought the problem was personal laundry had been inadvertently sent out with the linens to an outside laundry service, when the laundry should have instead been laundered at the facility. He said part of the problem was that some staff were unsure how to pass on such information (missing clothing).

During an interview on 2/11/16, at 3:57 p.m. the director of community life (DCL) stated she was the representative for resident council and tried to attend all meetings. She handled related resident grievances. The DCL explained if residents had concerns during the meeting, she ensure the issue was brought forth and delivered to the appropriate staff for follow up (such as food issues to the DM). The DCL stated if a resident brought up the same concern at the next meeting, she started the process all over again, except this time she would tell the staff person "the issue has come up again."

On 2/11/16, at 4:07 p.m. the DM stated he attended resident council with the DLC, where they talked to residents about food issues. The DM verified he was aware of resident concerns regarding food temperatures from mostly 2N and 3N. The DM explained the dietary department had purchased thermal cover and bottoms to help keep the food warmer. Staff measured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 17 temperatures of the food in the hot wells, and plates "go up the line as soon as they are prepared...We put the food on the plate and it's hot--then I'm not sure what happens once the plate is ready to be served. It's up to the nursing staff to deliver it to the resident room--it's a team effort. Sometimes my staff is just standing/waiting and there are no nursing assistants to serve the plates." The facility's 2/1/15, Resident Council and Tenant meeting Guidelines indicated "each individual department will report on issues/concerns/changes etc. and will report on follow-up of any previous issues or concerns identified by residents." The facility's 2/15, Feedback Form Guideline and Action Plan indicated the"Department Head or designee will investigate the grievance/comment/suggestion and record the findings of the investigation as well as the action plan for the resolution on the appropriate area on the attached Feedback Form Action Plan...Executive Director/Department Head is responsible for contacting the person who initiated the Feedback Form and provide them with feedback on the resolution on the concern within (3) working days of receiving the concern."	F 244		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 18 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and implemented prior to administration of a psychotropic drugs for 1 of 5 residents (R56) reviewed for unnecessary medication use; in addition, the facility failed to ensure the care plan was developed to include necessary interventions to promote healing and minimize the risk for further pressure ulcer breakdown for 1 of 2 residents (R222) reviewed with pressure ulcers. Findings include: R56's current care plan lacked identification of the use of psychotropic medications, goals, and appropriate interventions to promote sleep for R56. In addition, the nursing assistant (NA) current assignment sheet for R56 lacked any direction for NAs regarding measures to promote sleep.	F 279	1. With respect to R#56: the care plan has been revised to include the non pharmacological measures to promote sleep prior to administration of medications. With respect to R#222, the care plan has been revised to include all measures in place to promote wound healing and prevent further breakdown as well as R#222 rejection of care. R#222 has been provided the risks associated with rejection of care. The NAR assignment sheets have been revised to reflect the changes. 2. All residents currently receiving medications to promote sleep have been reviewed to assure non-pharmacological measures are identified prior to administration of any prn medications for sleep. All residents with current wounds have had their care plans reviewed to ensure the inclusion of all measures to promote healing and prevent further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19	F 279		

R56 was prescribed Trazodone HCL (anti-depressant) 25 milligrams (mg) as needed (prn) at bedtime to promote sleep according to the resident's 2/16, Medication Administration Record (MAR). After the pharmacy consultant recommended a dosage change of Trazodone from 25 mg to 25 mg prn the dose was decreased to prn on 10/19/15. Although the hours of sleep were documented on the Treatment Administration Record (TAR), it lacked any information related to non-pharmacological interventions that may have been attempted prior to administering the as needed medication.

An interview with the pharmacy consultant on 2/10/16, at 11:16 a.m. revealed Trazodone was first prescribed for R56 on 3/9/15, at 50 mg at bedtime to promote sleep, and the current dose was 25 mg prn. The medication had been 10 times in 1/16. The consultant further stated non-pharmacological interventions should have been attempted at least an hour prior to use of psychotropic medications including Trazodone, especially when it was prescribed as needed. She also stated she expected side-effects and effectiveness would be monitored.

On 2/10/16, at 11:53 a.m. a registered nurse (RN)-C reported the facility did not have specific non-pharmacological interventions identified to improve the resident's sleep. She stated, "We try to figure out her day. If she had enough to eat, if she is in pain, if she needs to be toileted or repositioned. If all else fails we give her a prn." RN-C verified the interventions were not documented in R56's MAR/TAR or outlined in her care plan.

During an interview on 2/12/16, at 11:54 a.m. the

breakdown including any rejections of care. The NAR assignment sheet has been updated to reflect any changes.
3. All nursing staff will be re-educated regarding non pharmacological measures to promote sleep and measures to prevent skin breakdown, what to report and how the information/interventions are to be communicated. Education will be completed by 3/23/16.
4. The director of nursing and/or designee will audit three residents each week for one month and then two residents per week for two months to assure the plan of care for the individual resident is being revised and followed.
5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20	F 279		

director of nursing (DON) stated regarding the Trazodone use, "When it is for sleep, especially for prn medications, you should chart what you did to help them rest and not just give them a pill. At least you should talk to them." The DON further explained she was unaware of current non-pharmacological interventions or monitoring of side effects and effectiveness for sleep and sleep medications for R56.

At 11:53 a.m. a registered nurse (RN)-C stated the facility did not have specific nonpharmacological interventions to improve sleep. She stated, "We try to figure out her day, if she had enough to eat, if she is in pain, if she needs to be toileted or repositioned. If all else fails we give her prn." RN-C verified these interventions were not documented in R56's records or care plan.

The Providence Place Practice guideline and Procedure for Sleep Monitoring, dated Sept 2013, directs staff to individualize staff non-pharmacological interventions intended to increase comfort and promote adequate sleep will be added to a resident care plan and NA (nursing assistant) sheet.

A 9/13, Practice Guideline and Procedure for Sleep Monitoring, directed staff to "individualize staff non-pharmacological interventions intended to increase comfort and promote adequate sleep will be added to a resident care plan and NA (nursing assistant) sheet."

A 9/13, Psychoactive Medication Adverse Effect Monitoring policy, noted was the purpose was to "provide monitoring guidelines to nursing staff when a resident has been ordered a new or a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21	F 279		

change in psychopharmacological medication."

R222's care plan was not developed to incorporate all necessary interventions to promote healing/prevent further breakdown.

R222's care plan last reviewed 12/15/15, revealed the resident had diagnoses including paraplegia (paralysis of lower limbs) and a history of multiple pressure ulcers related to immobility, including surgical repairs of a sacral ulcer on 2/23/15, and a stage 4 right ischial tuberosity (buttock) ulcer identified 11/24/15. The care plan indicated stage 2 pressure ulcers had developed on the resident's coccyx while he was hospitalized. Staff interventions included for staff to "educate resident/family/caregivers as to causes of breakdown...Encourage reposition/position changes during Customer Service Rounds...Avoid positioning on areas of concern. Pressure relieving device for bed, rotating low air loss mattress, turn, reposition at least every 2 hours, more often as needed or requested." The care plan did not indicate any concerns with the resident rejecting care (e.g. refusal to turn/reposition), and there were no approaches identified to educate the resident regarding the risks and benefits of his choices. In addition, the care plan lacked any information regarding the need to check the wheelchair cushion for proper inflation to minimize the risk for further pressure ulcer complications.

The current 2/9/16, Nursing Assistant Care Plan directed staff to assist R222 to "Repos: A2-4" [Reposition: assist every two to four hours] and "Reposition q2 [every two] hours/Nurse&NAR"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 22	F 279		

(nursing assistant). There were no instructions on the Nursing Assistant Care Plan related to monitoring the inflation of the wheelchair cushion.

R222 was observed in his room while lying on an air mattress in bed on 2/11/16, at 8:45 a.m. An electric, tilt-in-space wheelchair was in the room. The wheelchair had a seat cushion with a foam front and cutout in the rear filled with an air bladder where the resident would sit, as well as a contoured backrest. The surveyor briefly pressed on the air-filled portion, which contained air.

During interview with R222 on 2/11/16, at 8:45 a.m. he reported he had developed a pressure ulcer in June of 2015. Despite the use of an air-containing protective wheelchair cushion, the wound deteriorated and eventually required surgical repair. R222 asserted that prior to the discovery of the pressure ulcer, the air bladder was low and needed refilling. "I was getting sore...telling my nurse that my Roho air cushion had a hand pump in the closet to fill my seat. I told them it was low and needed to be filled...staff wouldn't do anything about it." Ulcers formed at the rear of both legs, with the right one becoming severe (larger and deeper). "[The area] developed a big ulcer at the point where the foam part meets the air part in an edge." R222 stated the right ulcer eventually required four debridements (surgically removing dead tissue) and surgery to close it with a flap of tissue.

R222 said that he had been going to Courage Kenny rehabilitation, where there they'd noted it [the air cushion] was completely flat, no date specified. R222 stated the Courage Kenny staff had inflated it and adjusted the pressure to meet his needs. After two debridement surgeries, R222

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 23	F 279		

said the physician had directed the facility staff to learn the proper assessment/inflation technique. The resident explained the staff were supposed to "...come and put their hands on the cushion while it was under my butt so they would get the idea of what a properly inflated cushion for me would be...that never happened," except by registered nurse (RN)-E "a couple of times." R222 then showed the surveyor a paper diagram illustrating how much space should have been between the cushion base and the buttocks when the resident was seated.

A 6/2/15, a quarterly Minimum Data Set (MDS) for R222 indicated: "Does this resident have one or more pressure ulcers at stage 1 or higher? No." However, the resident was identified at risk for pressure ulcer development, and treatment interventions were in place. R222 required extensive assistance from staff to reposition and transfer. MDS assessments consistently revealed R222 was cognitively intact and did not reject care or present other behavioral concerns.

A physician order dated 6/20/15 directed staff to: "Please contact wound clinic for input on managing Left IT [ischial tuberosity] decubitus ulcer and coccyx [tailbone] ulcer, and arrange appointment ASAP [as soon as possible] to be seen in wound clinic by [name of physician] or colleague."

An appointment referral form completed by Courage Kenny 6/23/15 indicated, "[R222's] cushion was completely flat!!!" The referral note further indicated Courage Kenny had added air during the session of an "appropriate amount to ensure proper positioning and pressure relief. Must check cushion for inflation daily. Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 24	F 279		

orders: Check cushion daily for inflation to avoid pressure sores."

Further review of R222's medical record including treatment administration sheets, and care plan, failed to indicate staff had been checking the cushion daily to ensure proper inflation to meet R222's needs. In addition, there was no evidence in any progress notes to indicate R222's cushion was ever checked for proper inflation.

Wound Summary documents for "Right thigh back" (a photo revealed it was the right ischial tuberosity/IT) indicated an initial measurement dated 6/23/15, of a stage 2 ulcer with a red (healthy) base which measured: 2.5 centimeters (cm) in length, 5.1 cm in width, and 0 cm in depth (2.5 x 5.1 x 0 cm). By 7/29/15, the ulcer was increased to stage 3 and was greater in size at 4.5 x 5.8 x 5.5 cm (a significant increase in depth).

Following surgical debridment, a progress note dated 8/6/15 included, "Comprehensive Courage Kenny and positioning evaluation was completed for [R222]. Braden score 14.0 indicating MODERATE RISK" due to co-morbidities, wound infections, diabetes, narcotic use, immobility, dependence on staff for activities of daily living, and current pressure ulcers." A progress note from 8/8/15 indicated, "Wound vac...resident refusing to get out of bed."

A significant change MDS dated 8/12/15, indicated R222 had one stage 3 and one stage 4 pressure ulcer, with measurements noted as 08. x 06. x 05.5 cm.

A progress note from a wound appointment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 25	F 279		

9/8/15, included: "Reason for appointment ...wheelchair cushion mapping. Cushion mapped well and [no] concerns when is properly inflated. Physician orders: Recommend therapist at facility [check] manual inflation of cushion one [time per] week. Roho cells are slightly under-inflated per [standard] guidance for best pressure relief." However, a review of the facility's charting summary did not address the resident's 9/8/15 appointment or physician's order for therapists to monitor the resident's wheelchair cushion. A therapy progress note dated 9/9/15 included: "Physical Therapy/ Occupational Therapy Requires Courage Kenny nursing to meet resident's medical needs. Promote recovery, and ensure medical safety. Condition of resident is such that there is potential for changes in condition without Courage Kenny nursing intervention."

A physician's progress note from 10/26/15, included: "wound improved...continue to pack foam in the undermined area of the wound. Can you call [physician name] in 1 week to discuss [plan of care--number provided]." A nursing note also indicated R222 was at the wound clinic for a dressing change. Although it was noted staff were to monitor wound vac and drainage from the wound, the notes did not reflect any follow-up call to the physician to ensure that R222's plan of care had been discussed as the physician had requested. In addition, review of the resident's care plan for that time indicated there had been no changes made to R222's care plan.

The physician's progress notes from 12/22/15 indicated, "Pressure mapping completed, if cushion slightly air filled on [right] side, then mapping is good on [bilateral ischial tuberosity].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 26 Recommend therapists check inflation on cushion [one time per] week." Review of the therapy notes following this visit did not identify whether the therapists were checking the cushion weekly for proper inflation. A therapy note dated 12/26/15 indicated, "Therapy services provided include. [incomplete sentence] Additional services are SUMMARY: Patient was in his chair for 15 minutes at 2000 [8:00 p.m.]. Repositioned twice on its [sic] own. Dressing changed; incision looks like it is healing well. The spot the surgeon cirled [sic] on his right buttock is firm and mildly blanchable compared to the surrounding..." Therapy notes from 12/28/15 indicated, "Therapy services include Physical Therapy. Additional services are Post-surgical services Restorative Nursing." On 12/29/15, a nursing progress note indicated, "refused turning and repositioning" and indicated the resident had said he would call for help when he was ready to be repositioned. The note did not reflect education of the resident related to his choice to decline repositioning. During an interview on 2/11/16, at 1:48 p.m. RN-E confirmed the cushion pump was on the back of R222's wheelchair in a bag. RN-E stated detailed instructions had been sent from Courage Kenny following his last wound debridement/surgical repair (11/2015) which directed staff to check for proper inflation weekly. RN-E stated R222 wanted to be up in the chair for longer periods of time, but believed he was supposed to be repositioned every two hours. She explained the two hour repositioning was noted on his care plan and on the care sheets. RN-E was again interviewed on 2/12/16, at 11:53 a.m. RN-E stated the resident was being repositioned every two hours, and was up several	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 27 hours a day, refusing to lie down. The surveyor then requested documentation regarding any assessment, or risk/benefit of not relieving pressure having been reviewed with the resident, and any related care plan interventions. RN-E stated, "I did express concerns about him being up so much," which she stated she had discussed during wound care, although documentation to that effect was not found in the resident's record. RN-E stated she was unsure whether the care plan had been updated to reflect R222's refusal to be repositioned. The facility's 9/10, Pressure Ulcer Prevention Program policy indicated pressure ulcer prevention would be based on community standards of practice that would be monitored by the interdisciplinary team. Revisions were to be made based on changes in a resident's condition or when new risk factors were identified. "2. An assessment of the resident's need for turning and repositioning based on individual risk factors...6. The summary analysis of these assessments and any others that affect the resident's individual pressure ulcer prevention and/or treatment plan. 7. The plan of care reflects approaches to stabilize and/or reduce or remove the individuals risk factors for Pressure Ulcer development and/or promote healing of existing Pressure Ulcers...13. Ongoing education of the resident and family in Pressure Ulcer Prevention."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 28 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was reviewed and revised following hospitalization for 1 of 1 residents (R167) whose treatments changed following hospitalization. Findings include: R167's hospital discharge summary, dated 2/5/16, revealed the resident developed a left lower extremity deep vein thrombosis (DVT) with significant lower leg extremity swelling and some discomfort on 1/25/16. R167 was discharged with a prescription for warfarin (anticoagulant used to minimize the risk for heart attack, stroke, and blood clots). A Quick Wrap instruction sheet for leg swelling was included. R167's plan of care had been last revised	F 280	1. With respect to R#167: physician orders have been clarified and the care plan has been updated to reflect any changes to his treatment plan post hospital stay. The NAR assignment sheet has been updated to reflect these changes. The resident has since discharged from the facility. 2. All residents who have returned from the hospital within the past three months have had their records reviewed for any changes to their plan of care with revisions/updates to the care plan as indicated. The NAR assignment sheet has been updated to reflect any changes. 3. All nursing staff will be re educated by 3/23/16 regarding updating the resident care plan upon receipt of new orders, hospital return or change in condition	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 280 Continued From page 29 F 280

12/17/15, however, did not include any problems, goals or interventions related to R167's DVT and use of warfarin. A 2/5/16 individual temporary care plan lacked any identification of R167's new problems with appropriate goals and interventions to manage the problems.

