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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7CIZ

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 **05/20/2014** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Supervisor 05/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/30/2014 (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
05/27/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5271

On 05/20/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 05/19/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 03/31/14 standard survey, effective 05/10/14. Refer to the CMS 2567B for both health and life safety code.

Effective 05/10/14, the facility is certified for 190 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5271

May 30, 2014

Mr. Michael Goblirsch, Administrator
Providence Place
3720 - 23rd Avenue South
Minneapolis, Minnesota 55407

Dear Mr. Goblirsch:

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 May 10, 2014, 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. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5088

May 20, 2014

Mr. Michael Goblirsch, Administrator
Providence Place
3720 - 23rd Avenue South
Minneapolis, Minnesota 55407

RE: Project Number S5271025

Dear Mr. Goblirsch:

On April 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 31, 2014. 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 May 20, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 19, 2014 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 survey, completed on March 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2014, effective May 10, 2014 and therefore remedies outlined in our letter to you dated April 16, 2014, will not be imposed.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions about this letter.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245271	A. Building B. Wing	5/20/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/10/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/10/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **05/10/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/10/2014**
ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **05/10/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/AK	05/20/2014	28230	05/20/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/31/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245271	01 - MAIN BUILDING 01	5/19/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0066	05/19/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	05/20/2014	03005	05/19/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
3/26/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7CIZ

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: **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 **03/31/2014** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR-Dietary Specialist 05/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/21/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5271

At the time of the extended survey completed 03/31/14, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7499

April 16, 2014

Mr. Joel Kelsh, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, Minnesota 55407

RE: Project Number S5271025

Dear Mr. Kelsh:

On March 31, 2014, a extended standard 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. In addition, at the time of the March 31, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5271168.

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. In addition, at the time of the March 31, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5271168 that was found to be unsubstantiated.

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:

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

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

<u>Remedies</u> - 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;

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

Telephone: (651) 201-3794
Fax: (651) 201-3790

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 May 10, 2014, 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 May 10, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 July 1, 2014 (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 October 1, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this letter.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

Enclosure

cc: Licensing and Certification File

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 03/31/2014

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. Your signature at the bottom of the first page of the CMS-2567 form 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 complaint investigation of H5271168 was conducted during the recertification survey and was unsubstantiated. In addition, an extended survey was conducted on 3/31/14.	F 000	The preparation of the following plan of correction for these deficiencies 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 these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: **F161** It is the policy of Providence Place that the facility purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to the 119 residents affected by the surety bond less than the total amount of the residents funds account, the bond amount was increased from $75,000 to $100,000. **Actions taken to identify other potential residents having similar occurrences:** All residents depositing funds in the resident trust account have been reviewed for security of funds under the new surety bond. **Measures put in place to ensure deficient practice does not occur:** Business Office Manager (BOM) will monitor resident trust account deposited amount to assure amount does not exceed the bond amount. **Effective implementation of actions will be monitored by:** BOM will monitor account directly and report findings to facility Executive Director. **Those responsible to maintain compliance will be:** The Executive Director and/or designee will review resident trust amounts each month.	
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident fund accounts were insured with a surety bond not less than the total amount of funds held for 119 residents who had fund accounts managed by the facility. Findings include: The facility's Continuation Certificate effective 7/25/07 and continued from 7/25/13 to 7/25/14,	F 161		

POC accepted for 4/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Michael Daly Goblirsch — Administrator — 4/29/14

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.

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F 161	Continued From page 1 indicated the bond was for the amount of $75,000, however, the resident fund account total was $83,342.51. On 3/31/14 at 9:00 a.m. the business manager reported the facility currently managed personal funds for 119 residents. At 9:30 a.m. the facility's administrator reported the amount of the surety bond did not cover the resident accounts, and he was unaware when the account totals had exceeded the surety bond amount.	F 161	The data collected will be presented to the Quality Assurance committee by the Executive Director. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure choices related to smoking were accommodated to the extent possible and/or the plan revised in a timely manner for 1 of 1 resident (R13) who had previously experienced a smoking incident that resulted in restricted smoking. Findings include: R207 reported concerns to the surveyor on 3/25/14, at 4:30 p.m. that R13 was not supposed to smoke alone, but staff did not have time to	F 242	**F242** It is the policy of Providence Place that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to R13, the interdisciplinary team reviewed his plan of care. Strategies for assuring safety while smoking have been developed in coordination with Consulting Psychologist. R13 will be provided a specified number of cigarettes at specified times provided the resident demonstrates that he is wearing his smoking apron. After smoking the resident may receive a can of pop provided he returns to the unit and shows staff he continues to wear his smoking apron. His care plan was updated to reflect these new safety strategies. Nursing assistant care sheets were updated to reflect effective methods of person centered approach and communication techniques to enhance the residents self	

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F 242	Continued From page 2 supervise the resident while smoking as planned. Because of this, the resident begged for cigarettes from other residents and smoked cigarette butts found in the smoke room. R207 said R13 had expressed that he was an old man and should be able to get his cigarettes. R13's behavior rounds documentation for the week of 12/26/13 through 1/2/14 revealed the resident had an increase in behavioral issues. A recent plan to provide supervised smoking program had been instituted and the resident became upset when staff were unavailable to accompany him to smoke. The resident was described as not easily re-directable and threatened and called others derogatory names. R13 was also bumming cigarettes from other residents and was found in the smoke room unsupervised. A summary note dated 1/16/14, described behaviors for the time period of 1/3/14 through 1/9/14. R13 was noted to be more agitated, yelling and screaming at staff regarding supervised smoking. Documentation from 1/23/14 through 1/26/14 showed the resident had been bumming cigarettes from other residents, was non-compliant with his smoking program, yelled and screamed at staff, and refused care and medication until staff provided him with a cigarette. R13's smoking assessment dated 1/22/14, indicated he demonstrated safe smoking habits, including safe and proper disposal of ashes and cigarettes. The plan was for one staff to assist the resident. The care plan dated 2/7/14, indicated a supervised smoking plan, not following the supervised smoking plan and not always using the smoking apron. Interventions were to check to make sure R13 had a smoking apron when	F 242	determination and provide safety. Effectiveness, of safety strategies will continue to be monitored for efficacy. **Actions taken to identify other potential residents having similar occurrences:** All residents identified to smoke were reviewed for safety. Their ongoing ability to smoke safely will be monitored through observations by staff and changes communicated to the appropriate staff; floor nurse, Clinical Director/Coordinator, Social Worker, or Shift Supervisor. Any change in their ability to smoke safely will be forwarded to licensed personnel who will initiate facility protocol. **Measures put in place to ensure deficient practice does not occur:** In-service training of staff on facility procedure for smoking rules and safety; and how to properly observe, assess, treat and document residents smoking conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete three resident smoking audits each week for one month and then two resident smoking audits each week for two months to assure proper smoking safety. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 242	Continued From page 3 doing hourly rounds. Other interventions included, wearing the smoking apron at all times. A second problem initiated on 7/28/11, indicated that R13 chose to smoke and did so independently, but had not been following the "smoke free" policy and continued to smoke outside. The goal was to remain free of burns and to follow the smoking policy. Interventions were to remind R13 where to smoke and to provide a smoking apron and encourage to wear it. A revised undated problem was hand-written on the plan and noted R13's smoking was supervised and they were instituting a trial of E-cigarettes. On 2/27/14, the staff were unable to redirect the resident when he became upset, and the resident was admitted to the hospital. He was found to have urinary retention with an infection. A care conference note dated 1/31/14 noted the concerns with increased behaviors in yelling, bumming cigarettes and being non-compliant with his smoking plan. A note dated 3/4/14, noted R13 was outside wearing only a T-shirt and very dirty sweat pants covered with cigarette ash. He was smoking a cigarette without supervision. On 3/5/14, R13 was again outside smoking unsupervised, although he was wearing a smoke apron. On 3/7/14, it was documented that a social worker (LSW) had spoken with the in-house psychologist regarding R13's unsafe smoking habits. On 3/17/14, R13 approached LSW-B and asked who had taken his cigarettes away. The resident became upset at the LSW and used abusive and threatening language. On 3/25/14, R13 approached LSW-B demanding cigarettes and yelled, "They are my ### cigarettes! I want	F 242	**Completion date for certification purposes only is May 10th, 2014.**	

