DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 11, 2025

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: February 27, 2025

Dear Administrator:

On February 27, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 25, 2025, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 26, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective March 26, 2025 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 26, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 26, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Providence Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 26, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 27, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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
E 000	Initial Comments On 2/24/25 to 2/27/25, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, for Long Term Care Facilities was conducted during a standard recertification survey. Providence Place was found to be in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/24/25 to 2/27/25, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Providence Place was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) at F578. The IJ began on 1/29/25, when a resident's Physician Orders for Life Sustaining Treatment (POLST) were not accurately transcribed into the electronic medical record (EMR) and, as a result, multiple nurses indicated they would perform resuscitation measures (i.e., CPR) against the resident's declared wishes and religious beliefs. The director of nursing (DON), assistant director of nursing (ADON), and registered nurse (RN)-C, were notified of the IJ for R84 on 2/24/25 at 7:40 p.m. The IJ was removed on 2/25/25 at 2:17 p.m., after an acceptable removal plan was verified as being	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 implemented. The following complaints were reviewed: H52718023C (MN110825) H52718345C (MN110652); non-compliance cited at F677. H52718343C (MN110626); non-compliance cited at F677. H52718342C (MN110567); non-compliance cited at F677. H52718344C (MN106287) H52718346C (MN105564) H52718304C (MN105284) H52718285C (MN104583) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=B	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		3/31/25

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F 550	Continued From page 2 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who required assistance during mealtime on a locked dementia unit had a dignified dining experience. Findings include:	F 550	F550 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	

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F 550	Continued From page 3 During observation on 2/24/25 at 5:18 p.m., nursing assistant (NA)-A and NA-N prepared the dining area and residents for a meal. NA-A was passing out desserts and drinks to a table with two residents, and NA-N was approximately ten feet away near the steam table. NA-A stated to NA-N, with two tables of residents in between them, to set-up all the "feeders" first. During interview on 2/24/25 at 5:38 p.m., NA-N stated they usually served residents who needed assistance last so they could assist them right away, but they had extra help so could assist those who needed help first. NA-N acknowledged NA-A used the term "feeders" and stated the term was wrong to use and they could have used a better term instead. NA-N stated private information was usually discussed one to one and not across the room but sometimes comments were made from across the room in the memory care area. NA-N stated there were approximately five residents who needed assistance with eating. During interview on 2/27/25 at 10:36 a.m., NA-I stated "feeders" was a term for babies and did not use the term. NA-I stated residents on the memory care area may not respond to someone who used the term "feeders" but it may make the residents feel like they were babies. During interview on 2/27/25 at 11:00 a.m., licensed practical nurse (LPN)-E stated the term "feeders" was not a "good one", and the term would make residents "feel bad". LPN-E compared the term to how staff used "clothing protector" instead of "bib". During interview on 2/27/25 at 2:43 p.m., the	F 550	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. All staff involved received re-education in the proper way to maintain resident dignity during mealtimes. 2. The facility has determined that all residents, both independent and those who require feeding assistance have the potential to be affected. 3. The facilities policy entitled Standards of Care Guidelines was reviewed and remains current. All Nursing staff and staff involved with residents during mealtimes have been re- educated on the facility guideline to ensure residents dignity is maintained during mealtimes 4. The Director of Nursing or designee will conduct random observations and audits of staff during mealtimes for the next 2 months to ensure staff are maintaining and promoting resident dignity during mealtimes in accordance with facility guidelines. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

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F 550	Continued From page 4 director of nursing (DON) agreed use of the term "feeders" was not dignified. A provided care sheet dated 2/25/25, identified a total of six residents needed assistance of one with eating. A provided Standards of Care Guidelines dated 7/2019, directed staff to care for residents in a manner which promoted maintenance, dignity, or enhancement of each person's quality of life.	F 550		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 577		3/31/25

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F 577	Continued From page 5 information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure complaint investigations for 2024 and 2025 and any plans of correction in effect with respect to the facility, and posting of notice of availability of such reports were posted in areas of the facility that were prominent and accessible to the public. This had the potential to affect all 155 residents, families and visitors who may have wished to review the information. Findings include: According to the Federal database Automated Survey Processing Environment (ASPEN) in 2024, the facility had in person complaint investigations on 5/1/24, 5/31/24, 6/13/24, 7/12/24, 8/19/24, 10/1/24, 10/30/24, 12/11/24, and 1/15/25. Per ACO deficiencies were issued for 10/1/24. During observation and review on 2/25/25 at 10:31 a.m., a three-ring binder titled Survey Results was posted inside facility entrance in a wire basket 60 inches off the ground. During observation and interview with R42 on 2/25/25 at 10:48 a.m., R42 was wheeling self into facility through entrance door and stated, "[survey results binder] is out of reach to anyone who does not have the ability to stand up". During observation and interview with R10 on 2/25/25 at 1:25 p.m., R10 wheeled self into facility through entrance door and stated, "No, I can't reach that. I would have to ask someone to get	F 577	F577 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. During the survey the Survey Binder was updated to include all of the required survey information and documents. The Survey Binder was placed in a location that readily accessible to residents, family members, and legal representatives of residents. 2. The facility has determined that all residents, family members, and legal representatives have the potential to be affected. 3. The facility reviewed the F577 requirement to ensure ongoing compliance. All staff have been re-educated on the requirements for survey postings. 4. The Executive Director or designee will conduct random audits x 2 months to ensure binder remains up to date with all required information and that it remains in a place accessible to residents, family members, and their legal representatives.	

