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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CMED

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00096

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

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

6. DATE OF SURVEY **04/02/2015** (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

X 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 :
Shawn Soucek - NE II 05/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath Program Assurance- 05/11/2015 (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
05/12/2015
(L33)

Posted 06/05/2015 Co.

DETERMINATION APPROVAL

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

CCN: 24 5271

On May 18, 2015 a Post Certificatoin Revisit (PCR) was completed to verify correction of deficiencies issued pursuant to an abbreviated standard survey (investigation of complaint number H5271174) completed on March 24, 2015 and a standard survey completed on April 2, 2015. Based on the revisits it has been deteremined deficiencies issued pursuant to the abbreviated standard survey completed on March 24, 2015 and the standard survey on April 2, 2014 have been corrected as of May 3, 2015.

Refer to the CMS 2567b forms for the results of the revisits.

Effective May 3, 2015, the facility is certified for 190 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245271

June 2, 2015

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

Dear Mr. Donahue:

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 3, 2015 the above facility is certified for:

190 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 28, 2015

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

RE: Project Number H5271174 and S5271026

Dear Mr. Donahue:

On April 9, 2015 and April 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey completed on March 24, 2015 and a standard survey, completed on April 2, 2015. The surveys found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 18, 2015, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) and on May 4, 2015 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 an abbreviated standard survey completed on March 24, 2015 and a standard survey completed on April 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to an abbreviated standard survey, completed on March 24, 2015 and a standard survey completed on April 2, 2015, effective May 3, 2015 and therefore remedies outlined in our letter to you dated April 9, 2015 and April 20, 2015, 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245271	A. Building B. Wing	5/18/2015

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/03/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **05/03/2015**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **05/03/2015**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **05/03/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	05/28/2015	34086	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015			

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 01 - MAIN BUILDING 01	5/4/2015

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 Reg. # NFPA 101 LSC K0076	Correction Completed 05/03/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 05/28/2015	**Signature of Surveyor:** 28120	**Date:** 05/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/1/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 28, 2015

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

Re: Reinspection Results - Project Number H5271174 and S5271026

Dear Mr. Donahue:

On May 18, 2015 survey staff of the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program, completed a reinspection of your facility, to determine correction of orders found on the complaint investigation completed March 24, 2015 and survey completed on April 2, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Forms submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00096	A. Building B. Wing	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **05/03/2015**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **05/03/2015**	ID Prefix **20960** Reg. # **MN Rule 4658.0600 Subp. 1** LSC	Correction Completed **05/03/2015**
ID Prefix **23010** Reg. # **MN Rule 4658.4635 A** LSC	Correction Completed **05/03/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	05/28/2015	34086	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015			

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	5/18/2015

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**04/30/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**04/30/2015**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/mm	05/28/2015	27956	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/24/2015			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00096	A. Building B. Wing	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**04/30/2015**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/mm	05/28/2015	27956	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/24/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CMED

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 **04/02/2015** (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

X 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 :
Shawn Soucek - NE II 05/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath Program Assurance- 05/11/2015 (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
05/12/2015 (L33)

Posted 06/05/2015 Co.

DETERMINATION APPROVAL

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

CCN: 24 5271

On May 18, 2015 a Post Certificatoin Revisit (PCR) was completed to verify correction of deficiencies issued pursuant to an abbreviated standard survey (investigation of complaint number H5271174) completed on March 24, 2015 and a standard survey completed on April 2, 2015. Based on the revisits it has been deteremined deficiencies issued pursuant to the abbreviated standard survey completed on March 24, 2015 and the standard survey on April 2, 2014 have been corrected as of May 3, 2015.

Refer to the CMS 2567b forms for the results of the revisits.

Effective May 3, 2015, the facility is certified for 190 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245271

June 2, 2015

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

Dear Mr. Donahue:

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 3, 2015 the above facility is certified for:

190 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 28, 2015

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

RE: Project Number H5271174 and S5271026

Dear Mr. Donahue:

On April 9, 2015 and April 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey completed on March 24, 2015 and a standard survey, completed on April 2, 2015. The surveys found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 18, 2015, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) and on May 4, 2015 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 an abbreviated standard survey completed on March 24, 2015 and a standard survey completed on April 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to an abbreviated standard survey, completed on March 24, 2015 and a standard survey completed on April 2, 2015, effective May 3, 2015 and therefore remedies outlined in our letter to you dated April 9, 2015 and April 20, 2015, 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245271	A. Building B. Wing	5/18/2015

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/03/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **05/03/2015**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **05/03/2015**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **05/03/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	05/28/2015	34086	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015			

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 01 - MAIN BUILDING 01	5/4/2015