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F 242	Continued From page 4 them!" When asked about using a lap tray the resident responded, "I don't want to wear it. It's big and it's bulky and I don't like it." On 3/26/14, LSW-A noted R13's care plan for smoking would be changed. It was determined the plan was ineffective, as the resident acquired cigarettes from other sources. R13 had agreed to wear a smoking apron. A psychology note dated 3/19/14, indicated that R13 continued to "holler out...and shows most disregulation with issues related to smoking. He is on a program where he must get cigarettes from the nurses and is expected to be supervised with smoking. He is often noncompliant with with this expectation and goes to the smoking room asking for cigarettes from other people or collecting cigarette butts...He continues to state he enjoys smoking, watching television and drinking pop." On 3/26/14, at 9:00 a.m. a psychologist (P)-A was interviewed. She explained that she had visited with R13 for the past three weeks regarding his smoking. She said the plan was for the resident to be provided seven cigarettes per day and to wear a smoking apron. R13 did not utilize the apron consistently and had multiple aprons. A lighter-weight apron had been tried to see if it would be more comfortable for the resident. The resident was described as potentially emotionally de-regulating easily due to mental helath issues. The resident also had poor cognition and a "carry over of events." P-A explained that smoking was an important daily pleasure for the resident, and he was also prescribed medications to help with mood and behavior. On 3/26/14 at 9:30 a.m. a social worker (LSW)-B	F 242		

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F 242	Continued From page 5 explained the history of R13's smoking plan. She explained that R13 was changed to supervised smoking after finding a sore on his leg that resembled a cigarette burn. The revised plan was for R13 to ask staff for a cigarette and then be accompanied to the smoking room for observation. R13 was also to wear a smoking apron for safety from burns. Staff held R13's cigarettes gave the resident up to seven cigarettes per day. She explained that smoking was considered a privilege and staff were to accompany R13 if they had time. Because staff did not always have the time he was only receiving about 1-3 cigarettes per day on average. LSW-B thought this was a frustration for R13 and was aware he obtained cigarettes from other residents and smoked unsupervised. She stated that they were now working on revising the program. On 3/27/14, at 9:00 a.m. LSW-B reported that the smoking issue had been discussed at R13's interdisciplinary team (IDT) meetings "for some months" and the team was going to re-assess to see if he if he could be independent and safe with smoking. Because R13 was not getting his seven cigarettes daily, the IDT decided to revise the plan to determine if it was still appropriate. Since the IDT began working on the revised plan last week, they had obtained a tray that he could remove, but the resident did not like it. They had since ordered a welding apron. She verified staff had not been concerned with R13's safety related to independent smoking, rather the issue was that he was not consistently wearing the apron. R13's supervised smoking intervention on his care plan was discontinued on 3/26/14, and a new problem was added that directed staff to give	F 242		

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F 242	Continued From page 6 a specified number of cigarettes when he showed he was wearing the smoking apron. R13 was interviewed on 3/27/14, at 12:10 p.m. He stated that he talked to "the boss" and staff was now going to provide him with a set number of cigarettes during the day and he could smoke on his own. He explained that previously he had asked for cigarettes, but staff did not have time to help him, therefore he could not smoke. He admitted he sometimes bought cigarettes from other residents or smoked butts he had found. He reported he had burned himself on a long ash quite a while ago. During the interview the resident was observed wearing a smoking apron.	F 242		
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).	F 279	**F279** It is the policy of Providence Place that the facility use results of assessments to develop, review, and revise the plan of care. That the facility develop comprehensive plans of care for each resident that include measurable objectives and timetables to meet their medical, nursing, mental and psychosocial needs identified in the assessment. That the care plan describes those services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to resident R178, the interdisciplinary team reviewed her care plan. The care plan was updated to reflect resident's confusion at meal time, resistance to assistance, and dislike of green vegetables. Techniques to ensure R178's nutritional needs are being met have been developed and communicated to staff via the Nursing Assistant assignment sheets. R178 will be observed during meal times for	

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F 279	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure care plan interventions were developed to ensure nutritional needs were met for 1 of 1 resident (R178) reviewed for dining. Findings include: R178's care plan dated 2/22/14, indicated a deficit with activities of daily living related to dementia, limited mobility and confusion, with eating assistance, set up and supervision required. The statement problem read, "[resident name] has a nutritional problem or potential nutritional problem" (actual or potential was not identified) related to diagnoses, use of a mechanically altered diet, use of nutritional supplements to meet nutritional needs and comfort cares. The nutritional goals were to maintain weight, hydration, laboratory testing within normal limits, and good skin integrity. The interventions consisted of providing diet as ordered, observing and reporting changes in condition to the medical provider. The care plan lacked development of a specific problem related to R178's confusion at meals, resistance to help with eating and dislike of green vegetables. In addition, plan lacked clear individualized goals and interventions to direct care with regard to the identified problems at meal time. R178 was not provided assistance during observations of the breakfast meal on 3/26/14. At 8:00 R178 was served hot cereal, eggs, toast, tea and milk with the cereal bowl on a plate and	F 279	intake, limited number of items will be offered at a time to increase the likelihood R178 will partake in the meal. Periodic cues will be offered during the meal for encouragement; food items that R178 is not eating will be removed and other items/alternates offered. Dietary preferences will be noted and diet offerings altered to align with current preferences. Nursing assistant care sheets were updated to reflect effective methods of person centered approach and communication techniques to enhance the residents self determination and improve nutritional intake. **Actions taken to identify other potential residents having similar occurrences:** All residents needing assistance with dining have been reviewed and assessed for concerns related to meeting their nutritional needs. Care plans and Nursing Assistant assignment sheets were reviewed and updated with documentation and interventions for those needing dining assistance. **Measures put in place to ensure deficient practice does not occur:** Direct care staff to continue completing mealtime intake via the Point of Care kiosks. Licensed nursing staff to observe mealtime for changes in resident ability to feed self and monitor intake records for changes in intake. Dietician to monitor and report on nutritional concerns (weight changes, diet changes, etc.) weekly at Interdisciplinary Team (IDT) meetings. In-service training of nursing staff on facility procedure for proper observation and monitoring of resident nutritional intake conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility documentation mechanisms and follow-up as indicated.	

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F 279	Continued From page 8 scrambled eggs placed on a plate beside the bowl. R178 sat alone at the front of the room with her back to the other residents and the staff. The resident ate a couple bites of hot cereal, and then poured milk onto the plate of eggs. She then poured tea into her hot cereal and stirred it around. She ate her toast. Although five staff assisted in the dining room no staff had checked on her by 8:30 a.m. and she had not attempted to eat her cereal or her eggs. R178 then apple juice into the tea cup and sipped the liquid. R178 had not eaten any more food by 8:45 a.m. and the six staff who were then in the room did not check on her. The resident then stirred her cereal and poured milk in the bowl to almost overflowing. She placed empty sugar packets on the plate in the milk. At 8:54 a.m. R178 tried unsuccessfully to scoop scrambled eggs, and then picked up a piece of egg with her fingers and ate it. At 8:56 a.m. staff passed by but did not look at her situation or offer help. Staff intermittently passed by the resident and at 8:58 a.m. a staff person looked directly at the resident's food, but did not offer assistance. R178 then sipped some of the cereal./milk/tea mixture. By 9:00 a.m. most residents had left the dining room. At 9:07, R178 was still sitting with no help. At 9:11 a.m. a staff attended to R178 for the first time in 71 minutes and asked the resident if she wanted to keep eating. Although the resident did not directly respond to the question, she was taken from the dining room. No concern was offered as to the state of her food or fresh food was not offered. The following day at 12:30 p.m. R178 had eaten the potatoes and meat, but had not eaten the green beans or drank the milk provided. On 3/28/14, at 10:30 a.m. family member (FM)-A was interviewed. FM-A expressed dissatisfaction	F 279	**Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete one dining room audit each week for one month and then one dining room audit every other week for two months to assure proper compliance with dining assistance and intake monitoring procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014.**	