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F 577	Continued From page 6 that for me if I wanted to look at it." During observation and interview with R265 on 2/25/25 at 1:39 p.m., R265 wheeled self into facility through entrance door and stated, "No I would not be able to reach that binder there. It is too high off the floor." During observation and interview with social serviced director (SSD) on 2/25/25 at 2:29 p.m., SSC stated the survey results binder is, "probably not within reach of anyone in a wheelchair unless they ask someone for it." During observation and interview with facility administrator on 2/25/25 at 2:49 p.m., the administrator stated he was responsible for "delegating the task of posting the survey results". The administrator stated, "probably not" when asked if a resident, visitor, or staff in wheelchairs were able to reach and review the survey results. The administrator stated, "I don't know why I moved that [wire rack containing the survey results] up. Should be lowered to within reach." During review of the facility's survey results, the administrator stated, "I don't see the results of any complaint surveys for 2024 and last month [January 2025]. Should be in there." Facility policy on posting of survey results was requested and not received.	F 577	Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC completion date: March 31, 2025	
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

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F 578	Continued From page 7 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's advance	F 578	F578 The preparation of the following plan of	

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F 578	Continued From page 8 directives was accurately and consistently documented in the resident's electronic health record (EHR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the residents wishes would be followed in the event of a cardiac arrest. This resulted in immediate jeopardy for 1 of 33 residents (R84) whose code status was not accurately documented and was reviewed for advanced directives. The immediate jeopardy began on 1/29/25, when the POLST was signed indicating do not resuscitate (DNR) and a physician's order for R84 to have a full code status remained. The immediate jeopardy was identified on 2/24/25. The assistant director of nursing (ADON) and director of nursing (DON) were notified of the immediate jeopardy on 2/24/25, at 7:40 p.m. The immediate jeopardy was removed on 2/25/25, however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (level D). Findings include: R84's admission Minimum Data Set (MDS) dated 2/4/25, indicated R84 had intact cognition and had been admitted to the facility on 1/29/25. R84's Transfer/Admission orders dated 1/29/25, indicated R84's code status was a full code with the page signed by the provider on 1/28/25. The report then indicated a copy of a signed POLST was still needed and this would need to be done by a provider, with the page signed on 1/29/25. R84's POLST dated 1/29/25, indicated DNR/allow natural death and was signed by R84 and nurse	F 578	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. R84 had her Code Status immediately updated during the survey to reflect her POLST. 2. The facility has determined that all residents have the potential to be affected 3. The facility reviewed the facilities Advanced Care Planning and POLST guideline to ensure it remains current and up to date. All facility Nurses, Social Workers, and Health Unit coordinators received immediate training on the facility guideline. All resident charts were immediately audited to ensure that resident wishes regarding their POLST or Advanced Care Planning matched the Physician order in the EMAR and on the EMAR banner. 4. The Director of Nursing or designee will complete Bi-monthly audits x 3months on each residents Code Status to ensure the physicians code status order and residents wishes match and are reflected in the EMAR and on the EMAR banner. DNS or designee will complete weekly audits x2 months on all new admissions to ensure the physicians code status order and residents wishes match	

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F 578	Continued From page 9 practitioner (NP)-A on 1/29/25. This POLST was found in both the EHR and paper chart with no further POLSTs found. R84's progress note dated: -1/29/25 at 3:20 p.m., indicated data was collected for R84's admission by nursing staff and R84's code status was DNR. -2/3/25 at 3:17 p.m., indicated R84's advanced directive could be found on her POLST and had the code status was DNR. -1/29/25 through 2/24/25 were reviewed and lacked documentation to support the resident wished to receive CPR if she was found with no pulse and was not breathing. R84's provider note dated 2/5/25, indicated R84 had recently moved to the facility from her home in the community due to an increased level of care need. The note indicated R84 was a Jehovah's Witness and was excited to talk with another "Witness" who lived in the building. The note listed R84's code status as DNR. The note indicated R84 was diagnosed with diabetes, a heart arrhythmia (the heart beats with an abnormal rhythm), and obstructive sleep apnea (OSA, repeatedly stopping and starting breathing while sleeping). R84's care plan dated 2/5/24, indicated R84's code status could be found on her POLST and the goal of the care plan was to have her code status wishes honored. The care plan indicated that code status would be reviewed quarterly and as needed with the resident/resident representative. The care plan indicated R84 followed Jehovah's Witness practices, and the facility would help to coordinate visits with spiritual leaders from the same faith.	F 578	and are reflected in the EMAR and on the EMAR banner. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 25, 2025	

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F 578	Continued From page 10 R84's Care Conference Summary dated 2/12/25, indicated a care conference was held with R84 attending. The note indicated R84's advance directives were reviewed with her, and no changes were needed to the "DNR" status. R84's order summary dated 2/23/25, included an order, "code status: full code", that was dated 1/29/25. R84's EHR banner, printed on 2/24/25, indicated R84's code status was full code. R84's clinical profile in the EHR, printed on 2/26/25, indicated R84 was her own representative. During an interview on 2/24/25 at 4:01 p.m., R84 confirmed she would not want to be resuscitated if she was found with no pulse and was not breathing. R84 stated she was one of Jehovah's Witnesses as part of her religious belief she would want to enter the "future world" if it was her time and would not want "to suffer" by being resuscitated. During an interview on 2/24/25 at 4:09 p.m., licensed practical nurse (LPN)-B stated he was not R84's nurse but if a resident was found pulseless and not breathing, he would look at the POLST in the "hard chart" to determine if CPR should be initiated. During an interview on 2/24/25 at 4:37 p.m., LPN-A stated she was R84's nurse this shift and although both the POLST or the EHR banner could be referenced to determine code status, she would reference the EHR banner to see if	F 578		

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F 578	Continued From page 11	F 578		

R84 needed to be resuscitated because it was easier to access. LPN-A stated that R84 was a full code per the EHR banner and the provider order so she would initiate CPR if R84 was found pulseless and not breathing. When asked to review R84's POLST, LPN-A exclaimed "ooooh" and stated the POLST indicated R84's code status was DNR and believed this was the accurate code status. LPN-A stated she would be "worried" staff would perform CPR on R84 against her wishes because of the mismatch.