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 Reg. # NFPA 101 LSC K0076	Correction Completed 05/03/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	05/28/2015	28120	05/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/1/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 28, 2015

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

Re: Reinspection Results - Project Number H5271174 and S5271026

Dear Mr. Donahue:

On May 18, 2015 survey staff of the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program, completed a reinspection of your facility, to determine correction of orders found on the complaint investigation completed March 24, 2015 and survey completed on April 2, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Forms submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00096	A. Building B. Wing	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **05/03/2015**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **05/03/2015**	ID Prefix **20960** Reg. # **MN Rule 4658.0600 Subp. 1** LSC	Correction Completed **05/03/2015**
ID Prefix **23010** Reg. # **MN Rule 4658.4635 A** LSC	Correction Completed **05/03/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	05/28/2015	34086	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015			

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	5/18/2015

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**04/30/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**04/30/2015**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/mm	05/28/2015	27956	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/24/2015			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00096	A. Building B. Wing	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**04/30/2015**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/mm	05/28/2015	27956	05/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/24/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CMED

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 **04/02/2015** (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

X 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):

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NE II 05/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/11/2015 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 20, 2015

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

RE: Project Number S5271026 and Complaint Number H5271174

Dear Mr. Donahue:

On April 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on March 24, 2015 that included an investigation of complaint number H5271174. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 2, 2015, a 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. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Email: gayle.lantto@state.mn.us
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 3, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 24, 2015 (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 September 24, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

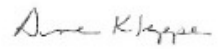
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	04/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
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: Based on observation, interview and document review, the facility failed to ensure care plan was followed for 1 of 1 resident R206. Findings include: R206's family member (FM) B was interviewed on 3/31/15, at 12:15 p.m. FM-B reported the resident did not receive assistance with grooming as she required, and needed "better assistance with showering...will have a week go by with no shower. They say we don't have to force anyone." FM-B explained the family was able to get the	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to; 1. With respect to resident #206, the	5/3/15

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

Electronically Signed | 04/27/2015

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	245271	A. BUILDING _____ B. WING _____	04/02/2015

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F 282	Continued From page 1 resident to shower by breaking down the task such as showing her the shower, and by re-approaching the resident. "She was smelly and her hair was matted down to her head." The family reportedly "pays" for her to get her hair washed. R206 was observed on 4/1/15, at 10:07 a.m. while participating in an activity program. The resident had approximately half inch of long white facial hairs on her chin. In addition, her hair appeared oily and unkempt. The following day at 8:18 a.m. while R206 was waiting for a family member to take her to an appointment, she again had untrimmed facial hair and hair was oily and stuck out in all directions. On 4/2/15, at 8:31 a.m. R206's family member (F)-A, came to accompany her on an appointment. F-A stated that R206 was frequently un-groomed and F-A had brought this concern to staffs' attention during previous care conferences. F-A walked with R206 to her room to brush her hair, however, F-A emerged from the room minutes later asking a NA where the resident's hair brush or a comb was located. A new hair brush was provided, and F-A stated to the surveyor, "See what I mean? She does not get proper grooming." On 4/2/15, at 8:36 a.m. a nursing assistant (NA)-A reported she had provided all morning cares for R206 (prior to F-A's arrival) and was finished providing those cares. NA-A stated she had not noticed R206 had facial hair, but normally assisted a resident with this if she noticed it. NA-A then viewed the resident and confirmed she had not trimmed her facial hair prior to her appointment. NA-A stated that she could not find	F 282	nurse manager is working with the staff to develop a routine for showering the resident, re-approaching or obtaining the assistance of the nurse when the resident refuses. The resident care plan and NAR assignment sheet have been updated accordingly. 2. All residents have been reviewed for refusal of showers and a plan of care established for approaches to promote a routine for bathing that best meets the resident needs. The NAR assignment sheet and resident care plan have been revised as indicated. 3. All nursing staff will receive education, by May 3, 2015, regarding managing challenges during bathing and grooming and interventions/approaches to ensure each individual's needs are met. 4. The Director of Nursing and/or designee will complete three resident care audits each week for one month and then two resident cares per week for two months to assure the plan of care for the individual resident is being	