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F 279	Continued From page 9 with the level of help R178 received in the dining room. FM-A stated that R178 mixed up food items and then complained that the food did not taste good. FM-A explained that R178 poured tea into her cereal and did recall how to use a fork. FM-A explained that he attended most of R178's care conferences. Although he had brought up the resident's need for assistance to the staff a couple of times, nothing had been done to improve the situation. R178 received a dietary supplement, but FM-A wanted instead to see the resident receive assistance to eat the food provided. On 3/28/14, at 11:00 a.m. a registered nurse (RN)-A was interviewed. RN-A stated that R178 ate very well in the morning, could get angry and upset when staff tried to provide help. RN-A was aware that FM-A reported R178 "plays" with her food. She went on to explain that breakfast was R178's best meal, but that sometimes she poured juice into her cereal and sometimes ate the whole meal. RN-A explained that the resident liked where she sat to eat, and staff tired to observe whether she was eating or not. RN-A stated that R178 did not like green vegetables and had no teeth, so needed to have something she could chew. The information provided by RN-A as well as a specific plan as to how staff would ensure R178's nutritional needs were met were lacking on the resident's care plan.	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	**F280** It is the policy of Providence Place that each resident has the right to participate in planning the care and treatment or changes in their care and treatment. That a comprehensive care plan be developed with 7 days of completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician,	

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F 280	Continued From page 10 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 revise the care plan smoking in a timely manner for 1 of 1 resident (R13) who expressed distress and displayed maldaptive behaviors surrounding smoking. Findings include: R13's smoking assessment dated 1/22/14, indicated he demonstrated safe smoking habits, including safe and proper disposal of ashes and cigarettes. The plan was for one staff to assist the resident. The care plan dated 2/7/14, indicated a supervised smoking plan, not following the supervised smoking plan and not always using the smoking apron. Interventions were to check to make sure R13 had a smoking apron when doing hourly rounds. The second intervention deleted on 3/26/14, was to take R13 down to the	F 280	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. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to R13, the interdisciplinary team reviewed his plan of care. Strategies for assuring safety while smoking have been developed in coordination with Consulting Psychologist. R13 will be provided a specified number of cigarettes at specified times provided the resident demonstrates that he is wearing his smoking apron. After smoking the resident may receive a can of pop provided he returns to the unit and shows staff he continues to wear his smoking apron. His care plan was updated to reflect these new safety strategies. Nursing assistant care sheets were updated to reflect effective methods of person centered approach and communication techniques to enhance the residents self determination and provide safety. Effectiveness, of safety strategies will continue to be monitored for efficacy. **Actions taken to identify other potential residents having similar occurrences:** All residents identified to smoke were reviewed for safety. Their ongoing ability to smoke safely will be monitored through observations by staff and changes communicated to the appropriate staff; floor nurse, Clinical Director/Coordinator, Social Worker, or Shift Supervisor. Any change in their ability to smoke safely will be forwarded to licensed personnel who will initiate facility protocol.	

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F 280	Continued From page 11 smoking room up to seven times per day to facilitate supervised smoking plan. Other interventions included, wearing the smoking apron at all times. A second problem initiated on 7/28/11, indicated that R13 chose to smoke and did so independently, but had not been following the "smoke free" policy and continued to smoke outside. The goal was to remain free of burns and to follow the smoking policy. Interventions were to remind R13 where to smoke and to provide a smoking apron and encourage to wear it. A revised undated problem was hand-written on the plan and noted R13's smoking was supervised and they were instituting a trial of E-cigarettes. R13's behavior rounds documentation for the week of 12/26/13 through 1/2/14 revealed the resident had an increase in behavioral issues. A recent plan to provide supervised smoking program had been instituted and the resident became upset when staff were unavailable to accompany him to smoke. The resident was described as not easily re-directable and threatened and called others derogatory names. R13 was also bumming cigarettes from other residents and was found in the smoke room unsupervised. A summary note dated 1/16/14, described behaviors for the time period of 1/3/14 through 1/9/14. R13 was noted to be more agitated, yelling and screaming at staff regarding supervised smoking. Documentation from 1/23/14 through 1/26/14 showed the resident had been bumming cigarettes from other residents, was non-compliant with his smoking program, yelled and screamed at staff, and refused care and medication until staff provided him with a cigarette. On 2/27/14, the staff were unable to redirect the	F 280	**Measures put in place to ensure deficient practice does not occur:** In-service training of staff on facility procedure for smoking rules and safety; and how to properly observe, assess, treat and document residents smoking conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility documentation mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete three resident smoking audits each week for one month and then two resident smoking audits each week for two months to assure proper smoking safety. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014.**	

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F 280	Continued From page 12 resident when he became upset, and the resident was admitted to the hospital. He was found to have urinary retention with an infection. A care conference note dated 1/31/14 noted the concerns with increased behaviors in yelling, bumming cigarettes and being non-compliant with his smoking plan. On 3/7/14, it was documented that a social worker (LSW) had spoken with the in-house psychologist regarding R13's unsafe smoking habits. On 3/17/14, R13 approached LSW-B and asked who had taken his cigarettes away. The resident became upset at the LSW and used abusive and threatening language. On 3/25/14, R13 approached LSW-B demanding cigarettes and yelled, "They are my ### cigarettes! I want them!" When asked about using a lap tray the resident responded, "I don't want to wear it. It's big and it's bulky and I don't like it." On 3/26/14, LSW-A noted R13's care plan for smoking would be changed. It was determined the plan was ineffective, as the resident acquired cigarettes from other sources. R13 had agreed to wear a smoking apron. A psychology note dated 3/19/14, indicated that R13 continued to "holler out...and shows most disregulation with issues related to smoking. He is on a program where he must get cigarettes from the nurses and is expected to be supervised with smoking. He is often noncompliant with with this expectation and goes to the smoking room asking for cigarettes from other people or collecting cigarette butts...." On 3/26/14, at 9:00 a.m. a psychologist (P)-A was interviewed. She explained that she had visited with R13 for the past three weeks regarding his	F 280		

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F 280	Continued From page 13 smoking. She said the plan was for the resident to be provided seven cigarettes per day and to wear a smoking apron. R13 did not utilize the apron consistently. The resident was described as potentially emotionally de-regulating easily due to mental helath issues. The resident also had poor cognition and a "carry over of events." P-A explained that smoking was an important daily pleasure for the resident, and he was also prescribed medications to help with mood and behavior. On 3/26/14 at 9:30 a.m. a social worker (SW)-B explained the history of R13's smoking plan. She explained that R13 was changed to supervised smoking after finding a sore on his leg that resembled a cigarette burn. The revised plan was for R13 to ask staff for a cigarette and then be accompanied to the smoking room for observation. R13 was also to wear a smoking apron for safety from burns. Staff held R13's cigarettes gave the resident up to seven cigarettes per day. She explained that smoking was considered a privilege and staff were to accompany R13 if they had time. Because staff did not always have the time he was only receiving about 1-3 cigarettes per day on average. SW-B thought this was a frustration for R13 and was aware he obtained cigarettes from other residents and smoked unsupervised. She stated that they were now working on revising the program. On 3/27/14, at 9:00 a.m. SW-B reported that the smoking issue had been discussed at R13's interdisciplinary team (IDT) meetings "for some months" and the team was going to re-assess to see if he if he could be independent and safe with smoking. Because R13 was not getting his seven	F 280		

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F 280	Continued From page 14 cigarettes daily, the IDT decided to revise the plan to determine if it was still appropriate. Since the IDT began working on the revised plan last week, they had obtained a tray that he could remove, but the resident did not like it. They had since ordered a welding apron. She verified staff had not been concerned with R13's safety related to independent smoking, rather the issue was that he was not consistently wearing the apron. R13's supervised smoking intervention on his care plan was discontinued on 3/26/14, and a new problem was added that directed staff to give a specified number of cigarettes when he showed he was wearing the smoking apron. R13 was interviewed on 3/27/14, at 12:10 p.m. He stated that he talked to "the boss" and staff was now going to provide him with a set number of cigarettes during the day and he could smoke on his own. He explained that previously he had asked for cigarettes, but staff did not have time to help him, therefore he could not smoke. He admitted he sometimes bought cigarettes from other residents or smoked butts he had found. He reported he had burned himself on a long ash quite a while ago.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	**F282** It is the policy of Providence Place that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to resident R67, all pain medication orders and pain relieving interventions have been reviewed, re-training and monitoring to assure residents pain levels are properly managed were	