During an interview on 2/24/25 at 5:09 p.m., health unit coordinator (HUC)-A stated when a resident was admitted, she would reference the hospital paperwork or admit orders to determine the code status to enter into the EHR until a POLST was reviewed with the resident and signed by the provider. HUC-A stated she was in charge of uploading POLSTs to the EHR and updating the physician order/EHR banner after reviewing the POLST. HUC-A confirmed R84's EHR banner/provider order did not match R84's most recent POLST. HUC-A stated she thought R84's accurate code status was DNR. HUC-A stated she was unsure how updating the EHR banner/provider order was missed after R84's POLST was completed. HUC-A stated she was supposed to be completing audits every two weeks to ensure resident code status in the EHR matched the POLST. HUC-A stated these audits had not been completed since R84 had been admitted in January as she felt they were "pretty short-staffed" and did not feel she had time.

During an interview on 2/24/25 at 5:09 p.m., LPN-C stated if a resident was found pulseless and not breathing, she would check their code status on the EHR banner, and if the banner said

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F 578	Continued From page 12 Full code, she would start CPR. During an interview on 2/24/25 at 6:19 p.m. with the director of nursing (DON) and the administrator, the DON stated if a resident was found pulseless and not breathing, staff could look at either the POLST or the EHR banner/provider order as they should all match, to determine if CPR should be initiated. The administrator stated that R84's profile or face sheet could be referenced to determine if the resident was her own representative and confirmed that she was. The DON stated that the HUCs were in charge of completing audits to ensure the POLST and the EHR banner/provider order indicating code status, matched. The DON stated as this was an informal process, the frequency of these audits did change based on results and the DON thought audits were being completed monthly. The DON stated the health information system supervisor (HISS) oversaw ensuring these audits were being completed. On 2/24/25 at 7:27 p.m., the DON stated she had reviewed her emails and confirmed that code status audits were to be completed every two weeks, not monthly, and these were not completed for the floor R84 resided so far this month. During an interview on 2/24/25 at 6:42 p.m., the HISS stated the HUCs were supposed to complete audits or resident code status every two weeks. HISS stated he and the DON had decided on the audit frequency when the HUC checklist was updated in January and confirmed that audits were to be completed every two weeks to ensure EHR code status accuracy. During an interview on 2/24/25 at 7:29 p.m., the	F 578		

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F 578	Continued From page 13 social services director (SSD) stated social workers reviewed code status wishes with residents at their care conferences and would review the POLST to see if it needed to be updated to honor the resident wishes. The SSD confirmed that R84 had wished to be DNR on her care conference on 2/12/25 and was her own decision-maker. During an interview on 2/25/25 at 1:30 p.m., registered nurse (RN)-C, the staff development coordinator stated she had assisted in educating staff members on the advance directive process. RN-C stated either the HUC, if working, or the nurse on duty would be in charge of ensuring when a new POLST was obtained, that the EHR banner/provider order matched the updated POLST. During an interview on 2/26/25 at 9:42 p.m., NP-A stated that on 1/29/25, she had a conversation with R84, as she was her own decision-maker, about her wishes in the circumstance that her heart stopped beating and she stopped breathing. NP-A stated R84 indicated she would not want to be resuscitated related to her religious beliefs. NP-A stated that it was important that R84's wishes to allow a natural death were honored as CPR would be a "violent death" for R84 and R84 had made it clear she did not want a "violent death". NP-A stated once she completed a POLST with a resident she would attach it to the resident's hard chart for the HUC to upload but did not go in herself and verify that the provider order matched the updated POLST as she expected the HUC to do this. NP-A stated after the "communication error" involving R84's code status order being a full code instead of being updated to a DNR, she would now ensure the	F 578		

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F 578	Continued From page 14	F 578		

EHR provider order matched the POLST after she completed a POLST with a resident.

The undated HUC Job Description, indicated the HUC would complete daily, weekly, and monthly audits as directed.

The HUC Duties Checklist revised on 1/2/25, indicated POLSTs were to be audited every two weeks, on the first and third Friday of every month.

The facility's Advanced Care Planning and POLST policy dated 12/18, indicated when the need for resuscitation occurred, the physician order, CPR/DNR section of the health care directive, and/or the POLST would be followed. The policy indicated if a resident was admitted with a signed POLST, it would be honored during the initial assessment period and a designated staff member must review the POLST with the resident as soon as possible to ensure its accuracy. The policy indicated the physician would review the POLST with the resident within the 14-day assessment period as part of the comprehensive assessment.

The facility's Cardiopulmonary Resuscitation policy dated 12/18, indicated that if a resident experienced cardiac arrest, facility staff would provide basic life support, including CPR in accordance with the resident's advanced directives.