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F 282	Continued From page 2 the resident's hair brush that morning, and had to get a new one. After she brushed her hair, the resident went back to her room and laid down on her bed. R206's Minimum Data Set (MDS) assessment dated 3/17/15, revealed the resident had diagnoses including Alzheimer's disease and bipolar disorder. In addition, R206 was identified as severely cognitively impaired. However the MDS also indicated the resident had reported feeling badly about herself several days during the assessment period and indicated R206 had reported it was very important to her to be able to make grooming and bathing choices. The MDS indicated R206 did not reject cares but required set up and encouragement and/or cueing from staff to perform grooming R206's care plan revised 1/18/15, indicated the resident had an ADL self-care performance deficit due to impaired cognition. It was noted R206 "requires cueing from staff for personal hygiene. Staff was instructed to encourage to comb or brush own hair, provide demonstrations and supervision set up with grooming." On 4/2/15, at 2:02 p.m. a registered nurse (RN)-A explained that R206 required cueing from staff for personal hygiene. RN-A stated it was an expectation staff provide grooming for all residents, so that they would be presentable in appearance. The facility's 3/24/15, Practice Guideline and Procedure titled Standards of Care Guidelines directed staff to assist men to shave daily and "female residents should be assisted as needed with shaving."	F 282	completed according to the individual plan of care. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

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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 grooming was provided for 1 of 1 resident (R206) who was reviewed for activities of daily living (ADL). Findings include: R206's family member (F)-B was interviewed on 3/31/15, at 12:15 p.m. F-B reported the resident did not receive assistance with grooming as she required, and needed "better assistance with showering...will have a week go by with no shower. They say we don't have to force anyone." F-B explained the family was able to get the resident to shower by breaking down the task such as showing her the shower, and by re-approaching the resident. "She was smelly and her hair was matted down to her head." The family reportedly "pays" for her to get her hair washed. R206 was observed on 4/1/15, at 10:07 a.m. while participating in an activity program. The resident had approximately half inch of long white facial hairs on her chin. In addition, her hair appeared oily and unkept. The following day at 8:18 a.m. while R206 was waiting for a family member to take her to an appointment, she again had untrimmed facial hair and hair hair was oily and stuck out in all directions.	F 311	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to; 1. With respect to resident #206, the nurse manager is working with the staff to develop a routine for grooming and showering the resident, re- approaching or obtaining the assistance of the nurse when the resident refuses. The resident care plan and NAR assignment sheet have been updated accordingly. 2. All residents have been reviewed for behaviors or refusal of cares and a plan of care established for approaches to promote a routine	5/3/15

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F 311	Continued From page 4 On 4/2/15, at 8:31 a.m. R206's F-A came to accompany her on an appointment. F-A stated that R206 was frequently un-groomed and F-A had brought this concern to staffs' attention during previous care conferences. F-A walked with R206 to her room to brush her hair, however, F-A emerged from the room minutes later asking a NA where the resident's hair brush was or a comb was located. A new hair brush was provided, and F-A stated to the surveyor, "See what I mean? She does not get proper grooming." On 4/2/15, at 8:36 a.m. a nursing assistant (NA)-A reported she had provided all morning cares for R206 (prior to FM-A's arrival) and was finished providing those cares. NA-A stated she had not noticed R206 had facial hair, but normally assisted a resident with this if she noticed it. NA-A then viewed the resident and confirmed she had not trimmed her facial hair prior to her appointment. NA-A stated that she could not find the resident's hair brush that morning, and had to get a new one. After she brushed her hair, the resident went back to her room and laid down on her bed. R206's care plan revised date 1/18/15, indicated the resident had an ADL self-care performance deficit due to impaired cognition. It was noted R206 "requires cueing from staff for personal hygiene. Staff was instructed to encourage to comb or brush own hair, provide demonstrations and supervision set up with grooming." R206's Minimum Data Set (MDS) assessment dated 3/17/15, revealed the resident had diagnoses including Alzheimer's disease and	F 311	for grooming and bathing that best meets the resident needs. The NAR assignment sheet and resident care plan have been revised as indicated. 3. All nursing staff will receive education, by May 3, 2015, regarding managing challenges during resident cares and bathing as well as interventions/approaches to ensure each individual's needs are met. 4. The Director of Nursing and/or designee will complete three resident care audits each week for one month and then two resident cares per week for two months to assure resident cares are provided in accordance with the plan of care. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 311	Continued From page 5 bipolar disorder. She was severely cognitively impaired, however, did report feeling badly about herself several days during the assessment period. She reported it was very important she be able to make grooming and bathing choices, and she did not reject cares. She required set up and encouragement and/or cueing from staff to perform grooming. R206's shower sheets and nursing progress notes from 3/15 were reviewed. The documentation lacked notations R206 had resisted grooming or bathing. A Grievances/Comments/Suggestions sheet dated 3/25/15, revealed concerns from R206's family that the resident was not being assisted to shower. On 4/2/15, at 2:02 p.m. a registered nurse (RN)-A explained that R206 required cueing from staff for personal hygiene. RN-A stated she would have expected staff to provide grooming for all residents, and that they be presentable in appearance. The facility's 3/24/15, Practice Guideline and Procedure titled Standards of Care Guidelines directed staff to assist men to shave daily and "female residents should be assisted as needed with shaving."	F 311		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		5/3/15