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F 282	Continued From page 15 Based on observation, interview and document review, the facility failed to follow care plan interventions for 1 of 1 resident (R67) reviewed for pain and for 1 of 3 residents (R238) reviewed for catheter use. Findings include: R67's care plan (created 3/24/14), indicated R67 had acute pain related to trauma and secondary to a left shoulder fracture, with resident reporting pain, protective behavior, guarding behavior, facial masking, irritability, self-focusing, and restlessness. Interventions included anticipating the need for pain relief especially prior to therapy or increased activity, respond immediately to complaints of pain, give medications as ordered, and observe/document verbal/nonverbal signs and symptoms of pain. diagnoses were schizophrenia, and fractured humerus requested pain medication and the medication was not available. R67 requested extra strength Tylenol 500 milligrams (mg) during a medication administration observation on 3/24/14, at 4:10 p.m. The resident displayed a flat affect. The trained medication aide (TMA)-A searched the medication cart and was unable to locate the Tylenol. TMA-A then informed the registered nurse (RN) of the missing medication bottle. TMA-A explained that the charge nurse would get the medication from the stock supply and also planned to re-order it for the next morning. TMA-A said the medication was not actually scheduled to be administered until 6:00 p.m. Because R67 experienced a recent fracture, staff gave the medication to the resident a bit early if she asked for it.	F 282	implemented. Regarding resident R238, all catheterization orders were reviewed, retraining and interventions to assure residents catheterization is completed properly and timely were implemented. **Actions taken to identify other potential residents having similar occurrences:** All residents with pain management programs and that require catheterization have been reviewed and assessed for concerns related to proper care plan implementation. Re-training regarding assuring proper care plan implementation was completed with licensed nursing and direct care staff. **Measures put in place to ensure deficient practice does not occur:** Licensed nursing and direct care staff to complete in-service training on facility procedure for proper care plan implementation conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility documentation mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete two care delivery audits each week for one month and then one care delivery audit every other week for two months to assure proper compliance with care plan implementation. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014.**	

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F 282	Continued From page 16 A review of the medical record indicated on 3/14/14 a physician order was obtained for Tylenol ES (extra strength) 500 milligrams orally two tables three times a day. R67's Medication Administration Record (MAR) on 3/24/14, at 7:55 p.m. showed the pain medication had not been administered, and RN-A said that the TMA was working on another floor at the time. The extra strength Tylenol was not signed off as having been given when a copy of the MAR was received on 3/27/14. At 8:00 p.m. RN-A indicated the TMA should have obtained medications from stock, extra strength Tylenol would have been in the facility's stock medication supply and the resident would not have to wait. On 3/26/14 at 2:00 p.m. the assistant director of nursing (ADON) was asked about the missed medication. The ADON indicated she spoke to TMA-A and was told the medication was given after 7:00 p.m. R238's care plan had been updated on 2/25/14, and indicated the resident was incontinent due to impaired mobility and multiple sclerosis and was to be straight catheterized every six hours. R238 was observed resting in bed on 3/26/14, from approximately 9:15 a.m. to 11:00 a.m. At 10:45 a.m. RN-E was asked when catheter care would be performed, and the nurse said she would check and get back to the surveyor. At 10:47 a.m. RN-E reported she needed female assistance inn order to catheterize R238, and the staff were assisting residents to get up for lunch, so the treatment would need to be completed after lunch. At 11:00 two nursing assistants	F 282		

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F 282	Continued From page 17 assisted the resident to get up for the noon meal. No catheterization was performed during the observational period. At 1:25 p.m. R238 was seated in a wheelchair outside her room. The resident reported she was comfortable and not experiencing any pain or discomfort. R238 was laid down in bed and at 1:45 p.m. RN-E catheterized the resident, producing 500 cubic centimeters (ccs) of golden-colored urine. R238 offered no complaints or signs of pain during the procedure. The resident had not been straight catheterized for nine hours, 45 minutes. On 3/28/14 at 12:43 RN-D verified R238 experienced frequent UTIs, and should have been catheterized closer to 10:00 a.m. according to the resident's care plan.	F 282		
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 ensure adequate pain control for 1 of 1 resident (R67) reviewed for pain. Findings include: R67's diagnoses were schizophrenia, and	F 309	**F 309** It is the policy of Providence Place that each resident receive 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. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to resident R67, all pain medication orders and pain relieving interventions have been reviewed, her care plan has been reviewed, a pain assessment has been completed. Re-training and monitoring to assure residents pain levels are properly managed were implemented. **Actions taken to identify other potential residents having similar occurrences:** All residents with changes in pain levels were reviewed for effective programs to reduce or prevent pain. Those residents identified to have concerns were assessed	

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F 309	Continued From page 18 fractured humerus requested pain medication and the medication was not available. R67 requested extra strength Tylenol 500 milligrams (mg) during a medication administration observation on 3/24/14, at 4:10 p.m. The resident displayed a flat affect. The trained medication aide (TMA)-A searched the medication cart and was unable to locate the Tylenol. TMA-A then informed the registered nurse (RN) of the missing medication bottle. TMA-A explained that the charge nurse would get the medication from the stock supply and also planned to re-order it for the next morning. TMA-A said the medication was not actually scheduled to be administered until 6:00 p.m. Because R67 experienced a recent fracture, staff gave the medication to the resident a bit early if she asked for it. A review of the medical record indicated on 3/14/14 a physician order was obtained for Tylenol ES (extra strength) 500 milligrams orally two tables three times a day. R67's initial Minimum Data Set (MDS) dated 3/7/14, revealed the resident did not experince pain or take pain medication. The following week on 3/14/14, however, the resident was sent to the emergency room with a left humerus fracture. No pain assessment had been completed after the fracture. The care plan (created 3/24/14), indicated R67 had acute pain related to trauma and secondary to a left shoulder fracture, with resident reporting pain, protective behavior, guarding behavior, facial masking, irritability, self-focusing, and restlessness. Interventions included anticipating	F 309	and care plans updated to include effective interventions. **Measures put in place to ensure deficient practice does not occur:** Processes for identifying, assessing changes in pain levels, and implementing new or revised care plan interventions were reviewed for effectiveness. Re-training of identifying, assessing and implementing processes to licensed and direct care staff conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete one care plan audit each week for one month and then one care plan audit every other week for two months to include proper care plan intervention implementation procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	

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F 309	Continued From page 19 the need for pain relief especially prior to therapy or increased activity, respond immediately to complaints of pain, give medications as ordered, and observe/document verbal/nonverbal signs and symptoms of pain. R67's Medication Administration Record (MAR) on 3/24/14, at 7:55 p.m. showed the pain medication had not been administered, and RN-A said that the TMA was working on another floor at the time. The extra strength Tylenol was not signed off as having been given when a copy of the MAR was received on 3/27/14. At 8:00 p.m. RN-A indicated the TMA should have obtained medications from stock, extra strength Tylenol would have been in the facility's stock medication supply and the resident would not have to wait. On 3/26/14 at 2:00 p.m. the assistant director of nursing (ADON) was asked about the missed medication. The ADON indicated she spoke to TMA-A and was told the medication was given after 7:00 p.m.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eating assistance was provided for 1 of 1 resident (R178) who required assistance and was reviewed for dining.	F 311	**F 311** It is the policy of Providence Place that a resident is given the appropriate treatment and services to maintain or improve his or her abilities. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to resident R178, the interdisciplinary team reviewed her care plan. The care plan was updated to reflect resident's confusion at meal time, resistance to assistance, and dislike of green vegetables. Techniques to ensure R178's nutritional needs are being met have been developed and communicated to staff via the Nursing Assistant assignment sheets. R178	