The immediate jeopardy that began on 1/29/25, was removed on 2/25/25 when the facility developed and implemented a systematic removal plan. The removal plan was verified through interview and documented review as the

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	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 578	Continued From page 15 facility had corrected R84's code status on the EHR banner/provider order to DNR, completed a facility-wide audit to ensure there were no other code status discrepancies, reviewed related policies and procedures, and provided education for all staff involved in ensuring advance directives were honored on the CPR and POLST policies/procedures and their respective roles in the process.	F 578		
F 583 SS=B	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		3/31/25

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F 583	Continued From page 16 provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This had the potential to affect all 72 residents of the second and third floor whose personal information was listed on exposed care sheets. Findings include: During continuous observation on 2/24/25 starting at 3:24 p.m., licensed practical nurse (LPN)-A locked the medication cart, closed the laptop screen, and left the medication cart with 2 North nurses' worksheet unattended face up. Information included name, room number, sleep/wake preferences, assistance needed with dressing, grooming bathing, toileting, including continence of bowel and bladder, turning assistance needed, mobility devices, diet, assistance needed with meals, skin integrity issues such as wounds, and personal interests such as puzzles, music, religious services, and reading books. -at 3:31 p.m., two staff members walked past the unattended care sheet. During observation and interview at 3:43 p.m., LPN-A walked back to the medication cart with	F 583	F583 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. Nursing staff identified received re-education regarding Confidentiality of Medical Records during survey 2. The facility has determined that all residents have the potential to be affected. 3. The facility reviewed the Confidentiality of Personal and Medical Records guideline to ensure it remains current. All facility staff will receive re-education on the facility guidelines to ensure that privacy of medical information is maintained. 4. The director of Nursing or designee will complete monthly audits x2 months to ensure the guidelines are followed to	

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F 583	Continued From page 17 unattended care sheet and stated, "the care sheet should not be left like that because people could look at the private information" and "care sheet has their [resident] name and it has patient identifying information. HIPAA problem." During continuous observation on 2/25/25 at 8:12 a.m., a medication cart was observed with 2 South nurses' worksheet unattended face up. Information included name, room number, sleep/wake preferences, assistance needed with dressing, grooming bathing, toileting, including continence of bowel and bladder, turning assistance needed, mobility devices, diet, assistance needed with meals, skin integrity issues such as wounds, and personal interests such as puzzles, music, religious services, and reading books. -at 8:14 a.m., a housekeeper pushing a cart walked past the unattended worksheet. -at 8:15 a.m., a resident with wheeled walker walked past the unattended worksheet. -at 8:18 a.m., a staff member walked past the unattended worksheet. -at 8:26 a.m., another staff member walked past the unattended worksheet. During observation and interview at 8:32 a.m., registered nurse (RN)-B walked up to the medication cart with unattended worksheet and stated, "[care sheet] should not be left like that because it has private information that should not be seen by anyone except me." During interview with director of nursing on	F 583	ensure the privacy of medical information. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

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F 583	Continued From page 18 2/27/25 at 10:35 a.m., DON stated the nursing care sheets, "should be flipped [sic] over" and not visible to unauthorized staff. DON stated, "it's a constant battle" and facility was "leaving reminders around" to staff to cover unattended patient identifying information. Facility policy on privacy practices was requested and not received.	F 583		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene cares (i.e., nail care, showering, facial hair removal, personal cares, dressing assistance) were offered and/or completed for 4 of 6 residents (R62, R37, R112, R64) reviewed for activities of daily living (ADLs) and whom were dependent on staff for such cares. Findings include: R62 R62's annual MDS, dated 1/8/25, identified R62 had intact cognition and had multiple medical conditions including progressive neurological disease, multiple sclerosis (MS), and malnutrition. Further, the MDS identified R62 demonstrated no rejection of care behaviors and required substantial/maximal assistance with personal	F 677	F677 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. R62 had nails clipped and cleaned during survey. R37 had grooming needs corrected during survey. R112 had grooming needs corrected during the survey. R64 had nails, grooming needs and clothing changed during survey.	3/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 677	Continued From page 19 hygiene cares. R62's most recent Body Audit 11-15-V8, dated 2/21/25, identified R62 had a bed bath completed and listed a section which read, "Nails." The section had questions to be answered by staff about what, if any, cares were completed. This identified R62's fingernails were clean and trimmed, and R62 had allowed the care to be completed. However, on 2/24/25 at 12:51 p.m., R62 was observed lying in bed while in his room. R62 was dressed in a hospital-style gown and had a bedside table pulled over himself at waist level with an opened can of Dr. Pepper on top. R62 had visibly long, soiled fingernails present on both hands with his left hand having black-colored debris around each nail fold (where skin meets nail), and several nails being multiple millimeters (mm) in length. R62 was asked about his nails and looked at them, then expressed aloud, "I want them cleaned." R62 stated he was unsure when his nails were last clipped but expressed he got a weekly bed bath. R62 reiterated he wanted his nails clipped and cleaned when asked. R62's care plan, printed 2/26/25, identified all of R62's actual or potential problem statements along with corresponding interventions for them. The care plan identified R62 had an ADL self-care deficit and was on hospice care. The care plan outlined R62 preferred to have a bed bath twice weekly and directed, "PERSONAL HYGIENE: Requires substantial/maximal assistance of 1 staff to complete." The care plan lacked any information on R62's nails, including any identified length preference, or evidence R62 refused nail care to be completed.	F 677	2. The facility has determined that all residents have the potential to be affected. 3. The facilities policy entitled Standards of Care Guidelines was reviewed and remains current. All Nursing staff received re-education on the Standards of Care Guidelines that included nail care, grooming, bathing, and hygiene needs. Facility wide audit was completed to ensure nail care, grooming, and hygiene needs were met. 4. Director of Nursing or designee will complete random monthly audits x 2 months to ensure the facility Standards of Care Guideline is followed regarding nail care, grooming, bathing, and hygiene needs. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