On 2/10/16, at 1:49 p.m. the RN-B and RN-A confirmed R167 had been hospitalized on 1/21/16, and discharged back to the facility on 2/5/16. RN-A and RN-B confirmed R167 had new diagnoses including DVT and was prescribed warfarin. RN-A reported a new care plan had not been developed for R167 since he was scheduled for a significant change Minimum Data Set (MDS) assessment in the next few weeks. RN-A explained a temporary care plan could have been initiated to address concerns the new issues, however, the care plan had not yet been developed. RN-B reported therapy staff were wrapping R167's legs and nursing staff was applying Jobst stockings. However, on 2/11/16, at 8:35 a.m. RN-B clarified the Jobst stockings were an order prior to R167's hospitalization and a new order had been obtained to instead wrap R167's legs. RN-B reported the care plan should have been updated on 2/5/16, when R167 returned from the hospital.

R167's physical therapy (PT) plan of care, dated 2/5/16, revealed R167 had lower legs bandaged for the assessment. No care plan goal related to leg bandaging or wrapping. A PT note dated 2/5/16, read "pt [patient] has LE [lower extremities] bandaged and instructions were sent, however no actual order for either therapy or nursing to performR [sic]."

On 2/11/16, at 8:30 a.m. the director of

---

including revisions to the NAR assignment sheet when changes occur.
4. The director of Nursing and/or designee will audit three resident care plans each week for one month and then two resident care plans per week for two months to assure the plan of care for the individual resident is being revised and followed.
5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow-up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 30 rehabilitation therapy reported physical therapy staff was not wrapping R167's legs, as they did not have a current goal or physician order. A review of progress notes, dated 2/5/16 to 2/10/16, did not indicate any information or contact with R167's primary physician regarding leg bandaging or wraps or length of time R167 could be out of bed. R167's orders report for 1/16 and 2/16, revealed an order for warfarin five days, effective 2/5/16 until 2/10/16, at which date the international normalized ratio (INR/ laboratory testing to determine how thick or thin the blood is) was to be obtained. An order was requested and obtained on 2/10/16, for leg wraps and directions for staff to now allow the resident to sit in the wheelchair for greater than three hours. The facility's 8/13, Care Plan Completion policy directed, "A resident care plan is initiated on admission. The comprehensive plan is updated/revised as changes occur." The policy directed staff to include on the care plan "All current and acute chronic clinical conditions for which they are receiving medication, treatment, and/or care, which may include...Medication therapy/Treatment/Labs/monitoring such as Coumadin [warfarin] (abnormal bleeding/bruising, edema)."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 31 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate care after hospitalization for 1 of 1 resident (R167) reviewed for post-hospital care. Findings include: R167's family member (F)-A was interviewed on 2/9/16, at 12:58 p.m. F-A, reported concerns after R167 returned to the facility from the hospital on 2/5/16. The resident reported had a blood clot while in the hospital and F-A was worried about him sitting up for long stretches of time. F-A reported she had seen R167 sitting in his wheelchair for several hours after his return from the hospital. She had reported her concerns to staff over the weekend. On Sunday, she thought care concerns were resolved, but then on Monday noted R167 was again sitting in his chair for long periods of time. F-A reported she thought there must have been a miscommunication with the staff about R167's changing needs. On 2/10/16, F-A again reiterated her concerns staff was not addressing R167's change in condition. Although R167 was getting his legs wrapped in the hospital, this was not occurring at the facility. F-A reported R167 had gained a lot of fluid weight in his legs. F-A showed the surveyor R167's legs which were covered by a blanket. The legs were swollen and bare without wraps or stockings. F-A reported R167's legs were less swollen prior to hospitalization. F-A reported she had spoken to a	F 309	1. With respect to R#167: physician orders have been clarified and the care plan has been updated to reflect any changes to his treatment plan post hospital stay. The NAR assignment sheet has been updated to reflect these changes. 2. All residents who have been hospitalized within the past three months have had their records reviewed for any changes to their plan of care with revisions/updates to the care plan as indicated. The NAR assignment sheet has been updated to reflect any changes. 3. All nursing staff will be re educated by 3/23/2016 regarding updating the resident care plan upon receipt of new orders, hospital return or change in condition including revisions to the NAR assignment sheet when changes occur. 4. The director of nursing and /or designee will audit three resident care plans each week for one month and then two resident care plans per week for two months to assure the plan of care for the individual resident is being revised and followed. 5. The data collected will be presented to the QAPI committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality meeting. At this time the committee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 32 registered nurse(RN)-B about her concerns, but was not sure how the changes were being communicated and addressed. F-A also expressed concerns the bed was no longer an appropriate size for R167. R167's hospital discharge summary, dated 2/5/16, revealed the resident developed a left lower extremity deep vein thrombosis (DVT) with significant lower leg extremity swelling and some discomfort on 1/25/16. R167 was discharged with a prescription for warfarin (anticoagulant used to minimize the risk for heart attack, stroke, and blood clots). A Quick Wrap instruction sheet for leg swelling was included. R167's plan of care had been last revised 12/17/15, and did not include any problems, goals or interventions related to R167's DVT and use of warfarin. A 2/5/16 individual temporary care plan lacked any identification of R167's new problems with appropriate goals and interventions to manage the problems. On 2/10/16, at 1:49 p.m. the RN-B and RN-A confirmed R167 had been hospitalized on 1/21/16, and discharged back to the facility on 2/5/16. RN-A and RN-B confirmed R167 had new diagnoses including DVT and was prescribed warfarin. RN-A reported a new care plan had not been developed for R167 since he was scheduled for a significant change Minimum Data Set (MDS) assessment in the next few weeks. RN-A explained a temporary care plan could have been initiated to address concerns the new issues, however, the care plan had not yet been developed. RN-B reported therapy staff were wrapping R167's legs and nursing staff was applying Jobst stockings. However, on 2/11/16, at	F 309	make the decision/re-commendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33	F 309		

8:35 a.m. RN-B clarified the Jobst stockings were an order prior to R167's hospitalization and a new order had been obtained to instead wrap R167's legs. RN-B reported the care plan should have been updated on 2/5/16, when R167 returned from the hospital.

R167's physical therapy (PT) plan of care, dated 2/5/16, revealed R167 had lower legs bandaged for the assessment. No care plan goal related to leg bandaging or wrapping. A PT note dated 2/5/16, read "pt [patient] has LE [lower extremities] bandaged and instructions were sent, however no actual order for either therapy or nursing to performR [sic]."

On 2/11/16, at 8:30 a.m. the director of rehabilitation therapy reported physical therapy staff was not wrapping R167's legs, as they did not have a current goal or physician order.

A review of progress notes, dated 2/5/16 to 2/10/16, did not indicate any information or contact with R167's primary physician regarding leg bandaging or wraps or length of time R167 could be out of bed.

R167's orders report for 1/16 and 2/16, revealed an order for warfarin five days, effective 2/5/16 until 2/10/16, at which date the international normalized ratio (INR/ laboratory testing to determine how thick or thin the blood is) was to be obtained. An order was requested and obtained on 2/10/16, for leg wraps and directions for staff to now allow the resident to sit in the wheelchair for greater than three hours.

The facility's 8/13, Care Plan Completion policy directed, "A resident care plan is initiated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 34 admission. The comprehensive plan is updated/revised as changes occur." The policy directed staff to include on the care plan "All current and acute chronic clinical conditions for which they are receiving medication, treatment, and/or care, which may include...Medication therapy/Treatment/Labs/monitoring such as Coumadin [warfarin] (abnormal bleeding/bruising, edema)."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop provide proper care and services including care plan development to promote healing and/or minimize the risk of further pressure ulcer development for 1 of 3 residents (R222) reviewed for pressure ulcers. Findings include: R222 was observed in his room while lying on an air mattress in bed on 2/11/16, at 8:45 a.m. An electric, tilt-in-space wheelchair was in the room.	F 314	1. A comprehensive assessment for skin risk factors including the braden and turning and repositioning guidance was completed for R#222. The information was documented on the residents plan of care and the NAR assignment sheet. R #222 roho cushion is checked for proper inflation as instructed and documented when complete. Rejection of care and interventions to promote healing has been updated on the resident plan of care. The NAR assignment sheet reflects all changes. R#222 has been educated	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35	F 314		

The wheelchair had a seat cushion with a foam front and cutout in the rear filled with an air bladder where the resident would sit, as well as a contoured backrest. The surveyor briefly pressed on the air-filled portion, which contained air.

During interview with R222 on 2/11/16, at 8:45 a.m. he reported he had developed a pressure ulcer in June of 2015. Despite the use of an air-containing protective wheelchair cushion, the wound deteriorated and eventually required surgical repair. R222 asserted that prior to the discovery of the pressure ulcer, the air bladder was low and needed refilling. "I was getting sore...telling my nurse that my Roho air cushion had a hand pump in the closet to fill my seat. I told them it was low and needed to be filled...staff wouldn't do anything about it." Ulcers formed at the rear of both legs, with the right one becoming severe (larger and deeper). "[The area] developed a big ulcer at the point where the foam part meets the air part in an edge." R222 stated the right ulcer eventually required four debridements (surgically removing dead tissue) and surgery to close it with a flap of tissue.

R222 said that he had been going to Courage Kenny rehabilitation, where there they'd noted it [the air cushion] was completely flat, no date specified. R222 stated the Courage Kenny staff had inflated it and adjusted the pressure to meet his needs. After two debridement surgeries, R222 said the physician had directed the facility staff to learn the proper assessment/inflation technique. The resident explained the staff were supposed to "...come and put their hands on the cushion while it was under my butt so they would get the idea of what a properly inflated cushion for me would be...that never happened," except by

regarding the risks of not following the plan of care for preventing further skin breakdown. The negotiated risk was reviewed with R#222 on 3/9/2016.
2. All residents with current wounds have had their care plans reviewed to ensure the inclusion of all measures to promote healing and prevent further breakdown including rejections of care. The NAR assignment sheet has been updated to reflect any changes. Nursing leadership meets weekly to review wounds and progression of healing with discussion of new strategies for delayed or worsening wounds.
3. All nursing staff will be re-educated regarding measures to prevent skin breakdown, what to report and how the information/interventions are to be communicated. Education will be complete by 3/23/2016.
4. The director of nursing and/or designee will audit three residents each week for one month and then two residents each week for one month and the two residents per week for two months to assure the plan of care for the individual resident is being revised and followed for promoting healing and preventing further breakdown.
5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding and necessary follow up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36	F 314		

registered nurse (RN)-E "a couple of times." R222 then showed the surveyor a paper diagram illustrating how much space should have been between the cushion base and the buttocks when the resident was seated.

A 6/2/15, a quarterly Minimum Data Set (MDS) for R222 indicated: "Does this resident have one or more pressure ulcers at stage 1 or higher? No." However, the resident was identified at risk for pressure ulcer development, and treatment interventions were in place. R222 required extensive assistance from staff to reposition and transfer. MDS assessments consistently revealed R222 was cognitively intact and did not reject care or present other behavioral concerns.

A physician order dated 6/20/15 directed staff to: "Please contact wound clinic for input on managing Left IT [ischial tuberosity] decubitus ulcer and coccyx [tailbone] ulcer, and arrange appointment ASAP [as soon as possible] to be seen in wound clinic by [name of physician] or colleague."

An appointment referral form completed by Courage Kenny 6/23/15 indicated, "[R222's] cushion was completely flat!!!" The referral note further indicated Courage Kenny had added air during the session of an "appropriate amount to ensure proper positioning and pressure relief. Must check cushion for inflation daily. Physician orders: Check cushion daily for inflation to avoid pressure sores."

Further review of R222's medical record including treatment administration sheets, and care plan, failed to indicate staff had been checking the cushion daily to ensure proper inflation to meet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 37	F 314		

R222's needs. In addition, there was no evidence in any progress notes to indicate R222's cushion was ever checked for proper inflation.

Wound Summary documents for "Right thigh back" (a photo revealed it was the right ischial tuberosity/IT) indicated an initial measurement dated 6/23/15, of a stage 2 ulcer with a red (healthy) base which measured: 2.5 centimeters (cm) in length, 5.1 cm in width, and 0 cm in depth (2.5 x 5.1 x 0 cm). By 7/29/15, the ulcer was increased to stage 3 and was greater in size at 4.5 x 5.8 x 5.5 cm (a significant increase in depth).

Following surgical debridment, a progress note dated 8/6/15 included, "Comprehensive Courage Kenny and positioning evaluation was completed for [R222]. Braden score 14.0 indicating MODERATE RISK" due to co-morbidities, wound infections, diabetes, narcotic use, immobility, dependence on staff for activities of daily living, and current pressure ulcers." A progress note from 8/8/15 indicated, "Wound vac...resident refusing to get out of bed."

A significant change MDS dated 8/12/15, indicated R222 had one stage 3 and one stage 4 pressure ulcer, with measurements noted as 08. x 06. x 05.5 cm.