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F 364	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to deliver room trays in a timely manner to ensure food remained palatable for 4 of 16 residents (R58, R119, R172 and R199) who received room trays during dining observations. Findings include: Four residents on the 2 north unit (R119, R58, R172 and R118) complained the room trays were not served at a proper temperature. On 3/30/15 at 3:47 p.m. R58 said, "my room tray is cold." At 4:00 p.m. R119 said the meals served to her in her room were "not hot". At 4:30 p.m. R172 said "no" when asked if the food was served at a proper temperature. On 3/31/15 at 9:48 a.m. R199 said, "not always" when asked if the food was served at a proper temperature. The room tray delivery service was observed on the 2 north unit of the facility on 3/30/15, at 6:00 p.m. Four room trays were observed to be placed on tables throughout the dining room at that time. The trays were set with beverages of juice, milk and a plate of food covered with a stainless steel cover with a thumb hole on the top. There were two trays set on one end of a table. R117 and R115 were seated at the table having their meals. The residents sat on opposite ends of the table with the room trays encroaching on their personal eating space. R115 stated she did not know who the trays were for but said, "They're room trays I guess."	F 364	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident meal deliveries; insulated plate covers have been ordered to help maintain the food temperature during delivery. One NAR is assigned room trays to assure timely delivery and monitoring throughout the meal. 2. Room trays have been reviewed for all units to assure the system for meal deliveries is consistent throughout all units; with the availability of insulated plate covers and assignment of one staff for passing and monitoring throughout each meal. 3. All staff will receive education regarding room	

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F 364	Continued From page 7 At 6:17 p.m. two of the four room trays were delivered. The other two other trays had not yet been delivered. One of the trays remained on a back table and the other tray was observed on a front table. At 6:28 p.m. the tray from the back table was delivered. At 6:31 p.m. the remaining tray from the front table was delivered. The room trays were observed to remain in the dining room from 17 to 30 minutes before being delivered to resident rooms. The breakfast meal delivery was observed on 4/1/15. At 7:57 a.m. food and beverages were placed on room trays. Tray delivery began at 8:15 with three trays. Six more trays were delivered at 8:20 a.m. and the last tray was delivered at 8:27 a.m. The trays sat in the dining room from 18-30 minutes. There had been two trays set up again on one side of a table next to R115. The trays were set close together on one side of the table encroaching on the dining space of 115. R115 was interviewed at 8:17 a.m. and replied, "yes" when asked if having the trays on the table was bothersome. R115 also expressed it would be nice if the the trays could be placed somewhere else. On 4/1/15, at the noon meal, trays were delivered between four to 27 minutes after set-up. At 12:08 p.m. room trays were observed being set-up with beverages and food. At 12:12 p.m., three of the trays were taken out for delivery. At 12:20 p.m., three more trays were delivered. At 12:27 p.m., one tray was delivered and at 12:35 p.m. the last tray was delivered after it was warmed in the microwave oven.	F 364	trays; delivery and monitoring requirements by 5/3/15. 4. The Director of Nursing and/or designee will audit three meals each week for one month and then two meals/week for two months for monitoring meal delivery to all residents in the dining room and for those who are receiving room trays. 5. The data collected will be presented to the QA and A committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 364	Continued From page 8 Licensed practical nurse (LPN)-A was interviewed on 4/2/15, at 8:15 a.m. She explained the room trays were placed at the residents' assigned seats. The reason for placing the trays at the tables was because the meal tickets were arranged in order of the table seating chart. LPN-A was not aware of the two trays placed on the edge of a table. In order to keep the food on the trays warm, the staff was to set up and deliver trays right away. LPN-A stated if a resident complained the food was not hot, it would be re-heated in the microwave oven. The dietary manager and the dietitian were interviewed on 4/2/15, at 8:35 a.m. They explained the process for tray delivery was to deliver right away to keep the food as warm as possible. They acknowledged 30 minutes would not be in keeping with their policy to deliver as soon as possible.	F 364		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were functioning for 1 of 1 resident (R65) reviewed for environmental concerns. Findings include:	F 463	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction	5/3/15