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F 677	Continued From page 20 On 2/26/25 at 9:33 a.m., R62 was again observed in bed. R62's nails remained long on both hands, however, the debris which had been present on 2/24/25 (two days prior) appeared lessened. R62 was again asked about his nail length and responded aloud, "They could take care of it [clip them]." Following, on 2/26/25 at 9:34 a.m., nursing assistant (NA)-B was interviewed and stated R62 needed total help with cares. NA-B explained the unit had a bathing schedule but NA-B stated they had not helped him with bathing recently. NA-B stated they were unsure where nail care, if offered and refused, would be documented adding aloud, "I don't know." NA-B then observed R62's fingernails and described them as "long and kinda dirty," adding further, "It needs work." NA-B stated R62's wife visited a few times each week and also, at times, would clip them and clean them. R62's medical record was reviewed and lacked evidence R62 had been offered or had his nails clipped and/or cleaned since 2/21/25, despite having visibly long and soiled nails on both hands which was verified by staff observation. On 2/26/25 at 9:38 a.m., licensed practical nurse (LPN)-D was interviewed, and stated R62 was "total care" and on hospice services. LPN-D stated they had noticed R62 seemed to be refusing more cares "more recently" and observed R62's fingernails at the request of the surveyor. LPN-D stated R62 had been eating chocolate and that was the reason for them to appear soiled, and expressed they believed hospice had just clipped them the week prior.	F 677		

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F 677	Continued From page 21 However, LPN-D acknowledged their appearance and expressed aloud, "They look like they need to be trimmed." LPN-D stated nail care should be completed "with baths" adding "and PRN [as needed]." LPN-D verified if nails were long, they could be clipped whenever needed. LPN-D continued and explained another NA had noticed them long the day prior, however, was unable to locate a clippers to address them. LPN-D then stated they felt R62's nails were not "extremely long for him" and thought they were "looking fine on Monday [2/24/25; also when observed by the surveyor]." LPN-D stated nail care wasn't charted by the NA staff but staff should "look at everybody, everyday." LPN-D stated nails should be kept clean and trimmed "so they [resident] don't scratch themselves." Later, on 2/26/25 at 10:17 a.m., LPN-D approached the surveyor and expressed nail care was charted in the completed Body Audit forms and, again, reiterated someone had clipped them the week prior to their recall. However, LPN-D stated they had just clipped R62's nails prior, and he allowed some of the nails to be addressed. R62's corresponding progress note, dated 2/26/25 at 10:07 a.m., identified text which read, "[R]esident allowed staff to cut nails on left hand and refused nails to be cut on the left [sic] hand." On 2/26/25 at 1:14 p.m., the assistant director of nursing (ADON) was interviewed. ADON explained nail care should be completed on bath days or when needed. ADON stated the NA should be checking nails with provision of cares and addressing it then, if needed, adding aloud such was "part of the daily cares." ADON stated if R62 consumed chocolate regularly causing his nails to be soiled, then they could also outlined	F 677		

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PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

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F 677	Continued From page 22 such within his care plan. ADON stated nails should be kept trimmed and clean as someone could scratch themselves or cause infection. ADON added, "Dignity is number one [reason]." A facility' provided Standards Of Care Guidelines policy, dated 7/2019, identified a section labeled, "Care of Body," which directed bathing should be completed as scheduled along with, "G. Assure fingernails are kept clean." R37 R37's annual Minimum Data Set (MDS) dated 12/19/24, indicated R37 had moderately impaired cognition, delusions, verbal behavioral symptoms directed towards others and not directed towards others, and did not reject cares. The MDS indicated diagnoses which included dementia, anxiety, depression, bipolar disease, and psychotic disorder. The MDS indicated R37 required partial and/or moderate assistance with shower and/or bathing self and setup or clean-up assistance with personal hygiene, which included shaving. R37's care plan printed 2/25/25, indicated R37 required assistance with bathing and was setup/clean-up assistance for personal hygiene. R37's care plan lacked information regarding R37's preference on chin hair and did not indicate R37 refused cares, besides wearing hearing aids appropriately. During observation and interview on 2/25/25 at 2:14 p.m., R37 had approximately 10 gray and brown colored hairs on their chin and stated "I do not like it" about the hair on their chin.	F 677		

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F 677	Continued From page 23 During observation on 2/26/25 at 11:00 a.m., R37's chin hair remained the same. During observation on 2/27/25 at 10:27 a.m., R37's chin hair remained the same. R112 R112's quarterly MDS dated 12/19/24, indicated R112 had short and long-term memory problems, severely impaired cognitive skills for daily decision making, inattention, and disorganized thinking. The MDS indicated R112 had verbal behavioral symptoms directed toward others and not directed toward others and rejected cares daily. The MDS indicated R112 had Alzheimer's disease, dementia, depression, and post-polio syndrome (condition which can affect people who have had polio and causes gradual muscle weakness and muscle loss). The MDS indicated R37 had impairment to both lower extremities, used a wheelchair, and was dependent on staff for shower/bathing self and required substantial/maximal assistance with personal hygiene. R112's care plan printed 2/27/25, indicated R112 required assistance with personal hygiene and showers/bathing. The care plan indicated R112 refused cares, showers, and yelled and swore at staff when they attempted to change R112's clothing or visibly soiled brief. The care plan directed staff to provide redirection when R112 had behaviors. The care plan lacked direction or preferences about R112's facial hair. R112's electronic medical record recorded R112 had a shower on 2/13/25, and lacked documentation of R112's chin hair. R112's record further lacked information on whether R112 had a	F 677		