A progress note from a wound appointment dated 9/8/15, included: "Reason for appointment ...wheelchair cushion mapping. Cushion mapped well and [no] concerns when is properly inflated. Physician orders: Recommend therapist at facility [check] manual inflation of cushion one [time per] week. Roho cells are slightly under-inflated per [standard] guidance for best pressure relief."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38 However, a review of the facility's Courage Kenny Charting summary did not address the resident's 9/8/15 appointment or physician's order for therapists to monitor the resident's wheelchair cushion. A therapy progress note dated 9/9/15 included: "Physical Therapy/ Occupational Therapy Requires Courage Kenny nursing to meet resident's medical needs. Promote recovery, and ensure medical safety. Condition of resident is such that there is potential for changes in condition without Courage Kenny nursing intervention." A physician's progress note from 10/26/15, included: "wound improved...continue to pack foam in the undermined area of the wound. Can you call [physician name] in 1 week to discuss [plan of care--number provided]." A nursing note also indicated R222 was at the wound clinic for a dressing change. Although it was noted staff were to monitor wound vac and drainage from the wound, the notes did not reflect any follow-up call to the physician to ensure that R222's plan of care had been discussed as the physician had requested. In addition, review of the resident's care plan for that time indicated there had been no changes made to R222's care plan. The physician's progress notes from 12/22/15 indicated, "Pressure mapping completed, if cushion slightly air filled on [right] side, then mapping is good on [bilateral ischial tuberosity]. Recommend therapists check inflation on cushion [one time per] week." Review of the therapy notes following this visit did not identify whether the therapists were checking the cushion weekly for proper inflation. A therapy note dated 12/26/15 indicated, "Therapy services provided include. [incomplete sentence] Additional services are	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39 SUMMARY: Patient was in his chair for 15 minutes at 2000 [8:00 p.m.]. Repositioned twice on its [sic] own. Dressing changed; incision looks like it is healing well. The spot the surgeon circled [sic] on his right buttock is firm and mildly blanchable compared to the surrounding..." Therapy notes from 12/28/15 indicated, "Therapy services include Physical Therapy. Additional services are Post-surgical services Restorative Nursing." On 12/29/15, a nursing progress note indicated, "refused turning and repositioning" and indicated the resident had said he would call for help when he was ready to be repositioned. The note did not reflect education of the resident related to his choice to decline repositioning. R222's care plan last reviewed 12/15/15, revealed the resident had diagnoses including paraplegia (paralysis of lower limbs) and a history of multiple pressure ulcers related to immobility, including surgical repairs of a sacral ulcer on 2/23/15, and a stage 4 right ischial tuberosity (buttock) ulcer identified 11/24/15. The care plan indicated stage 2 pressure ulcers had developed on the resident's coccyx while he was hospitalized. Staff interventions included for staff to "educate resident/family/caregivers as to causes of breakdown...Encourage reposition/position changes during Customer Service Rounds...Avoid positioning on areas of concern. Pressure relieving device for bed, rotating low air loss mattress, turn, reposition at least every 2 hours, more often as needed or requested." A nutritional problem was also identified related to morbid obesity and pressure ulcers. Interventions included Prostat (a protein supplement) every day to promote ulcer healing. The care plan did not indicate any concerns with the resident rejecting care (e.g. refusal to	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40	F 314		

turn/reposition), and there were no approaches identified to educate the resident regarding the risks and benefits of his choices. In addition, the care plan lacked any information regarding the need to check the wheelchair cushion for proper inflation to minimize the risk for further pressure ulcer complications.

The current 2/9/16, Nursing Assistant Care Plan directed staff to assist R222 to "Repos: A2-4" [Reposition: assist every two to four hours] and "Reposition q2 [every two] hours/Nurse&NAR" (nursing assistant). There were no instructions on the Nursing Assistant Care Plan related to monitoring the inflation of the wheelchair cushion.

During an interview on 2/11/16, at 1:48 p.m. RN-E confirmed the cushion pump was on the back of R222's wheelchair in a bag. RN-E stated detailed instructions had been sent from Courage Kenny following his last wound debridement/surgical repair (11/2015) which directed staff to check for proper inflation weekly. RN-E stated R222 wanted to be up in the chair for longer periods of time, but believed he was supposed to be repositioned every two hours. She explained the two hour repositioning was noted on his care plan and on the care sheets.

RN-E was again interviewed on 2/12/16, at 11:53 a.m. RN-E stated the resident was being repositioned every two hours, and was up several hours a day, refusing to lie down. The surveyor then requested documentation regarding any assessment, or risk/benefit of not relieving pressure having been reviewed with the resident, and any related care plan interventions. RN-E stated, "I did express concerns about him being up so much," which she stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 41 discussed during wound care, although documentation to that effect was not found in the resident's record. RN-E stated she was unsure whether the care plan had been updated to reflect R222's refusal to be repositioned. The facility's 9/10, Pressure Ulcer Prevention Program policy indicated pressure ulcer prevention would be based on community standards of practice that would be monitored by the interdisciplinary team. Revisions were to be made based on changes in a resident's condition or when new risk factors were identified. "2. An assessment of the resident's need for turning and repositioning based on individual risk factors...6. The summary analysis of these assessments and any others that affect the resident's individual pressure ulcer prevention and/or treatment plan. 7. The plan of care reflects approaches to stabilize and/or reduce or remove the individuals risk factors for Pressure Ulcer development and/or promote healing of existing Pressure Ulcers...13. Ongoing education of the resident and family in Pressure Ulcer Prevention."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 42 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		
	This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and implemented prior to administration of a psychotropic drug and to monitor for effectiveness and potential side effects for 1 of 5 residents (R56) reviewed for unnecessary medication use. Findings include: R56 was prescribed Trazodone HCL (anti-depressant) 25 milligrams (mg) as needed (prn) at bedtime to promote sleep according to the resident's 2/16, Medication Administration Record (MAR). After the pharmacy consultant recommended a dosage change of Trazodone from 25 mg to 25 mg prn the dose was decreased to prn on 10/19/15. Although the hours of sleep were documented on the Treatment Administration Record (TAR), it lacked any information related to		1. With respect R#56: The care plan has been revised to include the non-pharmacological measures to promote sleep prior to administration of medications. The NAR assignment sheets have been revised to reflect the changes. 2. All residents currently receiving medications to promote sleep have been reviewed to assure non-pharmacological measures are implemented prior to administration of any prn medications for sleep. The NAR assignment sheet has been updated to reflect any changes. 3. All nursing staff will be re educated regarding non-pharmacological measures to promote sleep, what to report and how the information/interventions are to be communicated. Education will be completed by 3/23/2016. 4. The director of nursing and/or designee will audit three residents each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 43 non-pharmalogical interventions, medication effectiveness, and side effects in the TARs from 9/1/15 through 2/12/16. R56's MAR and TAR from 2/1/16 through 2/12/16, revealed R56 received prn Trazodone four times, but lacked documentation of non-pharmacological interventions prior to its use or a notation regarding efficacy of the medication. The nursing assistant (NA) current assignment sheet for R56 lacked any direction for NAs regarding measures to promote sleep. In addition R56's current care plan lacked identification of the use of psychotropic medications, goals, and appropriate interventions to promote sleep for R56. An interview with the pharmacy consultant on 2/10/16, at 11:16 a.m. revealed Trazodone was first prescribed on 3/9/15, at 50 mg at bedtime to promote sleep. A dose reduction was attempted on 7/13/15, to 25 mg and then on 10/19/15, to the current dose 25 mg prn. She further the medication had not been administered in 11/5 to 12/15, but had been administered 10 times in 1/16. The consultant further stated non-pharmalogical interventions should have been attempted at least an hour prior to use of psychotropic medications including Trazodone, especially when it was prescribed as needed. She also stated she expected side-effects and effectiveness would be monitored. On 2/10/16, at 11:53 a.m. a registered nurse (RN)-C reported the facility did not have specific non-pharmacological interventions identified to potentiate the resident's sleep. She stated, "We try to figure out her day. If she had enough to eat, if she is in pain, if she needs to be toileted or	F 329	week for one month and then two residents per week for two months to assure non-pharmacological interventions are in place and implemented prior to the administration of a prn medication for sleep. 5. The data collected will be presented to the QAPI committee by the director of nursing. At this time the committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 44	F 329		

repositioned. If all else fails we give her a prn." RN-C verified the interventions were not documented in R56's MAR/TAR or outlined in her care plan.

During an interview on 2/12/16, at 11:54 a.m. the director of nursing (DON) stated it was "odd " there was no prn Trazodone use during the months of 11/15 and 12/15, and then was administered the medication 10 times during 1/16. She added, "When it is for sleep, especially for prn medications, you should chart what you did to help them rest and not just give them a pill. At least you should talk to them." The DON further explained she was unaware of current non-pharmacological interventions or monitoring of side effects and effectiveness for sleep and sleep medications for R56.

A 9/13, Practice Guideline and Procedure for Sleep Monitoring, directed staff to "individualize staff non-pharmacological interventions intended to increase comfort and promote adequate sleep will be added to a resident care plan and NA (nursing assistant) sheet."

A 9/13, Psychoactive Medication Adverse Effect Monitoring policy, noted was the purpose was to "provide monitoring guidelines to nursing staff when a resident has been ordered a new or a change in psychopharmacological medication. Medication monitoring will begin on the first day of the medication initiation and continue for seven days. If any adverse effect if found within the first 7 days, nursing will update the medical provider and document in the clinical record describing the nature of the adverse effect and the potential impact on the resident's mental or physical condition or functional or psychological status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 45 The facility supports the goal of determining the underlying causes of sleep disturbance so appropriate treatment of environment or medical reasons are ruled out prior to the use of psychotropic medications. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing for the clinical situation. Psychotropic medications include antidepressant(s)."	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure meals were attractively served and palatable for 8 of 170 residents (R17, R44, R105, R20, R192, R129, R119, R217) who offered food complaints. Findings include: During observation of the noon dining service on 2/8/16, residents were seated and waiting for the meal that was scheduled to begin at noon. Food was were served from the 2 north (2N) kitchenette starting at 12:27 p.m. R17 reported on 2/8/16, at 12:24 p.m. were often served late. The meat was often tough and she had recently been served slimy mushrooms.	F 364	1. Facility reviewed diets and personal preferences for R17, R44, R105, R20, R192, R129, R119, R217. Updates completed to their dietary program, care plan, and diet orders if indicated. 2. The facility has increased dietary management to provide assistance with current policies and procedures, assure protocols are within guidelines for managing meal preparation. An evening supervisor has been hired to ensure all meal services start on time, foods are temped and appropriate for service and meals are audited at the time served for palatability. 3. All food service staff has been re educated regarding food preparation,	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 364

Continued From page 46

R105 reported on 2/8/16, at 12:30 p.m. he did not like the food. He said he had been served half-cooked hamburgers and burnt eggs.

R20 reported on 2/8/16, at 12:30 p.m. the food was often served lukewarm and she preferred hot food. When she requested the food be reheated, it was often not microwaved until it was hot.

R192 said on 2/10/16, at 12:05 p.m. dinner was regularly served late, often a half hour. Regarding reportedly being served very mushy vegetables R192 stated, "ish."

R129 reported on 2/10/16, at 12:11 p.m. the food tasted "terrible," was cold, mushy, and sometimes undercooked. In addition, meals were regularly served a half hour after the scheduled time.

R119 said on 2/10/16, at 12:15 p.m. the food tasted terrible, was often cold and was often served late.

On 2/10/16, at 12:21 p.m. the dietary aide (DA)-A started serving trays from the kitchenette for the 3 North dining room for the noon lunch meal. Plates were frequently observed to sit on the ledge between the kitchenette and dining room for 5-10 minutes before being served to residents. At 1:13 p.m. after the last plate was served, a test tray was requested by surveyor. Foods tested for food palatability included: a hot dog, potato salad, pureed peas, pureed fish, mashed potatoes, chicken, fish filet and milk. The potato salad was bland and lukewarm. A temperature of the potato salad was taken at 79 F (Fahrenheit). The fish fillet was mushy. The chicken was tough, with a leather like appearance, pink on the inside and

F 364

procedure for tasting prior to service, measures for temperature testing prior to meal service to assure appropriate temperature of foods, plating, room tray expectations, and serving hot and cold food items. All food service staff will have received education by 3/23/16.
4. The director of food service and/or designee will audit meal palatability on a weekly basis. Comment cards will be distributed randomly at alternating meal times for resident input into palatability, meal and service ratings. Data will be gathered and addressed.
5. The data collected will be presented to the QAPI committee by the Director of Food service. the data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 47	F 364		

chewy.

On 2/11/16, at 1:58 p.m. the dietary manager (DM) reported cooks should be taste testing foods. DM reported that if food was sitting the steam tray for over an hour it likely would not taste good. DM reported food service was at times delayed due to nursing staff not having residents ready and at times due to dietary staff shortages.

The Taste Testing policy, dated 2010, directed staff "All food is taste tested prior to serving. Procedure: 1. The cook is responsible for tasting all food before it is served. 2. Proper tasting procedures should be used. Use one spoon to serve food onto a dish or bowl, and use a new spoon to taste the food 3. All food not passing the taste test due to seasoning, toughness, color, or other negative factors is not to be served until the problem has been corrected. "

R44 reported in an interview on 2/8/16, at 2:39 p.m. "The food was disgusting. I have diabetes and they kept bringing me potatoes, bread and juice. They consistently bring these. They (the food) are too high in salt. It is cheap food and not healthy." She further stated it was often breaded to cover up the taste and quality. When asked about the food items observed in her room she explained she bought "good" food with her own money whenever she could afford to. R22's 1/21/16, Minimum Data Set (MDS) assessment indicated she was cognitively intact and made appropriate decisions.

A Providence Place Grievance/Feedback form dated 2/2/16 initiated by R22 read, "Meal options are poor. It comes late and is cold. Wants whole

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 48	F 364		

milk," and a form dated 2/8/16 also initiated by R22 read, "I get cold scrambled eggs every day."