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F 311	Continued From page 20 Findings include: R178 was not provided assistance during observations of the breakfast meal on 3/26/14. At 8:00 R178 was served hot cereal, eggs, toast, tea and milk with the cereal bowl on a plate and scrambled eggs placed on a plate beside the bowl. R178 sat alone at the front of the room with her back to the other residents and the staff. The resident ate a couple bites of hot cereal, and then poured milk onto the plate of eggs. She then poured tea into her hot cereal and stirred it around. She ate her toast. Although five staff assisted in the dining room no staff had checked on her by 8:30 a.m. and she had not attempted to eat her cereal or her eggs. R178 then apple juice into the tea cup and sipped the liquid. R178 had not eaten any more food by 8:45 a.m. and the six staff who were then in the room did not check on her. The resident then stirred her cereal and poured milk in the bowl to almost overflowing. She placed empty sugar packets on the plate in the milk. At 8:54 a.m. R178 tried unsuccessfully to scoop scrambled eggs, and then picked up a piece of egg with her fingers and ate it. At 8:56 a.m. staff passed by but did not look at her situation or offer help. Staff intermittently passed by the resident and at 8:58 a.m. a staff person looked directly at the resident's food, but did not offer assistance. R178 then sipped some of the cereal./milk/tea mixture. By 9:00 a.m. most residents had left the dining room. At 9:07, R178 was still sitting with no help. At 9:11 a.m. a staff attended to R178 for the first time in 71 minutes and asked the resident if she wanted to keep eating. Although the resident did not directly respond to the question, she was taken from the dining room. No concern was offered as to the	F 311	will be observed during meal times for intake, limited number of items will be offered at a time to increase the likelihood R178 will partake in the meal. Periodic cues will be offered during the meal for encouragement; food items that R178 is not eating will be removed and other items/alternates offered. Dietary preferences will be noted and diet offerings altered to align with current preferences. Nursing assistant care sheets were updated to reflect effective methods of person centered approach and communication techniques to enhance the residents self determination and improve nutritional intake. **Actions taken to identify other potential residents having similar occurrences:** All residents needing assistance with dining have been reviewed and assessed for concerns related to meeting their nutritional needs. Care plans and Nursing Assistant assignment sheets were reviewed and updated with documentation and interventions for those needing dining assistance. **Measures put in place to ensure deficient practice does not occur:** Direct care staff to continue completing mealtime intake via the Point of Care kiosks. Licensed nursing staff to observe mealtime for changes in resident ability to feed self and monitor intake records for changes in intake. Dietician to monitor and report on nutritional concerns (weight changes, diet changes, etc.) weekly at Interdisciplinary Team (IDT) meetings. In-service training of nursing staff on facility procedure for proper observation and monitoring of resident nutritional intake conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:**	

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F 311	Continued From page 21 state of her food or fresh food was not offered. The following day at 12:30 p.m. R178 had eaten the potatoes and meat, but had not eaten the green beans or drank the milk provided. On 3/28/14, at 10:30 a.m. family member (FM)-A was interviewed. FM-A expressed dissatisfaction with the level of help R178 received in the dining room. FM-A stated that R178 mixed up food items and then complained that the food did not taste good. FM-A explained that R178 poured tea into her cereal and did recall how to use a fork. FM-A explained that he attended most of R178's care conferences. Although he had brought up the resident's need for assistance to the staff a couple of times, nothing had been done to improve the situation. R178 received a dietary supplement, but FM-A wanted instead to see the resident receive assistance to eat the food provided. On 3/27/14, at 11:30 a.m. a social worker (SW)-B was interviewed and was unaware FM-A had requested help for R178 in the dining room or that there were issues related to dining help for R178. The following day at 11:00 a.m. a registered nurse (RN)-A was interviewed. RN-A stated that R178 ate very well in the morning, could get angry and upset when staff tried to provide help. RN-A was aware that FM-A reported R178 "plays" with her food. She went on to explain that breakfast was R178's best meal, but that sometimes she poured juice into her cereal and sometimes ate the whole meal. RN-A explained that the resident liked where she sat to eat, and staff tired to observe whether she was eating or not. When asked how staff responded when the resident poured juice into her cereal, RN-A said it was usually an indication the resident was	F 311	Clinical Coordinators will monitor facility documentation mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete one dining room audit each week for one month and then one dining room audit every other week for two months to assure proper compliance with dining assistance and intake monitoring procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014.**	

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F 311	Continued From page 22 finished eating. RN-A stated that R178 did not like green vegetables and had no teeth, so needed to have something she could chew. "If the veggies are not done to her liking, she may not eat." She stated that they had not tried ground vegetables. R178's annual Minimum Data Set (MDS) assessment dated 1/28/14, indicated the resident was provided a mechanically altered diet and required set up assistance "oversight, encouragement, cueing" to eat. The corresponding Care Area Assessment (CAA) dated 1/28/14, indicated a problem with eating of "Mental errors: sequencing problems, incomplete performance, anxiety limitations, etc. Physical limitations: weakness, limited range of motion, poor coordination, poor balance, visual impairment, pain ,etc." A nutritional assessment completed 1/28/14 indicated a potential nutritional risk due to failure to thrive, and dementia. The assessment indicated an intake of 25-75% of meals and a supplement offered due to stage II pressure area on the resident's heel. R178's care plan dated 2/22/14, indicated a deficit with activities of daily living related to dementia, limited mobility and confusion, with eating assistance, set up and supervision required. The statement problem read, "[resident name] has a nutritional problem or potential nutritional problem" (actual or potential was not identified) related to diagnoses, use of a mechanically altered diet, use of nutritional supplements to meet nutritional needs and comfort cares. The nutritional goals were to maintain weight, hydration, laboratory testing within normal limits, and good skin integrity. The interventions consisted of providing diet as	F 311		

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F 311	Continued From page 23 ordered, observing and reporting changes in condition to the medical provider. The care plan lacked development of a specific problem related to R178's confusion at meals, resistance to help with eating and dislike of green vegetables. In addition, plan lacked clear individualized goals and interventions to direct care with regard to the identified problems at meal time.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide urinary management for 1 of 3 residents (R238) in the sample who were reviewed for catheter care. Findings included: R238 was observed resting in bed on 3/26/14, from approximately 9:15 to 11:00 a.m. At 10:45 a.m. RN-E was asked when catheter care would be performed, and the nurse said she would check and get back to the surveyor. At 10:47 a.m. RN-E reported she needed female	F 315	**F 315** It is the policy of Providence Place that the facility ensures that each resident that enters the facility without an indwelling catheter is not catheterized unless the residents condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as possible. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to resident R238, all catheterization orders were reviewed, retraining and interventions to assure residents catheterization is completed properly and timely were implemented. **Actions taken to identify other potential residents having similar occurrences:** All residents that require catheterization have been reviewed and assessed for concerns related to proper care plan implementation. Re-training regarding assuring proper care plan implementation was completed with licensed nursing and direct care staff. **Measures put in place to ensure deficient practice does not occur:** Licensed nursing and direct care staff to complete in-service training on facility procedure for proper care plan	

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F 315	Continued From page 24 assistance in order to catheterize R238, and the staff were assisting residents to get up for lunch, so the treatment would need to be completed after lunch. At 11:00 two nursing assistants assisted the resident to get up for the noon meal. No catheterization was performed during the observational period. At 1:25 p.m. R238 was seated in a wheelchair outside her room. The resident reported she was comfortable and not experiencing any pain or discomfort. R238 was laid down in bed and at 1:45 p.m. RN-E catheterized the resident, producing 500 cubic centimeters (ccs) of golden-colored urine. R238 offered no complaints or signs of pain during the procedure. The resident had not been straight catheterized for nine hours, 45 minutes. R238 had diagnoses including included multiple sclerosis, neurogenic bladder, retention of urine and history of urinary tract infections (UTIs). A physician order dated 3/18/14, directed staff to straight catheterize the resident every six hours. The Treatment Administration Record revealed R238 should have been cateterized at 10:00 a.m. The order read: "intermittent catheterize resident every six hours" and was scheduled at 4:00 and 10:00 a.m. and 4:00 and 10:00 p.m. The resident's care plan had been updated on 2/25/14 and indicated the resident was incontinent due to impaired mobility and multiple sclerosis and was to be straight catheterized every six hours. On 3/28/14 at 12:43 RN-D verified R238 experienced frequent UTIs, and should have been catheterized closer to 10:00 a.m. according to physician's orders.	F 315	implementation conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility documentation mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete two care delivery audits each week for one month and then one care delivery audit every other week for two months to assure proper compliance with care plan implementation. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014.**	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332	**F 332** It is the policy of Providence Place that the facility ensures that it is free of medication	

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F 332	Continued From page 25 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication errors were fewer than 5% during the medication pass for 3 of 5 residents (R63, R7, R104) whose medication administration was observed. This resulted in an error rate of 12.5%. Findings include: R7 received artificial tears on 3/24/14 at 4:49 p.m. by a trained medication assistant (TMA)-A. TMA-A administered the ophthalmic solution to the right eye and to the left eye socket after cleansing them with sanitary wipes. The resident's current physician order directed staff to administer artificial tears one drop solution ophthalmic four times a day, however, the order lacked instruction to staff as to which eye the drops were to be administered. On 3/24/14, at 6:11 p.m. a registered nurse (RN)-A reviewed the medical record and verified the resident should have only had the drop administered to the right eye. RN-A noted the order should have been more specific and needed to be clarified with the physician. The facility's policy for eye drop administration revised 4/20/12, did not address checking physician's order or the Medication Administration Record (MAR) prior to administration.	F 332	rates of five percent or greater. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to R63, R7, and R104, they have had their medication regimes reviewed and are receiving their medications as prescribed. Effectiveness, of preventing medication errors will continue to be monitored for efficacy. **Actions taken to identify other potential residents having similar occurrences:** All residents with ophthalmic medications, injectable insulin, and those receiving medications via gastric tubes were reviewed for proper administration. All identified will be monitored for ongoing compliance. Any medication error concerns will be forwarded to licensed personnel who will initiate facility protocol. **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff on facility procedure for proper medication administration conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete three medication administration audits each week for one month and then one medication administration audit every week for two months to assure proper compliance with medication administration procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that	