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F 677	Continued From page 24 shower or any refusals of shower or chin hair removal after 2/13/25. During observation on 2/24/25 at 5:08 p.m., R112 was in their wheelchair and had a thick amount of multiple chin hairs. R112 was not interviewable. During observation on 2/25/25 at 8:26 a.m., R112's chin hairs were unchanged. A second interview was attempted, and R112 was not interviewable. During observation on 2/27/25 at 10:26 a.m., R112's chin hairs were unchanged. During interview on 2/27/25 at 10:42 a.m., nursing assistant (NA)-I stated if staff saw chin hair on female residents, they took care of it since most residents were not able to shave themselves in the memory care area. NA-I stated they reapproached, reassured, and asked another staff person to help if a resident refused care. NA-I stated they reported to the nurse if reapproaching and reassuring did not work. NA-I stated they did not work with R37 often and had never shaved R37. NA-I confirmed R37's chin hair and stated staff should document if R37 refused shaving when showered, and R37 did not refuse cares. NA-I stated R112 did not refuse cares but had behaviors of yelling and screaming while staff assisted with cares. NA-I stated staff can shave R112 and did not work with R112 this morning. NA-I confirmed R112's chin hair, and stated staff could shave R112. During interview on 2/27/25 at 11:12 a.m., licensed practical nurse (LPN)-E stated staff documented in resident's medical record if a shower was refused, and staff were to shave	F 677		

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	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 25 female residents' chin hair when noticed. LPN-E confirmed R112's chin hair and stated R112 tried to kick and hit staff away when they helped with cares. LPN-E confirmed R37's chin hair and stated LPN-E did not notice the chin hair from a distance away and did not think R37 would refuse to shave. During interview on 2/27/25 at 12:55 p.m., NA-H stated they reapproached residents who refused care one or two times, asked another coworker to try, and then told the nurse. NA-H stated the facility had an electric shaver and blade they used for shaving. NA-H stated R112 refused cares, screamed and yelled at staff. NA-H stated they tried to shave R112 yesterday, and R112 refused. NA-H was not sure why R112 refused and stated cares depended on R112's mood. NA-H confirmed R37 had a shower yesterday and stated staff were supposed to shave residents on their shower day. NA-H stated R37 refused cares some days. During interview on 2/27/25 at 1:28 p.m., registered nurse (RN)-E stated they documented in resident's body audits if they refused shower or shaving. RN-E confirmed R112 did not have a documented body audit or documentation R112 refused shaving after 2/13/25. RN-E stated R37 had a body audit documented on 2/26/25, and did not indicate if R37 refused shaving. During observation and interview on 2/27/25 at 1:49 p.m., R112 did not have chin hairs. NA-G stated R112 yelled during cares but was cooperative. NA-G stated R112 tried to push their hand away, and then R112 allowed NA-G to shave them. NA-G stated R112 allowed cares if staff started the cares and did not approach R112	F 677		

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F 677	Continued From page 26 from the front or explain the cares to R112. During joint interview on 2/27/25 at 2:14 p.m. with the director of nursing (DON) and assistant director of nursing (ADON), the DON expected staff to give residents showers weekly and shave female chin hair. The DON expected staff to document refusals, and care planned those who refused cares or shaving of chin hairs. The ADON stated staff followed R112 while R112 wheeled self in wheelchair and R112 refused cares. The ADON expected staff to reapproach R112 when cares refused. The DON expected staff to document if R37 refused to shave chin hair when showered, and residents needed to look clean and presentable. A facility provided Standards of Care Guidelines policy dated 7/2019, identified a section labeled, "Care of Body," which directed bathing should be completed as scheduled along with, "E. Female residents should be assisted as needed with shaving." R64 R64's Minimum Data Set (MDS) dated 12/18/24, indicated moderate impaired cognition, diagnoses of dementia, schizoaffective disorder, bipolar and received antipsychotics on a routine basis. R64 needed substantial/maximal assistance with toileting hygiene and self-cares, and had no documented rejection of cares. R64's care plan printed 2/27/25, indicated a	F 677		

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F 677	Continued From page 27 self-care deficit and he was to be dressed and groomed according to personal preference daily as conditions allows. R64 required partial/moderate assist of one with upper and lower body dressing and supervision/touching assistance of one for personal hygiene. R64 preferred showers at 3:00 p.m., and required assist of one to wash/dry. Nursing assistants were to provide sponge bath on days shower cannot be tolerated, and observe and report changes in skin conditions. Nurse was to provide nail care. Furthermore, the care plan indicated R64 was continent of bowel and bladder, and independent with toileting and hygiene. R64's progress notes dated 2/6/25, indicated resident received a shower, but did not require nail care. R64's progress notes dated 2/7/25, indicated resident walked out of the dining room to the carpeted area, pulled down his pants, and defecated on the floor. When staff intervened, R64 asked where the bathroom was. R64's progress notes skin audit dated 2/13/25, indicated R64 was showered, and that nails were clean and trimmed. Nail care was not needed. R64's nursing assistant task documentation lacked evidence of shower, sponge bath, or nail care from 2/14/25, through 2/26/25. R64's progress notes with nurse practitioner (NP)-A dated 2/19/25 indicated, "writer also noticed pretty long nails and offered to trim, but patient declined". R64's progress notes skin audit dated 2/20/25,	F 677		

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F 677	Continued From page 28	F 677		

indicated resident was not given a shower and that nails were clean and trimmed, and nail care was not needed.