R217's quarterly Minimum Data Set dated 12/14/15, revealed the resident was cognitively intact. R217 stated in an interview on 2/9/16, at 12:55 p.m. that the food and the snacks served at the facility were a "failure" and 7 of 10 items on the menu in one week tasted "awful." R217 described the food as "horrible...no seasoning...mushy...lack of variety." R217 reportedly routinely attended resident council meetings, and said food issues were always brought up by residents at the meetings, and she personally spoke up about ongoing food concerns. The dietary manager had attended some of the meetings, and residents were told there were plans for new menus, but nothing had changed since last fall and they just kept rotating the same menus. When asked why the residents could not get more variety, the DM said the menu items were "seasonal." R217 explained broccoli was served "constantly," and although she used to like it, she no longer did. That day she had specifically requested the alternate vegetable so she would not be served broccoli, however, then was served broccoli regardless of her request. R217 stated that today she purposely asked for the second option for the meal so that she would not get broccoli and she was then served broccoli anyway. Vegetables were served kind of "mushy" and foods were often either "undercooked or overcooked." That day the resident was served "a veal patty that was undercooked--pink in the middle--almost cold." R217 stated she ate meals in her room and her food was nearly constantly served cold. Although mealtime was scheduled to begin at 12:00 p.m. she received her meal between 12:30 and 12:50 p.m. and room trays

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 49 were the last to be delivered. When R217 heard other residents complain chicken was served undercooked and pink in the middle, they were told by the DM to have their food reheated in the microwave. R217 requested her food be reheated "once," but staff did not return in a timely manner. When she was served the wrong beverage, the staff never returned with the proper one. When she was given pureed peaches instead of her regular diet, the nursing assistant just walked away and did bring her the correct diet. R217 reported food often was served on paper plates due to dishwasher being broken, and the paper plates did not keep the food warm. Approximately half the time food was not delivered to her room with both the bottom plate warmer and the cover that was supposed to help keep the food warm. At 6:20 p.m. R217 reported she was served a hamburger patty on a bun with mustard and ketchup packets, but nothing else. R217 reported ongoing concerns with food had been brought up to staff and "is not being followed up on here and keeps getting mentioned at every resident council meeting."	F 364		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse	F 497		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 50 aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct performance reviews for 2 of 5 nursing assistants (NA-B, NA-D). This had the potential to affect multiple residents in the facility where the NAs may have been assigned to work. Findings include: A sample of five NA employee records were reviewed on 2/12/16, and the records were reviewed to annual evaluations were conducted. 1) NA-B was hired on 2/25/13. The most recent evaluation for NA-B was completed on 11/14/15. 2) NA-D was hired on 11/7/05. NA-D's employee file contained evidence of one performance evaluation completed on 5/31/11. On 2/12/16, at 1:00 p.m. a policy and procedure for conducting annual reviews was requested. The administrator confirmed there was no such policy. He stated the facility would follow a generally accepted practice of conducting evaluations yearly.	F 497	1. With respect to the identified evaluation: a current evaluation of work performance was completed for employee NA-d. 2. All employee files have been reviewed for current evaluations and those out of compliance for annual evaluation will be completed over the next quarter. 3. The guideline for completing annual performance evaluations has been developed and all leadership trained on the expectations for completing evaluations. 4. The human resource director and/or designee will audit five employee files each week for two months to assure evaluations are completed on a timely basis. 5. The data collected will be presented to the QAPI committee by the human resource director. The data will be reviewed/discussed at the monthly quality meeting. Ath this time the committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C **02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaints H5271179 and H5271180 were investigated and were unsubstantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing	F 156		3/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1	F 156		

facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C **02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide liability notices for 1 of 3 residents (R44) reviewed for liability notices and beneficiary appeal rights. Findings include: R44's Admission Record indicated the resident was admitted to the facility on 10/2/15. A nursing progress note dated 11/4/15, indicated the resident discharged on 11/4/15. While at the facility, R44 received physical and occupational therapy services. R44's Medicare denial date was 10/29/15,	F 156	F156 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of state and federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to R#44, a verbal notice for non coverage was provided on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3	F 156		

according to the Notices of Medicare Non-Coverage (NOMNC) it was noted, however, the resident's responsible party's signature on the form was also dated 10/29/15.

A registered nurse (RN)-C stated in an interview on 2/12/16, at 11:12 a.m. she was responsible for issuing denial notices. RN-C explained R44 was not progressing in therapy and was therefore was denied Medicare services for skilled care. R44 was not able to sign the denial notice do to his cognitive deficiency. RN-C explained she received notice from therapy on 10/27/15, that R44's Medicare coverage was ending. She contacted R44's responsible party on 10/28/15, regarding the end of therapy date of 10/29/15. The son signed the NOMNC and dated it 10/29/15. RN-C further verified the guidance from Centers for Medicare Services (CMS) required no less than a two day notice should have been given when Medicare services were withdrawn. RN-C stated, "I gave him a 24 hour notice, not a 48 hour notice."

A progress note written 10/29/15, at 2:23 p.m. indicated RN-C spoke with R44's responsible party regarding NOMNC and last covered day for Medicare services was 10/30/15. The call was place to the son on 10/28/15. The NOMNC was left in the business office for him to sign as well as a copy.

The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, approved 10/31/11 stated: "A Medicare provider or health plan must give in advance , a completed copy of the NOMNC to beneficiaries/enrollees receiving skilled care--services no later than two days before the termination of services."

10/28/2015 and written notice of non-coverage was provided to his decision maker on 10/29/2015. R#44 discharged from the facility 11/4/2015.
2. Any resident who is currently on a skilled stay and pending discharge will be discussed daily mon-fri at the interdisciplinary meeting. Notices of liability will be completed and signed by the appropriate party with 48 hours advanced notice.
3. The IDT meeting minutes (form) and Guidelines has been revised to include discussion of all pending discharges. All admissions, billing, social service, MDSC and case manager and therapy staff will receive education regarding the process for communicating discharges and beneficiary notices within the required time frames.
4. The administrator and or/designee will audit two residents admitted within the past 30 days each week for one month and then one resident each week for two months to assure there is documentation of appropriate notifications.
5. The data collected will be resented to the QAPI committee by the administrator and/or designee. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any neccesary follow up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 4 An interview with the interim director of nursing on 2/12/16,at 11:43 a.m. revealed she expected staff to use the protocol set forth by CMS to provide a 48-our notice so residents would have time to plan for discharge.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate attire was maintained for 2 of 2 residents (R22, R186) who reported missing clothing. Findings include: R22 was interviewed on 2/10/16, at 2:43 p.m. to follow up on concerns regarding various concerns voiced by the resident during a formal interview on 2/8/16, at 2:39 p.m. voiced by the resident. R22 was admitted to the facility in 5/15, and at that time arrived with seven pair of pants, and much of her clothing had since "disappeared." The resident explained she currently had only one pair of pants, and four other pair were "missing." R22 explained that on Saturday morning (2/6/16) she had been informed "I had nothing to wear" with the exception of a shirt. When R22 complained of her missing clothing to the nursing assistant (NA) she reportedly responded, "'It	F 241	1. With respect to R #22, and R# 186: social services has approached the residents regarding missing clothing items. All items that were not found have been replaced. 2. All feedback forms for the past three months have been reviewed for Missing property. All residents identified with missing items have been followed up and the items found or replaced as able. 3. The system for logging in concerns and action plan results is revised to include a three day time frame. Concerns/forms are brought up daily in the morning idt meeting all staff will receive re-education regarding the missing property guideline and feedback form for reporting missing items by 3/23/16. 4. The director of nursing and/or designee will audit three residents each	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5	F 241		

happens.'" The NA then went to look for R22's missing clothing in the laundry and was unable to find any of the resident's pants. The resident stated she was "stuck in the chair with the horrible hospital gown" until noon, when the NA found her a pair of "very ugly" men's pants to wear. "It was humiliating to be defenseless without clothing and having someone looking for something for me to wear...I'm dependent on the staff for help and to take care of me." R22 stated she "gave up wearing bras" as they got lost in the laundry and "nobody cares...I feel better with a bra on." The resident gave the surveyor permission to look in her closet and dressers and the only clothing available was six shirts, two sweaters, shawl, coat, and no pants, and no bras.

R22's 1/21/16, Minimum Data Set (MDS) assessment indicated she was cognitively intact and required extensive assistance from staff to dress.

The licensed graduate social worker (LGSW) was interviewed on 2/10/16, at 3:03 p.m.
and stated she did not know much about resident clothing, and had not received a report that R22 was missing pants.

On 2/11/16, at 9:08 a.m. the director of social services (DSS) explained he had initiated a grievance for R22 on 2/9/16, following a report of missing clothing. The DSS reported the ombudsman had informed him R22 had no clothing over the weekend, and he planned to order clothing for the resident that day. At 10:25 a.m. the DSS said he had followed up with R22 and obtained a list of items she needed. In the meantime, they had found extra clothing in the laundry which was labeled with R22's name. The

week for two months for assuring that the resident is dressed in a dignified manner and has appropriate attire available.
5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6	F 241		

facility's plan was to replace the resident's missing clothing.

The director of nursing stated in an interview on 2/12/16, at 9:55 a.m. the staff should have reported R22's missing clothing.

The administrator explained on 2/12/16, at 10:05 a.m that approximately three months prior there had been complaints of missing resident clothing. He thought the problem was personal laundry was inadvertently being sent out with the linens to an outside laundry service, when the laundry should have instead been laundered at the facility. He said par of the problem was that some staff were unsure how to pass on such information. The facility's policy was to replace missing items if they were responsible.

R186 (whose room was at the far end of the hallway from the nursing station/elevator) was observed wearing only underwear as he was in wheelchair at the nursing station on 2/12/15, at approximately 1:10 p.m. The registered nurse (RN)-D was heard telling the resident, "Let's go downstairs [to the laundry room] and take a look." While still only wearing underwear, R186 and RN-D got onto the elevator. At 1:21 p.m. R186 explained, "I wear my shorts two to three times in a row and send them to laundry. I was missing eight pair of shorts today," and said he had reported the problem to the LGSW that day. R186 stated, "I don't want to wait another ten weeks for them to replace them like they did the last time when I lost six pair. I had to buy them myself. It bothers me that I had to come out in my underwear, but what am I supposed to do?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 7 R186's 11/28/15, MDS indicated he was cognitively intact. RN-D was approached at 2/12/16, at 1:30 p.m. and immediately stated, "I should have put a blanket on him [R186] instead of letting him go around in his underwear. It is dignity. He had no shorts. We went downstairs and found two pairs of his shorts. He told me six were still missing." The facility's 2/11 Personal Property Loss policy indicated the facility was not responsible for lost or missing items, however, would facilitate the recovery of items whenever possible. "The person reporting the loss should complete a Feedback Form" which was then given to the executive director." The policy delineated a process for looking for the missing items. The facility's 6/18/14, Promoting Resident Rights and Dignity policy noted each staff member was responsible for protecting and promoting each resident's rights.	F 241		
F 244 SS=F	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation,interview and document review, the facility failed to ensure a system for	F 244	1. With respect to the identified residents: each resident was met with	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 8	F 244		

addressing resident council concerns/grievances was implemented to ensure issues were resolved to residents' satisfaction to the extent possible. This practice had the potential to affect all 170 residents including complaints registered by several residents (R17, R105, R20, R195, R217, R48, R192, R129, R119) who reported un-addressed concerns regarding residents being served cold and inappropriately cooked food, as well as residents (R186, R22) who reported missing clothing.

Findings include:

SNF [Skilled Nursing Facility] Resident Council Meeting Agenda and Minutes from 8/15 to 1/16 were reviewed. The minutes included Concerns/Issues, Action, Resolution and Date, and Responsible Party. The minutes, however, revealed a lack of documentation showing the facility's actual resolutions to residents' concerns. Examples were as follows:

1) On 8/19/15, Old Business: a) a resident on 2 north reported room trays were late and "luke-warm" and two other residents on 2 north stated nursing assistants (NAs) who served meals need to be "more attentive and They [residents] feel like they are getting ignored." Additional issues included b) staff "still" not knocking c) missing clothing d) bathroom cleaning, and e) music selection during meals. The Action was to follow up with appropriate staff. The Resolution and Date was "Ongoing." New Business included a) salads were "still" being served after the main meal, and b) suggested residents complete anonymous audits related to their dining experience, staff not knocking (continued issue) and residents wanted a

individually and an action plan developed for resolution to concerns. A follow up meeting with each of the identified residents will be conducted to determine level of satisfaction and any further action needed.
2. The previous 6 months of resident council minutes have been reviewed and a plan of action developed for the identified concerns regarding: call lights, food quality, and missing items/laundry. A follow up resident council meeting is scheduled to discuss actions taken, and an continued areas of concern.
3. The system for logging in concerns and action plan results is revised to include a response within a 3 day time frame. Concerns/forms are brought up daily in the morning idt meeting. The leadership team will receive education regarding the procedure for follow up to resident council concerns and action plans for correction. Education will be completed by march 23 2016.
4. The executive director and/or designee will audit the resident council minutes, areas of concern identified and action plans post council. Action plans will be audited to assure satisfactory outcomes as much as possible.
5. The data collected will be presented to the qapi committee by the executive director. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 9 suggestion box. No plan of action or responsible party was designated. Although council members suggested residents complete audits, staff completed audits from 8/14/15 to 8/31/15. The audits did not include whether food was served at the proper temperatures. 2) On 9/16/15, Old Business was noted, with action including follow up with appropriate staff on issues, and inviting the administrator and director of nursing (DON) to the meetings. The Resolution and Date was "Ongoing." New Business: request to know where to find grievance forms, signage by the community book, housekeeping issues (smells, cleaning bathrooms), missing clothing, staff not knocking. Action was to add additional grievance forms, adding requested signage, follow up with housekeeping, and follow up with nursing staff. The Resident's Bill of Rights for right to voice grievances was covered, however, did not indicate whether staff asked the residents whether they felt their grievances were adequately addressed by facility staff. 3) On 10/21/15, Old Business included Resolution for grievance forms and signage was completed. "Completed/ongoing: New Housekeeping Director has been hired and concerns should be resolved. Ongoing: education with staff provided to assist with these concerns." New Business: Call lights still remain a concern, would like name tags visible, cleaning issues including elevator carpet and mold in the shower, food temperature and serving times, council member voting. Action Plan: Continue to educate at unit meetings, all staff reminded regarding name tags, housekeeping is addressing "many issues"-under new management and no mold in bathroom, but was cleaned, dietary manager explained food service delivery process is a team	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 10	F 244		

effort with nursing to pass meals.
4) On 11/9/15, Old Business: Resolutions "ongoing education, new housekeeping manager, and shower cleaned. New Business: call light times getting better but some residents felt could still improve. No Action listed.
5) On 12/16/15, Old Business: Call light resolution was "ongoing." New Business: Request to continue education on door knocking, call lights are longer than residents would like, "night shift needs a refresher," want sign as to who is supervisor on each shift.
6) On 1/20/16, Old Business: Continue to discuss knocking at unit meeting, DON explained how call light system works and has been steadily improving over the last few months, DON will find solution and post supervisors' names. Resolution was "Ongoing. "

In addition, the resident grievance log from 11/20/15 to 1/26/16 also included resident concerns consistent with concerns brought up in resident council meetings such as: 11/20 room cleaning and call lights; 12/3 room cleaning; 12/8, not getting snacks (3N); 12/8 lack of food variety (3N); 12/9 cold food (3N); 12/16 food issue (3N); showers; 12/18 room odors, showers; 12/22 dietary concerns (2N); 12/22 meal concern (3N); and 12/24 "residents" meal concerns; 1/6 call lights and cold food (2N); 1/13 food concerns (2N); and 1/25 dietary concerns (3N). The grievance log noted various staff members reviewed the resident concerns.