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F 463	Continued From page 9 R65's call light was tested on 3/30/15, at 4:05 p.m. When the button was pressed, it did not produce a visual or audible indication outside the resident's doorway to alert staff. A trained medication aide (TMA)-B verified the call light was not working at 4:08 p.m. TMA-B indicated her pager should have gone off when the button was pushed. She said she would tell the nurse manager, who would get engineering in. TMA- B paused to check the cord connection and found it loose in the wall unit's socket. When she replugged the cord into the unit the light was observed in the hall display and the chime was heard, and TMA-B's pager went off. TMA-B then said, "sometimes when the bed goes up and down this [a loose connection] happens. We will check it." On 3/30/15, at 4:50 p.m. the unit nurse manager, RN-A revealed they had an occasional problem with their call lights, adding, "My charge nurse will go through the lights on the unit a couple times a week, because we've seen this happen once or twice in the 2 months I've been here. Usually they pull completely apart and an alarm sounds. I will check that one." She made no indication of referring to a manufacturer manual for troubleshooting the cause (i.e. the location of the wall unit in relation to the headboard of the bed, how the cord was being routed, etc.) of the problem. R65's call light was not functioning properly when tested on 4/1/15, at 1:36 p.m. and 4/2/15, at 10:15 a.m. When R65 pushed the call button, it did not light up outside the room to alert staff. The surveyor tried to activate the light three	F 463	prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to the identified call light, the call light was replaced during the survey when the problem was identified. 2. All call lights on all units have been checked for proper function. Any call light identified in need of repair was replaced or repaired if indicated. 3. All call lights will be checked routinely for proper function. Maintenance has developed a tool for checking function of the call system with documentation on the TELs system. All staff has been educated regarding completing a maintenance requisition. All staff will receive education by May 3, 2015. 4. The Director of Nursing and/or designee will audit one unit's call lights each week for three months for assuring the call lights are in proper working order. 5. The data collected will be presented to the QA&A	

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F 463	Continued From page 10 additional times by pushing the red call button, but the light did not activate. When the call light cord attached to the control box on the wall above the head of the bed was moved and pushed into the box for a tighter fit, the light then activated. This had to be done both days in order for the light to activate. R65's care plan revised date of 2/26/15, indicated R65 was at risk of falling due to impaired mobility, osteoarthritis and cognitive impairment. R65 required extensive staff assistance for transfers, repositioning and turning. R65 utilized a wheelchair for ambulation. R65's care plan directed staff to ensure the call light was within reach, encourage the resident to use it when she needed assistance, and to respond promptly. On 4/2/15, at 10:15 a.m. an environmental tour was conducted. During the tour, the director of environmental services (DES) tested R65's call light and it again did not light up outside the room to alert staff. When he moved the call light cord around, the light activated. The DES verified the call light was not functioning properly, but had not been made aware of the problem. The DES stated the procedure for reporting non-functioning call lights was for staff to document any concerns on the repair log. The environmental/maintenance staff then reviewed the log twice daily and responded to concerns as needed. However, the DES said R65's non-functioning call light had not been noted on the log. A review of documentation on the log confirmed R65's non-functioning call light was not reported. The Nurse Call System data from 3/25/15 to 4/2/15, revealed R65 had been using her call light multiple times each day. The data specifically	F 463	committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

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(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 463	Continued From page 11 showed the call light was activated on 3/28/15, at 8:40 p.m. and not activated again until 43 hours, 23 minutes later when on 3/30/15, at 4:11 p.m. the surveyor tested and adjusted R65's call light. The facility's Practice Guideline and Procedure, Call Light revised date 3/12/14, indicted that all employees were oriented to the call system upon hire and annually thereafter.	F 463		

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 _____	**04/01/2015**

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Providence Place was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

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

Electronically Signed | 04/27/2015

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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K 000	Continued From page 1 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. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Providence Place is a 3-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1984 and was determined to be of Type II(222) construction. In 1995, an addition was constructed to the North side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 190 beds and had a census of 174 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		5/3/15

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K 076 SS=D	Continued From page 2 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice could affect some residents. Findings include: During facility tour on between 10:15 AM and 11:45 AM on 04/01/2015, observation revealed that there were two 41L liquid oxygen tanks in resident room 3312. One tank was in use by the resident and the other was being stored near the resident's corridor door. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 076	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to the identified resident/room, the tank was removed from the room on 4/1/15. 2. All resident who use liquid oxygen have the potential to be affected by the storage practice. The rooms for all residents who	

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K 076	Continued From page 3	K 076	utilize liquid oxygen have been audited to ensure proper oxygen storage. 3. All leadership staff will be educated on proper oxygen storage. 4. The administrator and/or designee will audit the rooms of two residents who use oxygen each week for one month and then audit the room of one resident who uses oxygen per week for two months to ensure proper oxygen storage. 5. The data collected will be presented to the QA committee by the Executive Director or designee. The data will be reviewed/discussed at the monthly quality assurance meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delievered: April 20, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5271026