R64's progress notes dated 2/26/25, indicated that registered nurse (RN)-D offered to trim nails, but resident refused nail care and resident would be added to the podiatry list.

R64's Toileting task documentation dated 2/26/25, indicated he needed extensive assistance for bladder incontinence twice, at 3:02 a.m. and 12:46 p.m. No other toileting was documented this day.

On 2/25/25 at 9:48 a.m., R64 was observed on the couch in the commons area with television turned on. His sweatshirt hood was pulled up, and he appeared to have full facial hair, and ungroomed nails one inch long with debris under the thumb and several fingernails on both hands. His long- sleeved blue hooded sweatshirt had wet or stained areas, his grey sweatpants had tears on the bottom, and his shoes were off and placed under table. R64 wore blue gripper socks and paced from the couch to the hallway.

On 2/25/25 at 11:54 a.m., R64 was observed seated at the lunch table. His left leg was wet from groin to knee.

On 2/25/25 at 1:07 p.m., R64 continued to pace unit, sweatpants continued to have darkened areas down his left leg. R64 smelled of urine. Staff were present around R64, but did not offer to toilet or assist R64.

On 2/25/25 at 1:20 p.m., R64 was observed to lay/sit on couch. His right blue gripper sock had a

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F 677	Continued From page 29	F 677		

hole in heel the size of a plum.

On 2/25/25 at 2:13 p.m., R64 continued to pace the unit.

During interview on 2/25/25 at 2:18 p.m., RN-D verified R64's bath day was Thursday afternoon., and had not noticed R64's torn sock.

On 2/26/25 at 7:12 a.m., R64 was dressed in the same gray sweatpants tears on bottom of pant legs and a long sleeve, navy hooded sweatshirt as the previous day. His fingernails remained as previously described.

On 2/26/25 at 11:22 a.m., R64 observed to be dressed in same outfit. No personal cares were documented.

During interview on 2/26/25 at 11:35 a.m., with RN-D stated nursing assistants should be charting refused for nail care or not needed. She stated she would talk with the primary nurse this afternoon regarding nail care, and will also attempt to offer nail care after lunch.

On 02/26/25 at 11:54 a.m., R64 was observed at lunch table wearing the same clothing and his left leg appeared wet.

On 2/26/25 at 1:11 p.m., R64 was observed back on the couch after lunch wearing the same clothes and smelling of urine. The pant leg appeared almost dry, and his fingernails were approximate one inch long.

During interview on 2/26/25 at 1:28 p.m., (NA)-F stated R64 was given a bath yesterday 2/25/25, however, nail care was not offered because it

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F 677	Continued From page 30 was not his regular bath day. NA-F stated, "not gonna [sic] offer all the things" as this shower was extra. NA-F verified that he changed R64's briefs this morning right before breakfast. NA-F stated the resident had a large bowel movement and was incontinent, put his hands up wide, and stated "boom". NA-F verified that R64 didn't get his clothes changed every day because he refused, and he didn't have many clothes or allow for dressing. NA-F verified the shower was not documented. When asked what should be done if a resident refused to change clothes, NA-F stated there was nothing they could do about that. NA-F verified that he did not report R64 had been in the same clothes from 2/25-2/26 to the nurse, and stated nail care would be done on Thursday evenings by the nurse. During interview on 2/26/25 at 1:31 p.m., RN-D stated she was not aware a shower was given on 2/25, and confirmed R64 was dressed in the same clothing and had a urine odor. During interview on 2/26/25 at 1:47 p.m., assistant director of nursing (ADON) stated the expectation was that staff change residents' clothes if they were soiled or had an odor. If the resident would not allow clothes to be changed the staff member should re-approach. If it was a laundry issue the staff should talk with social work, and if the resident lacked clothing they would get the family involved. If a resident refused to change clothes, the staff member should get someone else to try and maybe there was a reason the resident didn't want that person offering to help. If the resident could not make the decision, it was the staff's responsibility to change them out of odorous and dirty clothes, and to explain to the resident the risk/benefits of	F 677		

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	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 677	Continued From page 31 being in soiled clothes if they refused. If the nursing assistant could not get the resident in clean clothes, next step is to talk to the nurse who could also get the family involved. It is the expectation that nursing assistant will ask the resident if they want a shower on designated bath day, and if the resident refused or was not available to receive a shower on designated day, the staff member would offer the shower at the next opportunity. Nail care should be offered with every shower and if resident refused nail care it should be documented as refused. If shower or nail care was completed it was also expected to be documented. On 2/27/25 at 8:18 a.m., R64 was observed to be seated at dining room table in flannel pajama pants, a blue shirt, and blue grip socks. At 10:10 a.m., R64 was seated at the couch. Fingernails continues to appear approximately one inch long with brown colored substance under more than half of the fingernails. No odor was present. Policy-Standard of Care Guidelines dated July 2019 directed, on page two under Care of Body-Part A. Cleanliness-bath/showers as scheduled. This includes body, nails ears, hair. Nails are to be trimmed weekly or more often as needed. Part G. Assure fingernails are kept clean.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		3/31/25