FOOD AND CALL LIGHTS:

Two Feedback Forms revealed concerns consistent with comments made in resident council meetings. 1) On 12/9/15, a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C **02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 11	F 244		

voiced, "Concerns of cold food delivered to his room." Follow up with the resident on 12/11/15, indicated staff "Explained to resident that room trays are delivered after everyone in the dining room has been served--encouraged resident to eat in dining room. Staff will continue to monitor steam table temperatures to ensure they are correct." 2) On 1/6/16, a staff person reported for a resident on 2N expressed concerns that "Food is cold for all meals" and "Concerns of call light times being too long." The Action Plan was staff encouraged the resident to eat meals in the dining room as room trays were delivered after residents in the dining room have been served. Kitchen staff were to ensure food was served at correct temperatures/steam table at right temperature. The resolution was noted as discussed with the resident on 1/11/16, however, did not include information as to whether the resident expressed satisfaction regarding the follow up.

During an interview on 2/8/16, at 8:26 a.m. with the dietary manager (DM) he explained two staff had called in and he apologized that he was rushing around the kitchen to help the other staff on duty. The DM stated meals times for all floors were 8:00 a.m. 12:00 p.m. and 6:00 p.m.

Continuous dining observations on 2N were conducted on 2/8/16, from 12:09 p.m. to 12:37 p.m. Twenty-five residents were seated in the dining room waiting for the noon meal to be served. A cart containing salad ingredients was near the serving door by the kitchenette. At 12:17 p.m. a NA began asking residents whether they wanted a salad. At 12:26 p.m. the NA continued serving salads when the doors opened into the kitchenette to indicate the main meal was ready

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 12	F 244		

to be served. The first plate of food was served at 12:37 p.m. Forty-five minutes later at 12:48 p.m. a resident room tray was delivered to a resident.

R17 reported on 2/8/16, at 12:24 p.m. food was often served late. The meat was often tough and she had recently been served slimy mushrooms.

R105 reported on 2/8/16, at 12:30 p.m. he did not like the food. He said he had been served half-cooked hamburgers and burnt eggs.

R20 reported on 2/8/16, at 12:30 p.m. the food was often served lukewarm and she preferred hot food. When she requested the food be reheated, it was often not microwaved until it was hot.

R195 stated during an interview on 2/8/16, at 3:30 p.m. he ate his meals in his room. He did not eat the noon meal that day because it arrived late, was cold and was not what he had ordered. "The meatloaf was awful and I wanted corn not green beans." Then R195 pointed to the monthly menu "here see it states corn today not green beans." R195 stated that something needed to be done about the food and had requested to speak to the DM, but instead another dietary staff person was sent. In a follow up interview on 2/11/16, at 4:36 p.m. R195 described the food as "Always cold and always late. The eggs are cold and my milk was frozen." R195 explained that at a care conference four weeks ago he asked for the DM to come to his room to discuss food issues. "Just this morning my breakfast order was taken before 8:00 a.m. and delivered to me at 8:25 a.m. "I have my daughter bring in food because it's always chicken...no fresh fruit like bananas...everything comes in a can."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 13 R217 stated in an interview on 2/9/16, at 12:55 p.m. that the food and the snacks served at the facility were a "failure" and 7 of 10 items on the menu in one week tasted "awful." R217 described the food as "horrible...no seasoning...mushy...lack of variety." R217 reportedly routinely attended resident council meetings, and said food issues were always brought up by residents at the meetings, and she personally spoke up about ongoing food concerns. The dietary manager had attended some of the meetings, and residents were told there were plans for new menus, but nothing had changed since last fall and they just kept rotating the same menus. When asked why the residents could not get more variety, the DM said the menu items were "seasonal." R217 explained broccoli was served "constantly," and although she used to like it, she no longer did. That day she had specifically requested the alternate vegetable so she would not be served broccoli, however, then was served broccoli regardless of her request. R217 stated that today she purposely asked for the second option for the meal so that she would not get broccoli and she was then served broccoli anyway. Vegetables were served kind of "mushy" and foods were often either "undercooked or overcooked." That day the resident was served "a veal patty that was undercooked--pink in the middle--almost cold." R217 stated she ate meals in her room and her food was nearly constantly served cold. Although mealtime was scheduled to begin at 12:00 p.m. she received her meal between 12:30 and 12:50 p.m. and room trays were the last to be delivered. When R217 heard other residents complain chicken was served undercooked and pink in the middle, they were told by the DM to have their food reheated in the	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 14	F 244		

microwave. R217 requested her food be reheated "once," but staff did not return in a timely manner. When she was served the wrong beverage, the staff never returned with the proper one. When she was given pureed peaches instead of her regular diet, the nursing assistant just walked away and did bring her the correct diet. R217 reported food often was served on paper plates due to dishwasher being broken, and the paper plates did not keep the food warm. Approximately half the time food was not delivered to her room with both the bottom plate warmer and the cover that was supposed to help keep the food warm. At 6:20 p.m. R217 reported she was served a hamburger patty on a bun with mustard and ketchup packets, but nothing else. In addition, the resident expressed concerns snacks were not being passed to residents, rather were left at the nursing station. R217 reported ongoing concerns with food had been brought up to staff and "is not being followed up on here and keeps getting mentioned at every resident council meeting." R217's quarterly Minimum Data Set dated 12/14/15, revealed the resident was cognitively intact.

R48 reported in an interview on 2/9/16, at approximately 1:00 p.m. she consistently attended resident council meetings. R48 explained she preferred to eat her meals in her room, but "the food that is being served is cold and always late." A follow up interview on 2/11/16, at 4:26 p.m. R48 stated yesterday her dinner meal tray was delivered to her at 6:45 p.m. "cold and late." R48 explained that she had spoken to the DM about the food quality and his reply was, "'It not his fault--the nursing assistant has to get it to you on time.'" She went on to say if she asked to have her food re-heated the staff "gets upset,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 15	F 244		

so I don't ask because I don't want to get hollered at or then they give me an attitude. I just eat the cold food but I pay a lot of money to live here. Why can't I get a good meal?" R48 stated other residents suggested more choices like lasagna, Frito pie and creamed tuna over toast/rice. The DM just tells the residents they have to make sure all residents can eat the food, "so we never get it."

R192 said on 2/10/16, at 12:05 p.m. dinner was regularly served late, often a half hour. Regarding reportedly being served very mushy vegetables R192 stated, "ish."

R129 reported on 2/10/16, at 12:11 p.m. the food tasted "terrible," was cold, mushy, and sometimes undercooked. In addition, meals were regularly served a half hour after the scheduled time.

R119 said on 2/10/16, at 12:15 p.m. the food tasted terrible, was often cold and was often served late.

During an interview on 2/10/16, at approximately 11:55 a.m. the DM stated he had heard of complaints about milk being always spoiled from R195. The DM stated the facility went through milk so fast that it didn't even get close to the expiration date on the container. The DM explained he was on vacation the previous week, and this was the first time he heard R195 wanted to speak to him, and had not yet done so. The DM verified a dietary staff person had spoken to R195 about food issues, mainly about spoiled milk.

LAUNDRY:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 16	F 244		

R186 was observed wearing only underwear as he was in wheelchair at the nursing station on 2/12/16, at approximately 1:10 p.m. At 1:21 p.m. R186 explained, "I was missing eight pair of shorts today...I don't want to wait another ten weeks for them to replace them like they did the last time when I lost six pair. I had to buy them myself. It bothers me that I had to come out in my underwear, but what am I supposed to do?"

R22 reported on 2/10/16, at 2:43 p.m. that on 2/6/16 she had been informed "I had nothing to wear" with the exception of a shirt. When R22 complained of her missing clothing to the nursing assistant (NA) she reportedly responded, "'It happens.'" The NA then went to look for R22's missing clothing in the laundry and was unable to find any of the resident's pants. R22 also stated she "gave up wearing bras" as they got lost in the laundry and "nobody cares...I feel better with a bra on." The resident gave the surveyor permission to look in her closet and dressers and the only clothing available was six shirts, two sweaters, shawl, coat, and no pants and no bras.

The administrator explained on 2/12/16, at 10:05 a.m that approximately three months prior there had been complaints of missing resident clothing. He thought the problem was personal laundry had been inadvertently sent out with the linens to an outside laundry service, when the laundry should have instead been laundered at the facility. He said part of the problem was that some staff were unsure how to pass on such information (missing clothing).

During an interview on 2/11/16, at 3:57 p.m. the director of community life (DCL) stated she was the representative for resident council and tried to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 17 attend all meetings. She handled related resident grievances. The DCL explained if residents had concerns during the meeting, she ensure the issue was brought forth and delivered to the appropriate staff for follow up (such as food issues to the DM). The DCL stated if a resident brought up the same concern at the next meeting, she started the process all over again, except this time she would tell the staff person "the issue has come up again." On 2/11/16, at 4:07 p.m. the DM stated he attended resident council with the DLC, where they talked to residents about food issues. The DM verified he was aware of resident concerns regarding food temperatures from mostly 2N and 3N. The DM explained the dietary department had purchased thermal cover and bottoms to help keep the food warmer. Staff measured temperatures of the food in the hot wells, and plates "go up the line as soon as they are prepared...We put the food on the plate and it's hot--then I'm not sure what happens once the plate is ready to be served. It's up to the nursing staff to deliver it to the resident room--it's a team effort. Sometimes my staff is just standing/waiting and there are no nursing assistants to serve the plates." The facility's 2/1/15, Resident Council and Tenant meeting Guidelines indicated "each individual department will report on issues/concerns/changes etc. and will report on follow-up of any previous issues or concerns identified by residents." The facility's 2/15, Feedback Form Guideline and Action Plan indicated the"Department Head or designee will investigate the grievance/comment/suggestion and record the findings of the investigation as	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 18 well as the action plan for the resolution on the appropriate area on the attached Feedback Form Action Plan...Executive Director/Department Head is responsible for contacting the person who initiated the Feedback Form and provide them with feedback on the resolution on the concern within (3) working days of receiving the concern."	F 244		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and implemented	F 279	1. With respect to R#56: the care plan has been revised to include the non pharmacological measures to promote	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C **02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19 prior to administration of a psychotropic drugs for 1 of 5 residents (R56) reviewed for unnecessary medication use; in addition, the facility failed to ensure the care plan was developed to include necessary interventions to promote healing and minimize the risk for further pressure ulcer breakdown for 1 of 2 residents (R222) reviewed with pressure ulcers. Findings include: R56's current care plan lacked identification of the use of psychotropic medications, goals, and appropriate interventions to promote sleep for R56. In addition, the nursing assistant (NA) current assignment sheet for R56 lacked any direction for NAs regarding measures to promote sleep. R56 was prescribed Trazodone HCL (anti-depressant) 25 milligrams (mg) as needed (prn) at bedtime to promote sleep according to the resident's 2/16, Medication Administration Record (MAR). After the pharmacy consultant recommended a dosage change of Trazodone from 25 mg to 25 mg prn the dose was decreased to prn on 10/19/15. Although the hours of sleep were documented on the Treatment Administration Record (TAR), it lacked any information related to non-pharmacological interventions that may have been attempted prior to administering the as needed medication. An interview with the pharmacy consultant on 2/10/16, at 11:16 a.m. revealed Trazodone was first prescribed for R56 on 3/9/15, at 50 mg at bedtime to promote sleep, and the current dose was 25 mg prn. The medication had been 10 times in 1/16. The consultant further stated	F 279	sleep prior to administration of medications. With respect to R#222, the care plan has been revised to include all measures in place to promote wound healing and prevent further breakdown as well as R#222 rejection of care. R#222 has been provided the risks associated with rejection of care. The NAR assignment sheets have been revised to reflect the changes. 2. All residents currently receiving medications to promote sleep have been reviewed to assure non-pharmacological measures are identified prior to administration of any prn medications for sleep. All residents with current wounds have had their care plans reviewed to ensure the inclusion of all measures to promote healing and prevent further breakdown including any rejections of care. The NAR assignment sheet has been updated to reflect any changes. 3. All nursing staff will be re-educated regarding non pharmacological measures to promote sleep and measures to prevent skin breakdown, what to report and how the information/interventions are to be communicated. Education will be completed by 3/23/16. 4. The director of nursing and/or designee will audit three residents each week for one month and then two residents per week for two months to assure the plan of care for the individual resident is being revised and followed. 5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20 non-pharmacological interventions should have been attempted at least an hour prior to use of psychotropic medications including Trazodone, especially when it was prescribed as needed. She also stated she expected side-effects and effectiveness would be monitored. On 2/10/16, at 11:53 a.m. a registered nurse (RN)-C reported the facility did not have specific non-pharmacological interventions identified to improve the resident's sleep. She stated, "We try to figure out her day. If she had enough to eat, if she is in pain, if she needs to be toileted or repositioned. If all else fails we give her a prn." RN-C verified the interventions were not documented in R56's MAR/TAR or outlined in her care plan. During an interview on 2/12/16, at 11:54 a.m. the director of nursing (DON) stated regarding the Trazodone use, "When it is for sleep, especially for prn medications, you should chart what you did to help them rest and not just give them a pill. At least you should talk to them." The DON further explained she was unaware of current non-pharmacological interventions or monitoring of side effects and effectiveness for sleep and sleep medications for R56. At 11:53 a.m. a registered nurse (RN)-C stated the facility did not have specific nonpharmacological interventions to improve sleep. She stated, "We try to figure out her day, if she had enough to eat, if she is in pain, if she needs to be toileted or repositioned. If all else fails we give her prn." RN-C verified these interventions were not documented in R56's records or care plan.	F 279	meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21 The Providence Place Practice guideline and Procedure for Sleep Monitoring, dated Sept 2013, directs staff to individualize staff non-pharmacological interventions intended to increase comfort and promote adequate sleep will be added to a resident care plan and NA (nursing assistant) sheet. A 9/13, Practice Guideline and Procedure for Sleep Monitoring, directed staff to "individualize staff non-pharmacological interventions intended to increase comfort and promote adequate sleep will be added to a resident care plan and NA (nursing assistant) sheet." A 9/13, Psychoactive Medication Adverse Effect Monitoring policy, noted was the purpose was to "provide monitoring guidelines to nursing staff when a resident has been ordered a new or a change in psychopharmacological medication." R222's care plan was not developed to incorporate all necessary interventions to promote healing/prevent further breakdown. R222's care plan last reviewed 12/15/15, revealed the resident had diagnoses including paraplegia (paralysis of lower limbs) and a history of multiple pressure ulcers related to immobility, including surgical repairs of a sacral ulcer on 2/23/15, and a stage 4 right ischial tuberosity (buttock) ulcer identified 11/24/15. The care plan indicated stage 2 pressure ulcers had developed on the resident's coccyx while he was hospitalized. Staff interventions included for staff to "educate resident/family/caregivers as to causes of breakdown...Encourage	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 22	F 279		

reposition/position changes during Customer Service Rounds...Avoid positioning on areas of concern. Pressure relieving device for bed, rotating low air loss mattress, turn, reposition at least every 2 hours, more often as needed or requested." The care plan did not indicate any concerns with the resident rejecting care (e.g. refusal to turn/reposition), and there were no approaches identified to educate the resident regarding the risks and benefits of his choices. In addition, the care plan lacked any information regarding the need to check the wheelchair cushion for proper inflation to minimize the risk for further pressure ulcer complications.