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F 332	Continued From page 26 R104 received 3 units of Novolog insulin on 3/24/14, at 5:46 p.m. administered by RC-C RN-C entered the resident's room, removed the insulin vial from the enclosed plastic bottle and drew up the insulin. The top of the insulin vial was not cleansed in the usual manner prior to drawing up the insulin. After the medication was in the syringe, RN-C showed the syringe to the surveyor. Prior to administering the medication, RN-C was questioned about the accuracy of the insulin dose. The amount in the syringe was at least three units of Novolog insulin. RN-C stated it was accurate, and then administered the insulin to R104. The resident's current physician orders, however, directed staff to administer Novolog 100 unit/milliliters (mls) three times a day, inject 2 units with each meal. On 3/24/14, at 6:12 p.m. RN-A was questioned about the drawing up and measurement of R104's insulin, and stated the syringes were difficult and there was often a clear space at the top of the syringe. RN-A reported the withdrawing and measurement of insulin would be reviewed. RN-A verified R104 should only have received 2 units of Novolog insulin. The facility's procedure for insulin injection revised 4/20/12, directed staff to check the resident's prescription against the MAR. "Determine the correct amount of insulin to be withdrawn. Prepare syringe an needle. Swab rubber cap with alcohol wipe. Inject same amount of air into vial as the amount of insulin to be withdrawn. Hold insulin syringe with correct calibration at eye level and withdraw the prescribed amount."	F 332	time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	

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F 332	Continued From page 27 R63 received medications administered via a gastric tube (inserted into the stomach for medication and/or nutrition) on 3/26/14, at 8:50 a.m. by RN-A. RN-A administered the following medications: Immodium 20 mls and Mapap liquid (for Tylenol) 20.31 mls (or 650 milligrams (mg). The resident's physician orders dated 3/20/14, instead directed staff to administer Immodium A-D 20 mls, 1 mg/5 ml solution four times daily, and Tylenol 6.5 500 mg/5 mls liquid oral via the gastric tube (gt) three times daily. The Mapap liquid bottle label indicated 160/5 ml 20.31 mls (or 650 mg) orally three times daily. The Tylenol 6.5 mg oral /gt had been crossed out on the MAR, and 650 mg was hand written in its place. On 3/27/14, at 2:28 p.m. RN-A explained that R63 had never taken medication orally, and was unaware of the discrepancy. The facility's policy and procedure for transcription of orders,revised 5/03, directed staff: "Upon receipt of signed physician orders, transcribe orders onto medication administration record and times for administration. NOTE: all orders are to be transcribed verbatim. Order medications needed from pharmacy. "	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F 371** It is the policy of Providence Place that the facility ensures food is procured from approved sources and stores, distributes, and serves food under sanitary conditions. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to the 178 residents affected by the findings; the Vulcan convection oven has been cleaned; the Wolf flat top grill has been cleaned and missing and broken knobs replaced; all outdated and unsealed food items in walk in cooler and reach in freezer	

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F 371	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures to promote sanitation and food safety, and to ensure expired food was not stored for use. This had the potential to affect 176 of 180 residents who were served food from the kitchen. Findings include: Sanitation problems were observed during a kitchen and facility tour on 3/24/14, at 11:55 a.m. with the food service manager (FSM). The FSM confirmed the findings at the time of the observations. 1) Food splatters were built up on the inside glass doors and on the bottom of the Vulcan convection oven. A build up of a greasy brown substance was below the door hinges. 2) Two knobs were missing and two were broken of nine knobs on the Wolf flat top grill. Additionally, there was a buildup of grease and dust around and on the knobs. The drip pan under the flat top grill had a heavy food, grease, black grime buildup on the right side of the drip pan. 3) Outdated and/or unsealed and undated food was stored for use in the walk in cooler and reach in freezer in the main kitchen. The food included an unsealed/undated 10 ounce (oz.) bag of Boca vegetable protein nuggets; a pan of cooked, fried chicken legs was covered in plastic wrap and	F 371	have been removed; all food in food preparation area has been removed and disposed or properly stored; All expired milk in first floor north kitchenette was removed; expired applesauce in second floor south kitchenette was removed. Effectiveness, of providing appropriately procured food, stored, distributed and served under sanitary conditions will continue to be monitored for efficacy. **Actions taken to identify other potential residents having similar occurrences:** Deficient practice affected most residents, necessary cleaning and storage practice processes were reviewed and adjustments made to assure required compliance (see training below). **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff on facility procedure for proper food sanitation conducted by May 10th, 2014, with follow-up training as indicated. Training includes: Equipment Sanitation: the food service staff will maintain the sanitation of the dining and food service areas through compliance with cleaning schedules • The dietary staff will be re-educated on cleaning procedures and continue to follow cleaning lists and procedures for kitchen sanitation implemented by the food service director. • A cleaning schedule is posted for all cleaning tasks, including equipment sanitation and staff will initial the task as completed. • The food service director will review cleaning lists to ensure that procedures are being completed and staff is held accountable for all cleaning assignments.	

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F 371	Continued From page 29 dated 3/19/14. The reach in freezer contained a bin of open food items undated/unsealed that included a package of 18 gluten free cookies, an 8 oz. package of ginger snap cookies, and an opened 8 oz. package of chocolate chip cookies. A loaf of bread and 8 oz. of chocolate cookies were sealed but were undated. 4) The food preparation area also contained items that were not properly stored and/or labeled. A five pound (lb.) bag of Hershey's cocoa mix was opened, unsealed, and dated 10/5/13. A three pound bag of cornbread stuffing mix, was opened, unsealed, and dated 11/20/13. A 36 oz. box of wild rice blend, a 1 lb. 5 oz. box of cornflake crumbs, and a 12 oz. box of cream of gluten free rice mix were unsealed/undated. 5) The first floor north kitchenette refrigerator contained two 236 cubic centimeters of whole milk cartons with an expiration date of 3/20/14. 6) The second floor south kitchenette refrigerator contained a one liter plastic container of applesauce dated 3/20/14. Review of the facility Cleaning Instructions: Ovens and Ranges dated 2010, directed staff as follows: "Ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks), the ranges will be cleaned after each use...wash the drip pans as needed and/or according to the cleaning schedule". There was no direction for deep cleaning the units. Review of the facility Food Storage policy dated 2010, directed staff as follows: "Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and	F 371	• The food service director and/or designee will complete audits of equipment to ensure proper sanitation 3 times each week for 1 month and 2 times each week for 2 months. Food Storage: the food service staff will maintain the safety of food through compliance with food storage and labeling/dating procedures. • All stock will be rotated with each new order received by using the first in-first out method (old stock always used first). • All refrigerated food items will be covered, labeled, and dated after being opened. • Perishable, potentially hazardous foods must be consumed or discarded by expiration date on item or within 3 days of written date. • All dietary staff will be re-educated on labeling and dating policies and are responsible to ensure proper procedures are being followed. • The food service director will monitor compliance. • The food service director and/or designee will audit all food storage areas 3 times each week for 1 month and 2 times each week for 2 months and assure foods are labeled/dated and expired food items have been disposed. **Effective implementation of actions will be monitored by:** Food Service Manager will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Food Service Director and/or designee will complete three equipment and food	

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F 371	Continued From page 30 dated before being refrigerated. Leftover food is used within 3 days or discarded...All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates or frozen (where applicable) or discarded...All foods should be covered, labeled and dated...checked to assure that foods will be consumed by their safe use by dates or discarded." When interviewed on 3/24/14, at 11:55 a.m. the FSM confirmed all food items should have been sealed, dated and/or thrown out if past three days or the expiration date. In addition, the convection oven and grill/stove were in need of repair, and cleaning where soiled. He further stated the staff performed cleaning daily and "probably deep clean about one time per month."	F 371	storage area audits each week for one month and then two equipment and food storage area audits every week for two months to assure proper compliance with equipment sanitation and food storage procedures. The data collected will be presented to the Quality Assurance committee by the Food Service Director. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	**F 431** It is the policy of Providence Place that the facility employ or obtain services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. That all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to R63, her orders have been clarified to indicate proper route of administration and labels corrected. Two bottles of influenza vaccine in TCU refrigerator have been discarded. The 2	