Dear Mr. Donahue:

The above facility was surveyed on March 30, 2015 through April 2, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

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

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	04/02/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan was followed for 1 of 1 resident R206. Findings include: R206's family member (FM) B was interviewed on 3/31/15, at 12:15 p.m. FM-B reported the resident did not receive assistance with grooming as she required, and needed "better assistance with showering...will have a week go by with no shower. They say we don't have to force anyone." FM-B explained the family was able to get the resident to shower by breaking down the task such as showing her the shower, and by re-approaching the resident. "She was smelly and her hair was matted down to her head." The	2 565	corrected	5/3/15

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2 565	Continued From page 2 family reportedly "pays" for her to get her hair washed. R206 was observed on 4/1/15, at 10:07 a.m. while participating in an activity program. The resident had approximately half inch of long white facial hairs on her chin. In addition, her hair appeared oily and unkempt. The following day at 8:18 a.m. while R206 was waiting for a family member to take her to an appointment, she again had untrimmed facial hair and hair was oily and stuck out in all directions. On 4/2/15, at 8:31 a.m. R206's family member (F)-A, came to accompany her on an appointment. F-A stated that R206 was frequently un-groomed and F-A had brought this concern to staffs' attention during previous care conferences. F-A walked with R206 to her room to brush her hair, however, F-A emerged from the room minutes later asking a NA where the resident's hair brush or a comb was located. A new hair brush was provided, and F-A stated to the surveyor, "See what I mean? She does not get proper grooming." On 4/2/15, at 8:36 a.m. a nursing assistant (NA)-A reported she had provided all morning cares for R206 (prior to F-A's arrival) and was finished providing those cares. NA-A stated she had not noticed R206 had facial hair, but normally assisted a resident with this if she noticed it. NA-A then viewed the resident and confirmed she had not trimmed her facial hair prior to her appointment. NA-A stated that she could not find the resident's hair brush that morning, and had to get a new one. After she brushed her hair, the resident went back to her room and laid down on her bed.	2 565		

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2 565	Continued From page 3 R206's Minimum Data Set (MDS) assessment dated 3/17/15, revealed the resident had diagnoses including Alzheimer's disease and bipolar disorder. In addition, R206 was identified as severely cognitively impaired. However the MDS also indicated the resident had reported feeling badly about herself several days during the assessment period and indicated R206 had reported it was very important to her to be able to make grooming and bathing choices. The MDS indicated R206 did not reject cares but required set up and encouragement and/or cueing from staff to perform grooming R206's care plan revised 1/18/15, indicated the resident had an ADL self-care performance deficit due to impaired cognition. It was noted R206 "requires cueing from staff for personal hygiene. Staff was instructed to encourage to comb or brush own hair, provide demonstrations and supervision set up with grooming." On 4/2/15, at 2:02 p.m. a registered nurse (RN)-A explained that R206 required cueing from staff for personal hygiene. RN-A stated it was an expectation staff provide grooming for all residents, so that they would be presentable in appearance. The facility's 3/24/15, Practice Guideline and Procedure titled Standards of Care Guidelines directed staff to assist men to shave daily and "female residents should be assisted as needed with shaving." SUGGESTED METHOD OF CORRECTION: The DON or designee could audit cares for residents to ensure care plans are follwed. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

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2 565	Continued From page 4 (21) days.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grooming was provided for 1 of 1 resident (R206) who was reviewed for activities of daily living (ADL). Findings include: R206's family member (F)-B was interviewed on 3/31/15, at 12:15 p.m. F-B reported the resident did not receive assistance with grooming as she required, and needed "better assistance with showering...will have a week go by with no	2 915	corrected	5/3/15

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2 915	Continued From page 5	2 915		

shower. They say we don't have to force anyone." F-B explained the family was able to get the resident to shower by breaking down the task such as showing her the shower, and by re-approaching the resident. "She was smelly and her hair was matted down to her head." The family reportedly "pays" for her to get her hair washed.

R206 was observed on 4/1/15, at 10:07 a.m. while participating in an activity program. The resident had approximately half inch of long white facial hairs on her chin. In addition, her hair appeared oily and unkept. The following day at 8:18 a.m. while R206 was waiting for a family member to take her to an appointment, she again had untrimmed facial hair and hair hair was oily and stuck out in all directions.

On 4/2/15, at 8:31 a.m. R206's F-A came to accompany her on an appointment. F-A stated that R206 was frequently un-groomed and F-A had brought this concern to staffs' attention during previous care conferences. F-A walked with R206 to her room to brush her hair, however, F-A emerged from the room minutes later asking a NA where the resident's hair brush was or a comb was located. A new hair brush was provided, and F-A stated to the surveyor, "See what I mean? She does not get proper grooming."