The current 2/9/16, Nursing Assistant Care Plan directed staff to assist R222 to "Repos: A2-4" [Reposition: assist every two to four hours] and "Reposition q2 [every two] hours/Nurse&NAR" (nursing assistant). There were no instructions on the Nursing Assistant Care Plan related to monitoring the inflation of the wheelchair cushion.

R222 was observed in his room while lying on an air mattress in bed on 2/11/16, at 8:45 a.m. An electric, tilt-in-space wheelchair was in the room. The wheelchair had a seat cushion with a foam front and cutout in the rear filled with an air bladder where the resident would sit, as well as a contoured backrest. The surveyor briefly pressed on the air-filled portion, which contained air.

During interview with R222 on 2/11/16, at 8:45 a.m. he reported he had developed a pressure ulcer in June of 2015. Despite the use of an air-containing protective wheelchair cushion, the wound deteriorated and eventually required surgical repair. R222 asserted that prior to the discovery of the pressure ulcer, the air bladder

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 23	F 279		

was low and needed refilling. "I was getting sore...telling my nurse that my Roho air cushion had a hand pump in the closet to fill my seat. I told them it was low and needed to be filled...staff wouldn't do anything about it." Ulcers formed at the rear of both legs, with the right one becoming severe (larger and deeper). "[The area] developed a big ulcer at the point where the foam part meets the air part in an edge." R222 stated the right ulcer eventually required four debridements (surgically removing dead tissue) and surgery to close it with a flap of tissue.

R222 said that he had been going to Courage Kenny rehabilitation, where there they'd noted it [the air cushion] was completely flat, no date specified. R222 stated the Courage Kenny staff had inflated it and adjusted the pressure to meet his needs. After two debridement surgeries, R222 said the physician had directed the facility staff to learn the proper assessment/inflation technique. The resident explained the staff were supposed to "...come and put their hands on the cushion while it was under my butt so they would get the idea of what a properly inflated cushion for me would be...that never happened," except by registered nurse (RN)-E "a couple of times." R222 then showed the surveyor a paper diagram illustrating how much space should have been between the cushion base and the buttocks when the resident was seated.

A 6/2/15, a quarterly Minimum Data Set (MDS) for R222 indicated: "Does this resident have one or more pressure ulcers at stage 1 or higher? No." However, the resident was identified at risk for pressure ulcer development, and treatment interventions were in place. R222 required extensive assistance from staff to reposition and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 24	F 279		

transfer. MDS assessments consistently revealed R222 was cognitively intact and did not reject care or present other behavioral concerns.

A physician order dated 6/20/15 directed staff to: "Please contact wound clinic for input on managing Left IT [ischial tuberosity] decubitus ulcer and coccyx [tailbone] ulcer, and arrange appointment ASAP [as soon as possible] to be seen in wound clinic by [name of physician] or colleague."

An appointment referral form completed by Courage Kenny 6/23/15 indicated, "[R222's] cushion was completely flat!!!" The referral note further indicated Courage Kenny had added air during the session of an "appropriate amount to ensure proper positioning and pressure relief. Must check cushion for inflation daily. Physician orders: Check cushion daily for inflation to avoid pressure sores."

Further review of R222's medical record including treatment administration sheets, and care plan, failed to indicate staff had been checking the cushion daily to ensure proper inflation to meet R222's needs. In addition, there was no evidence in any progress notes to indicate R222's cushion was ever checked for proper inflation.

Wound Summary documents for "Right thigh back" (a photo revealed it was the right ischial tuberosity/IT) indicated an initial measurement dated 6/23/15, of a stage 2 ulcer with a red (healthy) base which measured: 2.5 centimeters (cm) in length, 5.1 cm in width, and 0 cm in depth (2.5 x 5.1 x 0 cm). By 7/29/15, the ulcer was increased to stage 3 and was greater in size at 4.5 x 5.8 x 5.5 cm (a significant increase in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 25	F 279		

depth).

Following surgical debridment, a progress note dated 8/6/15 included, "Comprehensive Courage Kenny and positioning evaluation was completed for [R222]. Braden score 14.0 indicating MODERATE RISK" due to co-morbidities, wound infections, diabetes, narcotic use, immobility, dependence on staff for activities of daily living, and current pressure ulcers." A progress note from 8/8/15 indicated, "Wound vac...resident refusing to get out of bed."

A significant change MDS dated 8/12/15, indicated R222 had one stage 3 and one stage 4 pressure ulcer, with measurements noted as 08. x 06. x 05.5 cm.

A progress note from a wound appointment dated 9/8/15, included: "Reason for appointment ...wheelchair cushion mapping. Cushion mapped well and [no] concerns when is properly inflated. Physician orders: Recommend therapist at facility [check] manual inflation of cushion one [time per] week. Roho cells are slightly under-inflated per [standard] guidance for best pressure relief." However, a review of the facility's charting summary did not address the resident's 9/8/15 appointment or physician's order for therapists to monitor the resident's wheelchair cushion. A therapy progress note dated 9/9/15 included: "Physical Therapy/ Occupational Therapy Requires Courage Kenny nursing to meet resident's medical needs. Promote recovery, and ensure medical safety. Condition of resident is such that there is potential for changes in condition without Courage Kenny nursing intervention."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 26	F 279		

A physician's progress note from 10/26/15, included: "wound improved...continue to pack foam in the undermined area of the wound. Can you call [physician name] in 1 week to discuss [plan of care--number provided]." A nursing note also indicated R222 was at the wound clinic for a dressing change. Although it was noted staff were to monitor wound vac and drainage from the wound, the notes did not reflect any follow-up call to the physician to ensure that R222's plan of care had been discussed as the physician had requested. In addition, review of the resident's care plan for that time indicated there had been no changes made to R222's care plan.

The physician's progress notes from 12/22/15 indicated, "Pressure mapping completed, if cushion slightly air filled on [right] side, then mapping is good on [bilateral ischial tuberosity]. Recommend therapists check inflation on cushion [one time per] week." Review of the therapy notes following this visit did not identify whether the therapists were checking the cushion weekly for proper inflation. A therapy note dated 12/26/15 indicated, "Therapy services provided include. [incomplete sentence] Additional services are SUMMARY: Patient was in his chair for 15 minutes at 2000 [8:00 p.m.]. Repositioned twice on its [sic] own. Dressing changed; incision looks like it is healing well. The spot the surgeon cirled [sic] on his right buttock is firm and mildly blanchable compared to the surrounding..." Therapy notes from 12/28/15 indicated, "Therapy services include Physical Therapy. Additional services are Post-surgical services Restorative Nursing." On 12/29/15, a nursing progress note indicated, "refused turning and repositioning" and indicated the resident had said he would call for help when he was ready to be repositioned. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 27	F 279		

note did not reflect education of the resident related to his choice to decline repositioning.

During an interview on 2/11/16, at 1:48 p.m. RN-E confirmed the cushion pump was on the back of R222's wheelchair in a bag. RN-E stated detailed instructions had been sent from Courage Kenny following his last wound debridement/surgical repair (11/2015) which directed staff to check for proper inflation weekly. RN-E stated R222 wanted to be up in the chair for longer periods of time, but believed he was supposed to be repositioned every two hours. She explained the two hour repositioning was noted on his care plan and on the care sheets.

RN-E was again interviewed on 2/12/16, at 11:53 a.m. RN-E stated the resident was being repositioned every two hours, and was up several hours a day, refusing to lie down. The surveyor then requested documentation regarding any assessment, or risk/benefit of not relieving pressure having been reviewed with the resident, and any related care plan interventions. RN-E stated, "I did express concerns about him being up so much," which she stated she had discussed during wound care, although documentation to that effect was not found in the resident's record. RN-E stated she was unsure whether the care plan had been updated to reflect R222's refusal to be repositioned.

The facility's 9/10, Pressure Ulcer Prevention Program policy indicated pressure ulcer prevention would be based on community standards of practice that would be monitored by the interdisciplinary team. Revisions were to be made based on changes in a resident's condition or when new risk factors were identified. "2. An

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 28 assessment of the resident's need for turning and repositioning based on individual risk factors...6. The summary analysis of these assessments and any others that affect the resident's individual pressure ulcer prevention and/or treatment plan. 7. The plan of care reflects approaches to stabilize and/or reduce or remove the individuals risk factors for Pressure Ulcer development and/or promote healing of existing Pressure Ulcers...13. Ongoing education of the resident and family in Pressure Ulcer Prevention."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 29 Based on interview and document review, the facility failed to ensure the care plan was reviewed and revised following hospitalization for 1 of 1 residents (R167) whose treatments changed following hospitalization. Findings include: R167's hospital discharge summary, dated 2/5/16, revealed the resident developed a left lower extremity deep vein thrombosis (DVT) with significant lower leg extremity swelling and some discomfort on 1/25/16. R167 was discharged with a prescription for warfarin (anticoagulant used to minimize the risk for heart attack, stroke, and blood clots). A Quick Wrap instruction sheet for leg swelling was included. R167's plan of care had been last revised 12/17/15, however, did not include any problems, goals or interventions related to R167's DVT and use of warfarin. A 2/5/16 individual temporary care plan lacked any identification of R167's new problems with appropriate goals and interventions to manage the problems. On 2/10/16, at 1:49 p.m. the RN-B and RN-A confirmed R167 had been hospitalized on 1/21/16, and discharged back to the facility on 2/5/16. RN-A and RN-B confirmed R167 had new diagnoses including DVT and was prescribed warfarin. RN-A reported a new care plan had not been developed for R167 since he was scheduled for a significant change Minimum Data Set (MDS) assessment in the next few weeks. RN-A explained a temporary care plan could have been initiated to address concerns the new issues, however, the care plan had not yet been developed. RN-B reported therapy staff were	F 280	1. With respect to R#167: physician orders have been clarified and the care plan has been updated to reflect any changes to his treatment plan post hospital stay. The NAR assignment sheet has been updated to reflect these changes. The resident has since discharged from the facility. 2. All residents who have returned from the hospital within the past three months have had their records reviewed for any changes to their plan of care with revisions/updates to the care plan as indicated. The NAR assignment sheet has been updated to reflect any changes. 3. All nursing staff will be re educated by 3/23/16 regarding updating the resident care plan upon receipt of new orders, hospital return or change in condition including revisions to the NAR assignment sheet when changes occur. 4. The director of Nursing and/or designee will audit three resident care plans each week for one month and then two resident care plans per week for two months to assure the plan of care for the individual resident is being revised and followed. 5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 30 wrapping R167's legs and nursing staff was applying Jobst stockings. However, on 2/11/16, at 8:35 a.m. RN-B clarified the Jobst stockings were an order prior to R167's hospitalization and a new order had been obtained to instead wrap R167's legs. RN-B reported the care plan should have been updated on 2/5/16, when R167 returned from the hospital. R167's physical therapy (PT) plan of care, dated 2/5/16, revealed R167 had lower legs bandaged for the assessment. No care plan goal related to leg bandaging or wrapping. A PT note dated 2/5/16, read "pt [patient] has LE [lower extremities] bandaged and instructions were sent, however no actual order for either therapy or nursing to performR [sic]." On 2/11/16, at 8:30 a.m. the director of rehabilitation therapy reported physical therapy staff was not wrapping R167's legs, as they did not have a current goal or physician order. A review of progress notes, dated 2/5/16 to 2/10/16, did not indicate any information or contact with R167's primary physician regarding leg bandaging or wraps or length of time R167 could be out of bed. R167's orders report for 1/16 and 2/16, revealed an order for warfarin five days, effective 2/5/16 until 2/10/16, at which date the international normalized ratio (INR/ laboratory testing to determine how thick or thin the blood is) was to be obtained. An order was requested and obtained on 2/10/16, for leg wraps and directions for staff to now allow the resident to sit in the wheelchair for greater than three hours.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C **02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 31 The facility's 8/13, Care Plan Completion policy directed, "A resident care plan is initiated on admission. The comprehensive plan is updated/revised as changes occur." The policy directed staff to include on the care plan "All current and acute chronic clinical conditions for which they are receiving medication, treatment, and/or care, which may include...Medication therapy/Treatment/Labs/monitoring such as Coumadin [warfarin] (abnormal bleeding/bruising, edema)."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate care after hospitalization for 1 of 1 resident (R167) reviewed for post-hospital care. Findings include: R167's family member (F)-A was interviewed on 2/9/16, at 12:58 p.m. F-A, reported concerns after R167 returned to the facility from the hospital on 2/5/16. The resident reported had a blood clot while in the hospital and F-A was worried about him sitting up for long stretches of time. F-A	F 309	1. With respect to R#167: physician orders have been clarified and the care plan has been updated to reflect any changes to his treatment plan post hospital stay. The NAR assignment sheet has been updated to reflect these changes. 2. All residents who have been hospitalized within the past three months have had their records reviewed for any changes to their plan of care with revisions/updates to the care plan as indicated. The NAR assignment sheet	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 32 reported she had seen R167 sitting in his wheelchair for several hours after his return from the hospital. She had reported her concerns to staff over the weekend. On Sunday, she thought care concerns were resolved, but then on Monday noted R167 was again sitting in his chair for long periods of time. F-A reported she thought there must have been a miscommunication with the staff about R167's changing needs. On 2/10/16, F-A again reiterated her concerns staff was not addressing R167's change in condition. Although R167 was getting his legs wrapped in the hospital, this was not occurring at the facility. F-A reported R167 had gained a lot of fluid weight in his legs. F-A showed the surveyor R167's legs which were covered by a blanket. The legs were swollen and bare without wraps or stockings. F-A reported R167's legs were less swollen prior to hospitalization. F-A reported she had spoken to a registered nurse(RN)-B about her concerns, but was not sure how the changes were being communicated and addressed. F-A also expressed concerns the bed was no longer an appropriate size for R167. R167's hospital discharge summary, dated 2/5/16, revealed the resident developed a left lower extremity deep vein thrombosis (DVT) with significant lower leg extremity swelling and some discomfort on 1/25/16. R167 was discharged with a prescription for warfarin (anticoagulant used to minimize the risk for heart attack, stroke, and blood clots). A Quick Wrap instruction sheet for leg swelling was included. R167's plan of care had been last revised 12/17/15, and did not include any problems, goals or interventions related to R167's DVT and use of warfarin. A 2/5/16 individual temporary care plan	F 309	has been updated to reflect any changes. 3. All nursing staff will be re educated by 3/23/2016 regarding updating the resident care plan upon receipt of new orders, hospital return or change in condition including revisions to the NAR assignment sheet when changes occur. 4. The director of nursing and /or designee will audit three resident care plans each week for one month and then two resident care plans per week for two months to assure the plan of care for the individual resident is being revised and followed. 5. The data collected will be presented to the QAPI committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33	F 309		

lacked any identification of R167's new problems with appropriate goals and interventions to manage the problems.