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	245271	A. BUILDING _____ B. WING _____	C 03/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 31 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to maintain medication storage sanitation, temperature, labeling, and disposal of expired medications, potentially affecting 2 of 2 residents (R169, R39) whose suppository medications had expired, as well as the 98 residents in the facility who may have been administered stored unlabeled/undated and/or expired medications. Findings include: On 3/26/14, at 8:20 a.m. through 9:00 a.m. a registered nurse (RN)-A was dispensing medications to be administered to R63. Numerous labels on the medications did not coincide with how the medications were administered to the resident. All medications were given via gastric tube (GT) and R63's physician orders dated 3/20/14, instructed staff as follows: Tylenol (for pain) 6.5 mg 500 mg/5 ml	F 431	South and 3 South medication carts have been cleaned and all out dated or improperly labeled medications have been appropriately disposed or labeled. All expired medications in the 2 North and 3 North medication room refrigerators have been properly disposed. **Actions taken to identify other potential residents having similar occurrences:** All medication orders have been reviewed for accuracy and consistency between orders, medication administration record and medication card/bottle labels. All facility medication carts and medication rooms have been inspected for compliance with facility protocols for proper handling and storage of drugs and biologicals. Staff will be monitored with observational audits for continued compliance. Any infection control concerns will be forwarded to licensed personnel who will initiate facility protocol. **Measures put in place to ensure deficient practice does not occur:** Processes have been developed to assure periodic review of medication carts and rooms for cleanliness, medication storage and disposal. Processes will continue for order reconciliation. In-service training of nursing staff on facility processes conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete three medication cart/room audits each week for one month and then one medication cart/room audit every week for two months to assure proper compliance with medication carts and rooms for cleanliness, medication storage and disposal	

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F 431	Continued From page 32 liquid oral/GT three times daily, gabapentin (anticonvulsant) 8 ml 250 mg/5 ml solution GT four times daily, acidophilus (to maintain normal flora) 50 ml capsule enteral tube twice daily, Lisinopril (for high blood pressure) 5 mg GT every day, cyanocobalamin (generic for vitamin B12) 500 mcg GT everyday, hydrocortisone (corticosterioid) 10 mg GT every day, Spiriva (for asthma) handihaler 18 mcg capsule inhalation everyday. Advair diskus (for asthma) 250-50 mcg/dose every 12 hours. The labels noted the resident was to receive the medications orally, including Mapap liquid (for Tylenol), gabapentin, acidophilus, Lisinopril, and hydrocortisone, and the vitamin B12 was to be administered sublingually (under the tongue). A Spiriva inhaler was placed along with Advair 250/50 inhaler in a plastic zipped bag that was labeled "ventolin hfa 108 mcg/act 2 puffs every 4 hours if needed." RN-A verified the information on the medication labels. Facility policy and procedure, undated, indicated to compare information on the medication label with the Medication Administration Record (MAR) when removing form storage, when removing from container and when returning to storage. If label directions are incorrect, nurse or medication aide should apply a "direction change" sticker to the medication label. If the medication and MAR do not match, do not administer the medication. Investigate the discrepancy. On 2/28/14, in the transitional care unit (TCU) medication storage room refrigerator there were two open bottles of influenza virus flulaval. One was dated opened 12/3/13, the other bottle was opened and was not dated. This was verified by RN -B at 2:37 p.m.	F 431	procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May10th, 2014**	

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F 431	Continued From page 33 The facility's undated policy Medication Storage and Expiration Guidelines directed the following storage guidelines for influenza vaccine (Flulaval) "Unopened: manufacturer's expiration date, opened-refrigerated expires 30 days after opening" (date when opened), and "Medications found undated when opened will be presumed to have been opened as of the date of dispensing." The Flulaval was received at the facility on 9/10/13. Manufacturer's storage recommendations were to discard the medication after being opened for 28 days. The 2 south medication cart had a clear liquid spilled on the base of the top drawer in the right back corner. The liquid had soaked onto an eye drop label making the label illegible. Multiple single dose units of eye drops were loose in top drawer. An empty medication (stock) bottle with out lid was stored in the first drawer. The second drawer had excessive debris on the base of the drawer and well as a collection of dust and brown matter on the ledge of the back of the drawer. The third drawer had soiled towels placed on the base of the drawer covering up stained areas. Orange streak-like markings were noted on the base of drawers. Two bottles of a prednisolone suspension (eye drops for ocular inflammation) were stored in the cart, however, the medications had been discontinued and were available for resident use. A bottle of betaxol ophthalmic suspension (eye drops for glaucoma) was labeled to be discarded by 3/16/14, but remained in the medication cart. The third drawer of the cart was soiled with dark brown flaked markings. On 3/28/14, at 8:35 a.m. RN-A verified both ophthalmic solutions should have been removed	F 431		

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F 431	Continued From page 34 from the cart and disposed of. RN-A also noted the carts were very soiled and should have been cleaned. Although the facility had a cleaning schedule for the carts, RN-A said it did not seem staff had been following the schedule on the unit. The 3 south medication cart was observed on 3/28/14, at 9:15 a.m. and was soiled with a brown colored fluid that had dripped from the top drawer to the third drawer. The assistant director of nursing (ADON) was present, and stated that it appeared cleaning was not being completed on a regular basis. The 3 north medication room was observed on 3/28/14, at 9:20 a.m. with RN-B. A bottle of tuberculin solution (with shortened use date) had been dispensed on 1/24/14. It was opened but not dated, and was stored in the refrigerator for use. The 2 north medication refrigerator was observed on 3/28/14, at 9:55 a.m. A bottle of Ultimate probiotic supplement was opened, however, had not been properly labeled including a resident's name. Three tuberculin vials from the house stock were stored in the refrigerator. The first bottle was dispensed on 2/6/14, and was opened but not dated. The second vial was opened 2/21/14, but was not dated. A third vial was dispensed 3/3/14, but was not dated when opened. In addition, the refrigerator held an opened box of bisacodyl suppositories for R169. Three suppositories remained and the expiration date was 10/26/13. A box of bisacodyl suppositories for R39 had been opened and 10 suppositories remain, but had expired 2/28/14. The house stock of five prochlorper (used for nausea) suppositories 25 mg were opened but	F 431		

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F 431	Continued From page 35 had expired 10/11/13. At 11:37 a.m. the medication issues from 2 north were discussed with the assistant director of nursing. On 3/28/14, at 1:15 p.m. RN-D explained that the staff would have looked at the medication including the tuberculin solution, prior to administering it to a resident. On 3/28/14, at 2:15 p.m. the director of nursing (DON) was updated on the findings of the medication storage throughout the facility. The DON said that the facility had a system for cleaning and documenting cleaning for medication storage. In addition, the expired medications had since been removed from the medication carts and refrigerators. The facility's undated Medication Storage and Expiration Guidelines indicated "All time dated medications have an expiration date printed on the container." Multi-dose injection vials such as those for tuberculosis screening were to be disposed of within one month after opening. The facility's policy for cleaning medication carts revised 11/08, directed staff to ensure medication carts were routinely cleaned to "maintain cart in optimal condition and prevent growth of microorganisms." The cart was to be cleaned weekly inside and out with soap and water. Staff was also directed to "Check medications for expiration dates when cleaning the inside of the cart and dispose of any expired/discontinued medications per procedure."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	**F 441** It is the policy of Providence Place that the facility establish and maintain an infection control program designed to provide a safe,	

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F 441	Continued From page 36 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to R7, she has been assessed and no ill effects noted from the incident noted on 3-24-14. Staff has been re-trained on proper ophthalmic medication administration. R104 has been monitored and no ill effects noted from incident on 3-25-14, staff has been re-trained on proper insulin preparation and administration. **Actions taken to identify other potential residents having similar occurrences:** All residents receiving ophthalmic and insulin medications were identified. Proper administration processes were reviewed and staff was re-trained on proper procedures. Staff will be monitored with observational audits for continued compliance. Any infection control concerns will be forwarded to licensed personnel who will initiate facility protocol. **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff on facility procedure for proper ophthalmic and insulin preparation and administration conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will complete three Medication Administration audits each week for one month and then one Medication Administration audit every week for two months to assure proper	