On 4/2/15, at 8:36 a.m. a nursing assistant (NA)-A reported she had provided all morning cares for R206 (prior to FM-A's arrival) and was finished providing those cares. NA-A stated she had not noticed R206 had facial hair, but normally assisted a resident with this if she noticed it. NA-A then viewed the resident and confirmed she had not trimmed her facial hair prior to her

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2 915	Continued From page 6 appointment. NA-A stated that she could not find the resident's hair brush that morning, and had to get a new one. After she brushed her hair, the resident went back to her room and laid down on her bed. R206's care plan revised date 1/18/15, indicated the resident had an ADL self-care performance deficit due to impaired cognition. It was noted R206 "requires cueing from staff for personal hygiene. Staff was instructed to encourage to comb or brush own hair, provide demonstrations and supervision set up with grooming." R206's Minimum Data Set (MDS) assessment dated 3/17/15, revealed the was severely cognitively impaired, however, did report feeling badly about herself several days during the assessment period. She reported it was very important she be able to make grooming and bathing choices, and she did not reject cares. She required set up and encouragement and/or cueing from staff to perform grooming. R206's shower sheets and nursing progress notes from 3/15 were reviewed. The documentation lacked notations R206 had resisted grooming or bathing. A Grievances/Comments/Suggestions sheet dated 3/25/15, revealed concerns from R206's family that the resident was not being assisted to shower. On 4/2/15, at 2:02 p.m. a registered nurse (RN)-A explained that R206 required cueing from staff for personal hygiene. RN-A stated she would have expected staff to provide grooming for all residents, and that they be presentable in appearance.	2 915		

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2 915	Continued From page 7 The facility's 3/24/15, Practice Guideline and Procedure titled Standards of Care Guidelines directed staff to assist men to shave daily and "female residents should be assisted as needed with shaving." SUGGESTED METHOD OF CORRECTION: The DON or designee could monitor and evaluate resident appearance to ensure all residents are clean and well groomed, particularly those residents who need assistance with activities of daily living. The DON or designee could ensure proper techniques for encouraging residents with cognitive difficulties to complete ADL cares are utilized by all staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to deliver room trays in a timely manner to ensure food remained palatable for 4 of 16 residents (R58, R119, R172 and R199) who received room trays during dining observations. Findings include:	2 960	corrected	5/3/15

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	00096	A. BUILDING: _____ B. WING _____	04/02/2015

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2 960	Continued From page 8 Four residents on the 2 north unit (R119, R58, R172 and R118) complained the room trays were not served at a proper temperature. On 3/30/15 at 3:47 p.m. R58 said, "my room tray is cold." At 4:00 p.m. R119 said the meals served to her in her room were "not hot". At 4:30 p.m. R172 said "no" when asked if the food was served at a proper temperature. On 3/31/15 at 9:48 a.m. R199 said, "not always" when asked if the food was served at a proper temperature. The room tray delivery service was observed on the 2 north unit of the facility on 3/30/15, at 6:00 p.m. Four room trays were observed to be placed on tables throughout the dining room at that time. The trays were set with beverages of juice, milk and a plate of food covered with a stainless steel cover with a thumb hole on the top. There were two trays set on one end of a table. R117 and R115 were seated at the table having their meals. The residents sat on opposite ends of the table with the room trays encroaching on their personal eating space. R115 stated she did not know who the trays were for but said, "They're room trays I guess." At 6:17 p.m. two of the four room trays were delivered. The other two other trays had not yet been delivered. One of the trays remained on a back table and the other tray was observed on a front table. At 6:28 p.m. the tray from the back table was delivered. At 6:31 p.m. the remaining tray from the front table was delivered. The room trays were observed to remain in the dining room from 17 to 30 minutes before being delivered to resident rooms. The breakfast meal delivery was observed on 4/1/15. At 7:57 a.m. food and beverages were placed on room trays. Tray delivery began at 8:15	2 960		

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2 960	Continued From page 9	2 960		

with three trays. Six more trays were delivered at 8:20 a.m. and the last tray was delivered at 8:27 a.m. The trays sat in the dining room from 18-30 minutes.

There had been two trays set up again on one side of a table next to R115. The trays were set close together on one side of the table encroaching on the dining space of 115. R115 was interviewed at 8:17 a.m. and replied, "yes" when asked if having the trays on the table was bothersome. R115 also expressed it would be nice if the the trays could be placed somewhere else.