On 2/10/16, at 1:49 p.m. the RN-B and RN-A confirmed R167 had been hospitalized on 1/21/16, and discharged back to the facility on 2/5/16. RN-A and RN-B confirmed R167 had new diagnoses including DVT and was prescribed warfarin. RN-A reported a new care plan had not been developed for R167 since he was scheduled for a significant change Minimum Data Set (MDS) assessment in the next few weeks. RN-A explained a temporary care plan could have been initiated to address concerns the new issues, however, the care plan had not yet been developed. RN-B reported therapy staff were wrapping R167's legs and nursing staff was applying Jobst stockings. However, on 2/11/16, at 8:35 a.m. RN-B clarified the Jobst stockings were an order prior to R167's hospitalization and a new order had been obtained to instead wrap R167's legs. RN-B reported the care plan should have been updated on 2/5/16, when R167 returned from the hospital.

R167's physical therapy (PT) plan of care, dated 2/5/16, revealed R167 had lower legs bandaged for the assessment. No care plan goal related to leg bandaging or wrapping. A PT note dated 2/5/16, read "pt [patient] has LE [lower extremities] bandaged and instructions were sent, however no actual order for either therapy or nursing to performR [sic]."

On 2/11/16, at 8:30 a.m. the director of rehabilitation therapy reported physical therapy staff was not wrapping R167's legs, as they did not have a current goal or physician order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 34 A review of progress notes, dated 2/5/16 to 2/10/16, did not indicate any information or contact with R167's primary physician regarding leg bandaging or wraps or length of time R167 could be out of bed. R167's orders report for 1/16 and 2/16, revealed an order for warfarin five days, effective 2/5/16 until 2/10/16, at which date the international normalized ratio (INR/ laboratory testing to determine how thick or thin the blood is) was to be obtained. An order was requested and obtained on 2/10/16, for leg wraps and directions for staff to now allow the resident to sit in the wheelchair for greater than three hours. The facility's 8/13, Care Plan Completion policy directed, "A resident care plan is initiated on admission. The comprehensive plan is updated/revised as changes occur." The policy directed staff to include on the care plan "All current and acute chronic clinical conditions for which they are receiving medication, treatment, and/or care, which may include...Medication therapy/Treatment/Labs/monitoring such as Coumadin [warfarin] (abnormal bleeding/bruising, edema)."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop provide proper care and services including care plan development to promote healing and/or minimize the risk of further pressure ulcer development for 1 of 3 residents (R222) reviewed for pressure ulcers. Findings include: R222 was observed in his room while lying on an air mattress in bed on 2/11/16, at 8:45 a.m. An electric, tilt-in-space wheelchair was in the room. The wheelchair had a seat cushion with a foam front and cutout in the rear filled with an air bladder where the resident would sit, as well as a contoured backrest. The surveyor briefly pressed on the air-filled portion, which contained air. During interview with R222 on 2/11/16, at 8:45 a.m. he reported he had developed a pressure ulcer in June of 2015. Despite the use of an air-containing protective wheelchair cushion, the wound deteriorated and eventually required surgical repair. R222 asserted that prior to the discovery of the pressure ulcer, the air bladder was low and needed refilling. "I was getting sore...telling my nurse that my Roho air cushion had a hand pump in the closet to fill my seat. I told them it was low and needed to be filled...staff wouldn't do anything about it." Ulcers formed at the rear of both legs, with the right one becoming severe (larger and deeper). "[The area]	F 314	1. A comprehensive assessment for skin risk factors including the braden and turning and repositioning guidance was completed for R#222. The information was documented on the residents plan of care and the NAR assignment sheet. R #222 roho cushion is checked for proper inflation as instructed and documented when complete. Rejection of care and interventions to promote healing has been updated on the resident plan of care. The NAR assignment sheet reflects all changes. R#222 has been educated regarding the risks of not following the plan of care for preventing further skin breakdown. The negotiated risk was reviewed with R#222 on 3/9/2016. 2. All residents with current wounds have had their care plans reviewed to ensure the inclusion of all measures to promote healing and prevent further breakdown including rejections of care. The NAR assignment sheet has been updated to reflect any changes. Nursing leadership meets weekly to review wounds and progression of healing with discussion of new strategies for delayed or worsening wounds. 3. All nursing staff will be re-educated regarding measures to prevent skin breakdown, what to report and how the information/interventions are to be communicated. Education will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36 developed a big ulcer at the point where the foam part meets the air part in an edge." R222 stated the right ulcer eventually required four debridements (surgically removing dead tissue) and surgery to close it with a flap of tissue. R222 said that he had been going to Courage Kenny rehabilitation, where there they'd noted it [the air cushion] was completely flat, no date specified. R222 stated the Courage Kenny staff had inflated it and adjusted the pressure to meet his needs. After two debridement surgeries, R222 said the physician had directed the facility staff to learn the proper assessment/inflation technique. The resident explained the staff were supposed to "...come and put their hands on the cushion while it was under my butt so they would get the idea of what a properly inflated cushion for me would be...that never happened," except by registered nurse (RN)-E "a couple of times." R222 then showed the surveyor a paper diagram illustrating how much space should have been between the cushion base and the buttocks when the resident was seated. A 6/2/15, a quarterly Minimum Data Set (MDS) for R222 indicated: "Does this resident have one or more pressure ulcers at stage 1 or higher? No." However, the resident was identified at risk for pressure ulcer development, and treatment interventions were in place. R222 required extensive assistance from staff to reposition and transfer. MDS assessments consistently revealed R222 was cognitively intact and did not reject care or present other behavioral concerns. A physician order dated 6/20/15 directed staff to: "Please contact wound clinic for input on managing Left IT [ischial tuberosity] decubitus	F 314	complete by 3/23/2016. 4. The director of nursing and/or designee will audit three residents each week for one month and then two residents each week for one month and the two residents per week for two months to assure the plan of care for the individual resident is being revised and followed for promoting healing and preventing further breakdown. 5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding and necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 37	F 314		

ulcer and coccyx [tailbone] ulcer, and arrange appointment ASAP [as soon as possible] to be seen in wound clinic by [name of physician] or colleague."

An appointment referral form completed by Courage Kenny 6/23/15 indicated, "[R222's] cushion was completely flat!!!" The referral note further indicated Courage Kenny had added air during the session of an "appropriate amount to ensure proper positioning and pressure relief. Must check cushion for inflation daily. Physician orders: Check cushion daily for inflation to avoid pressure sores."

Further review of R222's medical record including treatment administration sheets, and care plan, failed to indicate staff had been checking the cushion daily to ensure proper inflation to meet R222's needs. In addition, there was no evidence in any progress notes to indicate R222's cushion was ever checked for proper inflation.

Wound Summary documents for "Right thigh back" (a photo revealed it was the right ischial tuberosity/IT) indicated an initial measurement dated 6/23/15, of a stage 2 ulcer with a red (healthy) base which measured: 2.5 centimeters (cm) in length, 5.1 cm in width, and 0 cm in depth (2.5 x 5.1 x 0 cm). By 7/29/15, the ulcer was increased to stage 3 and was greater in size at 4.5 x 5.8 x 5.5 cm (a significant increase in depth).

Following surgical debridment, a progress note dated 8/6/15 included, "Comprehensive Courage Kenny and positioning evaluation was completed for [R222]. Braden score 14.0 indicating MODERATE RISK" due to co-morbidities, wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38 infections, diabetes, narcotic use, immobility, dependence on staff for activities of daily living, and current pressure ulcers." A progress note from 8/8/15 indicated, "Wound vac...resident refusing to get out of bed." A significant change MDS dated 8/12/15, indicated R222 had one stage 3 and one stage 4 pressure ulcer, with measurements noted as 08. x 06. x 05.5 cm. A progress note from a wound appointment dated 9/8/15, included: "Reason for appointment ...wheelchair cushion mapping. Cushion mapped well and [no] concerns when is properly inflated. Physician orders: Recommend therapist at facility [check] manual inflation of cushion one [time per] week. Roho cells are slightly under-inflated per [standard] guidance for best pressure relief." However, a review of the facility's Courage Kenny Charting summary did not address the resident's 9/8/15 appointment or physician's order for therapists to monitor the resident's wheelchair cushion. A therapy progress note dated 9/9/15 included: "Physical Therapy/ Occupational Therapy Requires Courage Kenny nursing to meet resident's medical needs. Promote recovery, and ensure medical safety. Condition of resident is such that there is potential for changes in condition without Courage Kenny nursing intervention." A physician's progress note from 10/26/15, included: "wound improved...continue to pack foam in the undermined area of the wound. Can you call [physician name] in 1 week to discuss [plan of care--number provided]." A nursing note also indicated R222 was at the wound clinic for a dressing change. Although it was noted staff were	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39 to monitor wound vac and drainage from the wound, the notes did not reflect any follow-up call to the physician to ensure that R222's plan of care had been discussed as the physician had requested. In addition, review of the resident's care plan for that time indicated there had been no changes made to R222's care plan. The physician's progress notes from 12/22/15 indicated, "Pressure mapping completed, if cushion slightly air filled on [right] side, then mapping is good on [bilateral ischial tuberosity]. Recommend therapists check inflation on cushion [one time per] week." Review of the therapy notes following this visit did not identify whether the therapists were checking the cushion weekly for proper inflation. A therapy note dated 12/26/15 indicated, "Therapy services provided include. [incomplete sentence] Additional services are SUMMARY: Patient was in his chair for 15 minutes at 2000 [8:00 p.m.]. Repositioned twice on its [sic] own. Dressing changed; incision looks like it is healing well. The spot the surgeon circled [sic] on his right buttock is firm and mildly blanchable compared to the surrounding..." Therapy notes from 12/28/15 indicated, "Therapy services include Physical Therapy. Additional services are Post-surgical services Restorative Nursing." On 12/29/15, a nursing progress note indicated, "refused turning and repositioning" and indicated the resident had said he would call for help when he was ready to be repositioned. The note did not reflect education of the resident related to his choice to decline repositioning. R222's care plan last reviewed 12/15/15, revealed the resident had diagnoses including paraplegia (paralysis of lower limbs) and a history of multiple pressure ulcers related to immobility,	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40	F 314		

including surgical repairs of a sacral ulcer on 2/23/15, and a stage 4 right ischial tuberosity (buttock) ulcer identified 11/24/15. The care plan indicated stage 2 pressure ulcers had developed on the resident's coccyx while he was hospitalized. Staff interventions included for staff to "educate resident/family/caregivers as to causes of breakdown...Encourage reposition/position changes during Customer Service Rounds...Avoid positioning on areas of concern. Pressure relieving device for bed, rotating low air loss mattress, turn, reposition at least every 2 hours, more often as needed or requested." A nutritional problem was also identified related to morbid obesity and pressure ulcers. Interventions included Prostat (a protein supplement) every day to promote ulcer healing. The care plan did not indicate any concerns with the resident rejecting care (e.g. refusal to turn/reposition), and there were no approaches identified to educate the resident regarding the risks and benefits of his choices. In addition, the care plan lacked any information regarding the need to check the wheelchair cushion for proper inflation to minimize the risk for further pressure ulcer complications.

The current 2/9/16, Nursing Assistant Care Plan directed staff to assist R222 to "Repos: A2-4" [Reposition: assist every two to four hours] and "Reposition q2 [every two] hours/Nurse&NAR" (nursing assistant). There were no instructions on the Nursing Assistant Care Plan related to monitoring the inflation of the wheelchair cushion.

During an interview on 2/11/16, at 1:48 p.m. RN-E confirmed the cushion pump was on the back of R222's wheelchair in a bag. RN-E stated detailed instructions had been sent from Courage Kenny

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 41 following his last wound debridement/surgical repair (11/2015) which directed staff to check for proper inflation weekly. RN-E stated R222 wanted to be up in the chair for longer periods of time, but believed he was supposed to be repositioned every two hours. She explained the two hour repositioning was noted on his care plan and on the care sheets. RN-E was again interviewed on 2/12/16, at 11:53 a.m. RN-E stated the resident was being repositioned every two hours, and was up several hours a day, refusing to lie down. The surveyor then requested documentation regarding any assessment, or risk/benefit of not relieving pressure having been reviewed with the resident, and any related care plan interventions. RN-E stated, "I did express concerns about him being up so much," which she stated she had discussed during wound care, although documentation to that effect was not found in the resident's record. RN-E stated she was unsure whether the care plan had been updated to reflect R222's refusal to be repositioned. The facility's 9/10, Pressure Ulcer Prevention Program policy indicated pressure ulcer prevention would be based on community standards of practice that would be monitored by the interdisciplinary team. Revisions were to be made based on changes in a resident's condition or when new risk factors were identified. "2. An assessment of the resident's need for turning and repositioning based on individual risk factors...6. The summary analysis of these assessments and any others that affect the resident's individual pressure ulcer prevention and/or treatment plan. 7. The plan of care reflects approaches to stabilize and/or reduce or remove the individuals	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 42 risk factors for Pressure Ulcer development and/or promote healing of existing Pressure Ulcers...13. Ongoing education of the resident and family in Pressure Ulcer Prevention."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and implemented	F 329	1. With respect R#56: The care plan has been revised to include the non-pharmacological measures to	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 43 prior to administration of a psychotropic drug and to monitor for effectiveness and potential side effects for 1 of 5 residents (R56) reviewed for unnecessary medication use. Findings include: R56 was prescribed Trazodone HCL (anti-depressant) 25 milligrams (mg) as needed (prn) at bedtime to promote sleep according to the resident's 2/16, Medication Administration Record (MAR). After the pharmacy consultant recommended a dosage change of Trazodone from 25 mg to 25 mg prn the dose was decreased to prn on 10/19/15. Although the hours of sleep were documented on the Treatment Administration Record (TAR), it lacked any information related to non-pharmalogical interventions, medication effectiveness, and side effects in the TARs from 9/1/15 through 2/12/16. R56's MAR and TAR from 2/1/16 through 2/12/16, revealed R56 received prn Trazodone four times, but lacked documentation of non-pharmacological interventions prior to its use or a notation regarding efficacy of the medication. The nursing assistant (NA) current assignment sheet for R56 lacked any direction for NAs regarding measures to promote sleep. In addition R56's current care plan lacked identification of the use of psychotropic medications, goals, and appropriate interventions to promote sleep for R56. An interview with the pharmacy consultant on 2/10/16, at 11:16 a.m. revealed Trazodone was first prescribed on 3/9/15, at 50 mg at bedtime to	F 329	promote sleep prior to administration of medications. The NAR assignment sheets have been revised to reflect the changes. 2. All residents currently receiving medications to promote sleep have been reviewed to assure non-pharmacological measures are implemented prior to administration of any prn medications for sleep. The NAR assignment sheet has been updated to reflect any changes. 3. All nursing staff will be re educated regarding non-pharmacological measures to promote sleep, what to report and how the information/interventions are to be communicated. Education will be completed by 3/23/2016. 4. The director of nursing and/or designee will audit three residents each week for one month and then two residents per week for two months to assure non-pharmacological interventions are in place and implemented prior to the administration of a prn medication for sleep. 5. The data collected will be presented to the QAPI committee by the director of nursing. At this time the committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 44	F 329		

promote sleep. A dose reduction was attempted on 7/13/15, to 25 mg and then on 10/19/15, to the current dose 25 mg prn. She further the medication had not been administered in 11/5 to 12/15, but had been administered 10 times in 1/16. The consultant further stated non-pharmalogical interventions should have been attempted at least an hour prior to use of psychotropic medications including Trazodone, especially when it was prescribed as needed. She also stated she expected side-effects and effectiveness would be monitored.