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F 441	Continued From page 37 Based on observation, interview and document review, the facility failed to implement procedures to minimize the spread of infection during medication administration for 2 of 5 residents (R7, R104) whose medication administration was observed. Findings include: R7 received eye drops on 3/24/14 at 4:47 p.m. administered by the trained medication assistant (TMA)-A. TMA-A donned gloved prior to the administration, and used a disposable pre-dampened cloth to wipe the resident's eyes three times, as there was a thick matter on the resident's eyelashes and in the corner of both eyes. Without removing her gloves or washing her hands, TMA-A administered the eye drops. Immediately upon leaving the room, TMA-A was asked about the potential for cross contamination when she had not cleansed her hands between unclean and clean processes. TMA-A acknowledged she should have removed the soiled gloves, washed her hands, and then re-applied clean gloves prior to administering R7's eye drops. On 3.24.15 at 6:00 p.m. a registered nurse (RN)-A verified the TMA had not followed standard infection control practices, and glove changing and hand washing should have been performed prior to administering the eye drops. The facility's policy for eye drop administration revised 4/20/12, directed staff to wash hands using soap and water, and to don gloves. The policy did not specify the potential for cross contamination.	F 441	compliance with Medication Administration procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	

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F 441	Continued From page 38 R104 was administered insulin on 3/24/14, at 5:30 p.m. by a registered nurse (RN)-C, who entered the resident's room, removed an insulin vial from the enclosed plastic bottle, and drew up Novolog insulin. RN-C did not wash her hands prior to the insulin preparation, nor was the top of the insulin vial cleansed prior to drawing up the insulin. After the observation, RC-C was asked about the observation. RN-C reported she had washed her hands prior to entering R104's room, had cleansed the insulin vial in the medication room, and then placed the vial back into the plastic container prior to proceeding to R104's room. On 3/28/14, at 6:00 p.m. RN-A confirmed staff should have washed their hands either immediately before entering a resident's room, or while in the room. RN-A also indicated the insulin vial should have been cleansed at the time the insulin was being drawn up and not placed back into the plastic bag prior to injection. The facility procedure for insulin injections dated 4/20/12, directed staff to wash hands thoroughly prior to preparation and to swab the rubber cap with an alcohol wipe prior to injecting same amount of air into the vial.	F 441		
F 497 SS=C	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	F 497	**F 497** It is the policy of Providence Place that the facility complete performance reviews on every nurses 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 aide's performance reviews and may address the	

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F 497	Continued From page 39 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 ensure annual performance evaluations of 5 of 5 nursing assistants (NA-A, NA-B, NA-C, NA-D, NA-E) employed by the facility greater than 12 months had been completed as required. Findings include: NA-E was hired by the facility on 7/2/12, however, no performance evaluation was found in the employee's personnel record. NA-D was hired by the facility on 4/2/08. A review of the personnel record revealed the last performance for NA-D had been completed on 12/31/11. On 3/31/14 at 3:25 p.m. the director of nurses (DON) stated the facility had a human resources (HR) director who had left the facility in 2011 who had been responsible for tracking evaluations. Since the employee's departure, another staff had been assigned the responsibility. The new staff person, however, was unaware until recently, that employee evaluations were part of her responsibilities. The DON explained that none of the evaluations would have been current for that reason, but the new HR director had developed a spreadsheet alerting staff when evaluations were	F 497	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. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** With respect to the 5 nurses aides, all have had evaluations completed. **Actions taken to identify other potential residents having similar occurrences:** All nursing staff has been reviewed for current performance evaluations those that have been identified to need a performance evaluation have been scheduled to have performance evaluations within the next 6 months. **Measures put in place to ensure deficient practice does not occur:** In-service training of nursing staff on facility procedure for proper performance evaluations conducted by May 10th, 2014, with follow-up training as indicated. **Effective implementation of actions will be monitored by:** Clinical Coordinators will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Director of Nursing and/or designee will monitor successful completion of employee evaluations per developed schedule. The ongoing status of evaluation completion will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	

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F 497	Continued From page 40 due. The new HR director was on vacation for two weeks, and the DON said he would attempt to locate the spreadsheets. The DON did provide information that email notifications had been sent to facility staff on 2/19/14 reminding them that evaluations were due. A spreadsheet as to the employee names, hire dates and evaluation due dates was provided. A second email dated 3/18/14, from the HR director indicated that since the previous email, none of the employee evaluations had been turned in. The staff was again provided with additional names of employees in addition to those already sent in the 2/19/14 email. As of the survey exit date of 3/31/14, none of the evaluations for NA-A, NA-B, NA-C, NA-D and NA-E had been completed.	F 497		

F527/023

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

PRINTED: 04/16/2014
FORM APPROVED
OMB NO. 0938-0391

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	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2014**

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PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 OR, By Email to: Marian.Whitney@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.	K 000	Pack JR 5-1-14 RECEIVED APR 29 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-10-14
EXIT: 3-31-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Daly Tobel	Administrator	4/29/14

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.

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 _____	**03/26/2014**

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

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Providence Place was found not in 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 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. It is licensed for 190 beds and had a census of 186 at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**K 066** It is the policy of Providence Place that smoking is prohibited in any room, ward, or compartment where flammable liquids,	5-10-14

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K 066 K 066 SS=E	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide a metal container for the disposal of smoking materials in the basement smoking area, in accordance with LSC(00) Section 19.7.4(4). This deficient practice could effect all occupants of the building. Finding include:	K 066 K 066	combustible gases, or oxygen is stored and in any other hazardous location, and such area is posted with signs that read NO SMOKINIG or with the international symbol for no smoking. That smoking by patients classified is not responsible is prohibited, except when under direct supervision. That ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. That metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. To assure continued compliance the following plan has been implemented. **Regarding cited residents:** No residents were cited. Facility has approximately 26 resident who smoke and could be affected by the deficient practice. With respect to the identified garbage can, it was immediately removed from the resident smoke room on 3/27/2014. **Actions taken to identify other potential residents having similar occurrences:** All residents who use the smoke room have been educated on the Smoke Room Rules. Permanent fire safe (metal) signage of Smoke Room Rules is displayed in smoke room. **Measures put in place to ensure deficient practice does not occur:** The smoke room has been furnished with a large metal FM Approved Fire-Safe/Self Extinguishing trash receptacle with "Trash Only" printed directly on lid. Multiple fire-safe steel construction cigarette ashtray will be used. Locks securing the neck and base sections of the fire safe ashtrays have been added to restrict unauthorized access to used cigarettes and ash. All plastic garbage cans have been removed from the basement community areas to limit access to plastic receptacles. All staff who office out of the basement have received education for	

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K 066	Continued From page 3 Based on an observation made by MDH Surveyor (LH) on 3-26-14 at approximately 2:00PM, and passed on to the Fire Satey Supervisor (PJS) who then contacted this inspector (JJ), the facility had a plastic trash container located next to the required metal container provided for the proper disposal of smoking materials in the smoking area located in the basement of the facility. This deficient practice was confirmed by SFMD Supervisor (PJS) based on a site visit on 3-27-14.	K 066	assuring their doors are closed and locked prior to exiting their office spaces to restrict access to any additional unsafe items. All housekeeping staff has been educated (see attached) for routine cleaning and removal of all flammable materials including plastic trash receptacles. Other staff who office in the basement and receptionist have been educated (see attached) to assure safety in the smoke room. Environmental Services currently cleans the smoke room twice throughout the day every day. Environmental Services removes trash, any unsafe or flammable items and cigarette butts and ash from the room when noted. All cigarette butts and ash are emptied into a FM Approved Fire-Safe/Self Extinguishing receptacle located in the smoke room. A schedule for routine observations of the smoke room will be implemented to assure that any unsafe objects brought in from other areas are removed. **Effective implementation of actions will be monitored by:** Environmental Services Director will monitor facility report mechanisms and follow-up as indicated. **Those responsible to maintain compliance will be:** The Environmental Services Director and/or designee will continue to complete daily Smoke Room audits to assure proper compliance with Smoke Room procedures. The data collected will be presented to the Quality Assurance committee by the Environmental Services Director. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. **Completion date for certification purposes only is May 10th, 2014**	