On 4/1/15, at the noon meal, trays were delivered between four to 27 minutes after set-up. At 12:08 p.m. room trays were observed being set-up with beverages and food. At 12:12 p.m., three of the trays were taken out for delivery. At 12:20 p.m., three more trays were delivered. At 12:27 p.m., one tray was delivered and at 12:35 p.m. the last tray was delivered after it was warmed in the microwave oven.

Licensed practical nurse (LPN)-A was interviewed on 4/2/15, at 8:15 a.m. She explained the room trays were placed at the residents' assigned seats. The reason for placing the trays at the tables was because the meal tickets were arranged in order of the table seating chart. LPN-A was not aware of the two trays placed on the edge of a table. In order to keep the food on the trays warm, the staff was to set up and deliver trays right away. LPN-A stated if a resident complained the food was not hot, it would be re-heated in the microwave oven.

The dietary manager and the dietitian were interviewed on 4/2/15, at 8:35 a.m. They

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2 960	Continued From page 10 explained the process for tray delivery was to deliver right away to keep the food as warm as possible. They acknowledged 30 minutes would not be in keeping with their policy to deliver as soon as possible. SUGGESTED METHOD OF CORRECTION: The dietary manager and the DON or designee could evaluate the current method for tray delivery to develop a system to ensure the efficient delivery of room trays. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights	23010		5/3/15

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23010	Continued From page 11 must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were functioning for 1 of 1 resident (R65) reviewed for environmental concerns. Findings include: R65's call light was tested on 3/30/15, at 4:05 p.m. When the button was pressed, it did not produce a visual or audible indication outside the resident's doorway to alert staff. A trained medication aide (TMA)-B verified the call light was not working at 4:08 p.m. TMA-B indicated her pager should have gone off when the button was pushed. She said she would tell the nurse manager, who would get engineering in. TMA- B paused to check the cord connection and found it loose in the wall unit's socket. When she replugged the cord into the unit the light was observed in the hall display and the chime was heard, and TMA-B's pager went off. TMA-B then said, "sometimes when the bed goes up and down this [a loose connection] happens. We will check it." On 3/30/15, at 4:50 p.m. the unit nurse manager, RN-A revealed they had an occasional problem with their call lights, adding, "My charge nurse will go through the lights on the unit a couple times a week, because we've seen this happen once or twice in the 2 months I've been here. Usually they pull completely apart and an alarm sounds. I will check that one." She made no indication of referring to a manufacturer manual for	23010	corrected.	

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23010	Continued From page 12	23010		

troubleshooting the cause (i.e. the location of the wall unit in relation to the headboard of the bed, how the cord was being routed, etc.) of the problem.

R65's call light was not functioning properly when tested on 4/1/15, at 1:36 p.m. and 4/2/15, at 10:15 a.m. When R65 pushed the call button, it did not light up outside the room to alert staff. The surveyor tried to activate the light three additional times by pushing the red call button, but the light did not activate. When the call light cord attached to the control box on the wall above the head of the bed was moved and pushed into the box for a tighter fit, the light then activated. This had to be done both days in order for the light to activate.

R65's care plan revised date of 2/26/15, indicated R65 was at risk of falling due to impaired mobility, osteoarthritis and cognitive impairment. R65 required extensive staff assistance for transfers, repositioning and turning. R65 utilized a wheelchair for ambulation. R65's care plan directed staff to ensure the call light was within reach, encourage the resident to use it when she needed assistance, and to respond promptly.

On 4/2/15, at 10:15 a.m. an environmental tour was conducted. During the tour, the director of environmental services (DES) tested R65's call light and it again did not light up outside the room to alert staff. When he moved the call light cord around, the light activated. The DES verified the call light was not functioning properly, but had not been made aware of the problem. The DES stated the procedure for reporting non-functioning call lights was for staff to document any concerns on the repair log. The environmental/maintenance staff then reviewed the log twice daily and

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23010	Continued From page 13 responded to concerns as needed. However, the DES said R65's non-functioning call light had not been noted on the log. A review of documentation on the log confirmed R65's non-functioning call light was not reported. The Nurse Call System data from 3/25/15 to 4/2/15, revealed R65 had been using her call light multiple times each day. The data specifically showed the call light was activated on 3/28/15, at 8:40 p.m. and not activated again until 43 hours, 23 minutes later when on 3/30/15, at 4:11 p.m. the surveyor tested and adjusted R65's call light. The facility's Practice Guideline and Procedure, Call Light revised date 3/12/14, indicted that all employees were oriented to the call system upon hire and annually thereafter. SUGGESTED METHOD OF CORRECTION: The administrator and/or maintenance director could review the location of the call lights, in regard to bed position, to ensure call lights do not become inactivated due to bed adjustments. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	23010		