On 2/10/16, at 11:53 a.m. a registered nurse (RN)-C reported the facility did not have specific non-pharmacological interventions identified to potentiate the resident's sleep. She stated, "We try to figure out her day. If she had enough to eat, if she is in pain, if she needs to be toileted or repositioned. If all else fails we give her a prn." RN-C verified the interventions were not documented in R56's MAR/TAR or outlined in her care plan.

During an interview on 2/12/16, at 11:54 a.m. the director of nursing (DON) stated it was "odd " there was no prn Trazodone use during the months of 11/15 and 12/15, and then was administered the medication 10 times during 1/16. She added, "When it is for sleep, especially for prn medications, you should chart what you did to help them rest and not just give them a pill. At least you should talk to them." The DON further explained she was unaware of current non-pharmacological interventions or monitoring of side effects and effectiveness for sleep and sleep medications for R56.

A 9/13, Practice Guideline and Procedure for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 45 Sleep Monitoring, directed staff to "individualize staff non-pharmacological interventions intended to increase comfort and promote adequate sleep will be added to a resident care plan and NA (nursing assistant) sheet." A 9/13, Psychoactive Medication Adverse Effect Monitoring policy, noted was the purpose was to "provide monitoring guidelines to nursing staff when a resident has been ordered a new or a change in psychopharmacological medication. Medication monitoring will begin on the first day of the medication initiation and continue for seven days. If any adverse effect if found within the first 7 days, nursing will update the medical provider and document in the clinical record describing the nature of the adverse effect and the potential impact on the resident's mental or physical condition or functional or psychological status. The facility supports the goal of determining the underlying causes of sleep disturbance so appropriate treatment of environment or medical reasons are ruled out prior to the use of psychotropic medications. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing for the clinical situation. Psychotropic medications include antidepressant(s)."	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure meals were attractively served and palatable for 8 of 170 residents (R17, R44, R105, R20, R192, R129, R119, R217) who offered food complaints. Findings include: During observation of the noon dining service on 2/8/16, residents were seated and waiting for the meal that was scheduled to begin at noon. Food was were served from the 2 north (2N) kitchenette starting at 12:27 p.m. R17 reported on 2/8/16, at 12:24 p.m. were often served late. The meat was often tough and she had recently been served slimy mushrooms. R105 reported on 2/8/16, at 12:30 p.m. he did not like the food. He said he had been served half-cooked hamburgers and burnt eggs. R20 reported on 2/8/16, at 12:30 p.m. the food was often served lukewarm and she preferred hot food. When she requested the food be reheated, it was often not microwaved until it was hot. R192 said on 2/10/16, at 12:05 p.m. dinner was regularly served late, often a half hour. Regarding reportedly being served very mushy vegetables R192 stated, "ish." R129 reported on 2/10/16, at 12:11 p.m. the food tasted "terrible," was cold, mushy, and sometimes undercooked. In addition, meals were regularly served a half hour after the scheduled time.	F 364	1. Facility reviewed diets and personal preferences for R17, R44, R105, R20, R192, R129, R119, R217. Updates completed to their dietary program, care plan, and diet orders if indicated. 2. The facility has increased dietary management to provide assistance with current policies and procedures, assure protocols are within guidelines for managing meal preparation. An evening supervisor has been hired to ensure all meal services start on time, foods are temped and appropriate for service and meals are audited at the time served for palatability. 3. All food service staff has been re educated regarding food preparation, procedure for tasting prior to service, measures for temperature testing prior to meal service to assure appropriate temperature of foods, plating, room tray expectations, and serving hot and cold food items. All food service staff will have received education by 3/23/16. 4. The director of food service and/or designee will audit meal palatability on a weekly basis. Comment cards will be distributed randomly at alternating meal times for resident input into palatability, meal and service ratings. Data will be gathered and addressed. 5. The data collected will be presented to the QAPI committee by the Director of Food service. the data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 47 R119 said on 2/10/16, at 12:15 p.m. the food tasted terrible, was often cold and was often served late. On 2/10/16, at 12:21 p.m. the dietary aide (DA)-A started serving trays from the kitchenette for the 3 North dining room for the noon lunch meal. Plates were frequently observed to sit on the ledge between the kitchenette and dining room for 5-10 minutes before being served to residents. At 1:13 p.m. after the last plate was served, a test tray was requested by surveyor. Foods tested for food palatability included: a hot dog, potato salad, pureed peas, pureed fish, mashed potatoes, chicken, fish filet and milk. The potato salad was bland and lukewarm. A temperature of the potato salad was taken at 79 F (Fahrenheit). The fish fillet was mushy. The chicken was tough, with a leather like appearance, pink on the inside and chewy. On 2/11/16, at 1:58 p.m. the dietary manager (DM) reported cooks should be taste testing foods. DM reported that if food was sitting the steam tray for over an hour it likely would not taste good. DM reported food service was at times delayed due to nursing staff not having residents ready and at times due to dietary staff shortages. The Taste Testing policy, dated 2010, directed staff "All food is taste tested prior to serving. Procedure: 1. The cook is responsible for tasting all food before it is served. 2. Proper tasting procedures should be used. Use one spoon to serve food onto a dish or bowl, and use a new spoon to taste the food 3. All food not passing the taste test due to seasoning, toughness, color, or other negative factors is not to be served until the	F 364	regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 48	F 364		

problem has been corrected. "

R44 reported in an interview on 2/8/16, at 2:39 p.m. "The food was disgusting. I have diabetes and they kept bringing me potatoes, bread and juice. They consistently bring these. They (the food) are too high in salt. It is cheap food and not healthy." She further stated it was often breaded to cover up the taste and quality. When asked about the food items observed in her room she explained she bought "good" food with her own money whenever she could afford to. R22's 1/21/16, Minimum Data Set (MDS) assessment indicated she was cognitively intact and made appropriate decisions.

A Providence Place Grievance/Feedback form dated 2/2/16 initiated by R22 read, "Meal options are poor. It comes late and is cold. Wants whole milk," and a form dated 2/8/16 also initiated by R22 read, "I get cold scrambled eggs every day."

R217's quarterly Minimum Data Set dated 12/14/15, revealed the resident was cognitively intact. R217 stated in an interview on 2/9/16, at 12:55 p.m. that the food and the snacks served at the facility were a "failure" and 7 of 10 items on the menu in one week tasted "awful." R217 described the food as "horrible...no seasoning...mushy...lack of variety." R217 reportedly routinely attended resident council meetings, and said food issues were always brought up by residents at the meetings, and she personally spoke up about ongoing food concerns. The dietary manager had attended some of the meetings, and residents were told there were plans for new menus, but nothing had changed since last fall and they just kept rotating the same menus. When asked why the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 49 could not get more variety, the DM said the menu items were "seasonal." R217 explained broccoli was served "constantly," and although she used to like it, she no longer did. That day she had specifically requested the alternate vegetable so she would not be served broccoli, however, then was served broccoli regardless of her request. R217 stated that today she purposely asked for the second option for the meal so that she would not get broccoli and she was then served broccoli anyway. Vegetables were served kind of "mushy" and foods were often either "undercooked or overcooked." That day the resident was served "a veal patty that was undercooked--pink in the middle--almost cold." R217 stated she ate meals in her room and her food was nearly constantly served cold. Although mealtime was scheduled to begin at 12:00 p.m. she received her meal between 12:30 and 12:50 p.m. and room trays were the last to be delivered. When R217 heard other residents complain chicken was served undercooked and pink in the middle, they were told by the DM to have their food reheated in the microwave. R217 requested her food be reheated "once," but staff did not return in a timely manner. When she was served the wrong beverage, the staff never returned with the proper one. When she was given pureed peaches instead of her regular diet, the nursing assistant just walked away and did bring her the correct diet. R217 reported food often was served on paper plates due to dishwasher being broken, and the paper plates did not keep the food warm. Approximately half the time food was not delivered to her room with both the bottom plate warmer and the cover that was supposed to help keep the food warm. At 6:20 p.m. R217 reported she was served a hamburger patty on a bun with mustard and ketchup packets, but nothing else.	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 50 R217 reported ongoing concerns with food had been brought up to staff and "is not being followed up on here and keeps getting mentioned at every resident council meeting."	F 364		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct performance reviews for 2 of 5 nursing assistants (NA-B, NA-D). This had the potential to affect multiple residents in the facility where the NAs may have been assigned to work. Findings include: A sample of five NA employee records were reviewed on 2/12/16, and the records were reviewed to annual evaluations were conducted.	F 497	1. With respect to the identified evaluation: a current evaluation of work performance was completed for employee NA-d. 2. All employee files have been reviewed for current evaluations and those out of compliance for annual evaluation will be completed over the next quarter. 3. The guideline for completing annual performance evaluations has been developed and all leadership trained on the expectations for completing evaluations.	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING ______ B. WING ______	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 51 1) NA-B was hired on 2/25/13. The most recent evaluation for NA-B was completed on 11/14/15. 2) NA-D was hired on 11/7/05. NA-D's employee file contained evidence of one performance evaluation completed on 5/31/11. On 2/12/16, at 1:00 p.m. a policy and procedure for conducting annual reviews was requested. The administrator confirmed there was no such policy. He stated the facility would follow a generally accepted practice of conducting evaluations yearly.	F 497	4. The human resource director and/or designee will audit five employee files each week for two months to assure evaluations are completed on a timely basis. 5. The data collected will be presented to the QAPI committee by the human resource director. The data will be reviewed/discussed at the monthly quality meeting. Ath this time the committee will make the decision/recommendation regarding any necessary follow up studies.	

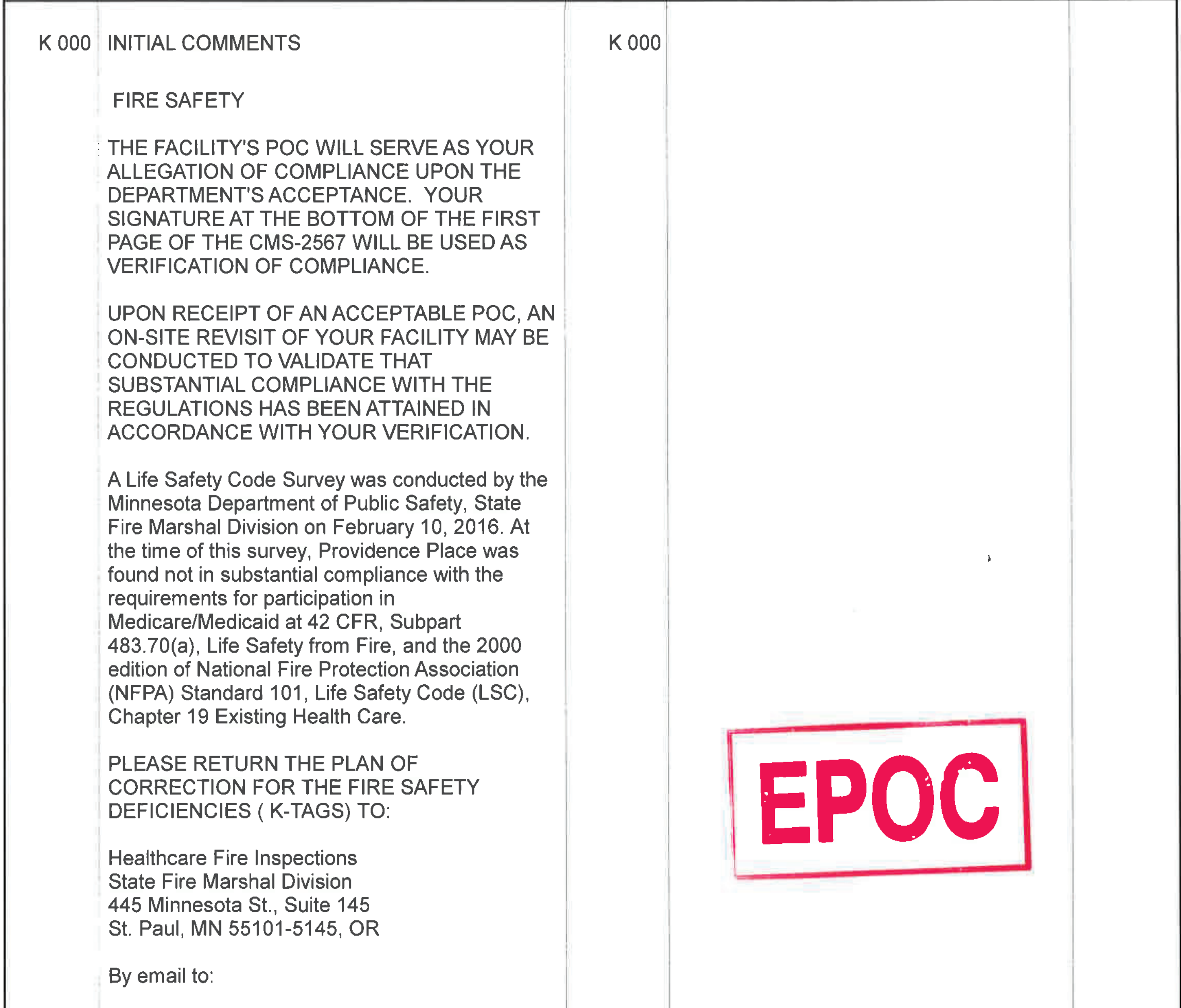
F5271025

PRINTED: 03/24/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 10, 2016. At the time of this survey, Providence Place was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Providence Place is a 3-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1984 and was determined to be of Type II(222) construction. In 1995, an addition was constructed to the North side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 190 beds and had a census of 169 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH** **MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=E	Continued From page 2 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 41 residents. Findings include: On facility tour between 09:30 AM and 01:00 PM on February 10, 2016, observation revealed that the smoke compartment, on the third floor, south side, east wing had penetrations through the smoke barrier wall, above the doors. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 025	1. with respect to the smoke compartment on third floor the penetrations have been sealed with fire retardant caulk as of 2/11/16. 2. Any resident residing in the facility has the potential to be affected by the non sealing of a smoke compartment. 3. All smoke compartments have been reviewed by the director of maintenance for penetrations and all have been sealed. 4. Director of maintenance or designee will audit penetrations monthly to ensure all are sealed timely. 5. Data will be collected and reviewed the QAPI committee monthly.	