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F 684	Continued From page 32 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure developed skin conditions were identified, assessed and acted upon in a timely manner to promote healing and reduce the risk of complication (i.e., infection, worsening) for 2 of 2 residents (R103, R158) reviewed who had skin impairments. Findings include: R103 R103's admission Minimum Data Set (MDS), dated 12/12/24, identified R103 had intact cognition, demonstrated no delusional thinking, and was dependent on staff for dressing and bed mobility. Further, the MDS identified R103 had several medical complications including cancer and diabetes mellitus, but had no current skin impairments (i.e., ulcers, surgical wounds, lesions on the foot). R103's care plan, printed 2/25/25, outlined all of R103's identified potential or actual problems along with corresponding interventions. The care plan outlined R103 had a self-care deficit and needed assistance with lower body dressing, bathing, and bed mobility; R103 had a history of false accusations against the staff along with exaggerated statements (i.e., they left me in bed for 10 days); and R103 was at risk for actual skin impairments due to her impaired mobility, incontinence and diabetes mellitus. The care plan directed to keep her linens dry and wrinkle free	F 684	F684 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. R103 had a physician updated and new orders received for treatment during survey. R158 had a physician updated and new orders received for treatment during the survey. 2. The facility has determined that all residents have the potential to be affected. 3. The facilities guideline for Skin Management was reviewed to ensure it remains current. All Nursing staff will receive re-education on the facility Skin Management guidelines including body audits, documentation, and follow up. A Facility wide audit was completed by Nursing staff to ensure identification of any current skin issues. 4. Director of Nursing or designee will complete random monthly audits x2 months to ensure the facilities Skin	

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F 684	Continued From page 33 along with, "Skin Observation," and, "Observe skin during cares. Report any changes to nurse." On 2/24/25 at 1:22 p.m., R103 was observed lying in bed while in her room. R103 was interviewed and expressed multiple concerns about her care while at the nursing home. R103 stated she had dry skin on her feet which wasn't being addressed adding aloud, "I think they need to be looked at." R103's feet were observed and both feet had visibly dry, flaking and, at times, cracked skin on the soles of the feet extending up towards the ankle. R103 stated her feet were sore and that she had asked staff about them "several weeks ago" but there was little response from them adding, "They feign interest and move on to something else." R103 stated there was no active treatment being done to them to her knowledge (i.e., lotion, medicated ointment) and reiterated she felt they needed to be addressed. R103's most recent Body Audit 11-15-V8, dated 2/19/25, identified R103 received a shower and had no skin impairments identified. R103's heels were recorded as, "a. Firm." When interviewed on 2/25/25 at 2:12 p.m., nursing assistant (NA)-C stated they had worked with R103 multiple times and explained R103 often, if not always, refused to get up from the bed. NA-C stated R103 only wanted female caregivers and the cares completed for her were mostly "briefs [change] and the meals." NA-C explained staff did reposition her, at times, but it required "always two people" due to R103 having pain and needing so much assistance with turning. NA-C verified they had helped R103 with morning cares that day (2/25/25), however, when asked about the dry skin on her feet, NA-C	F 684	Management program guideline is followed. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

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F 684	Continued From page 34	F 684		

responded they had not looked at them. NA-C stated nobody had told them about R103's feet being dry or needing lotion, and verified they only applied lotion "when she [R103] ask." NA-C stated R103 had never asked them personally to apply lotion and reiterated they did not check the skin on her feet with morning cares adding aloud, "No." NA-C stated the nurses were responsible to check the skin on the feet.

R103's Treatment Administration Record (TAR), dated 2/2025, identified all of R103's current treatments ordered along with spaces for staff to record their administration or refusals. The TAR lacked any treatments or monitoring of R103's developed skin condition.

On 2/25/25 at 2:19 p.m., licensed practical nurse (LPN)-D was interviewed. LPN-D stated they worked full-time during the week but had only "once or twice I think" seen R103's feet. LPN-D observed R103's feet and verified their condition but added aloud they were "not dry like that" last time they had seen them. LPN-D stated skin, including on the feet, should be checked weekly on "bath day." LPN-D stated R103's care plan intervention to monitor skin during cares should include checking her feet adding aloud, "It should, yes." LPN-D stated the medical record would have any assessed skin condition or subsequent interventions for them would be most likely in the Body Audit forms. LPN-D reiterated they had "not seen her feet dry like that" prior and expressed they were unsure how long they had been in such condition. LPN-D stated nobody had reported R103's feet skin condition to them, however, if they had then it would have been looked at and orders for treatment obtained. LPN-D reviewed R103's medical record, including TAR, and

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F 684	Continued From page 35 verified no active treatments or monitoring on R103's feet were being done. LPN-D stated they would update the medical provider and get an order for it. LPN-D stated they were unsure why a shower had been recorded (Body Audit 02/25/25) as R103 remained mostly in bed; however, expressed it was important to ensure a skin condition was acted upon timely as R103 was bariatric and had "more possibilities for breakdown." R103's medical record was reviewed and lacked evidence R103's dry skin on her feet had been identified or acted upon until 2/25/25 despite R103 saying the condition had been present for several weeks, nor despite the care plan directing staff to check R103's skin with cares and direct care staff saying this had not been completed. On 2/26/25 at 1:03 p.m., the assistant director of nursing (ADON) was interviewed. ADON stated skin should be inspected daily while the NA is doing cares. If something "abnormal" was spotted, then it should be reported to the nurse. ADON stated R103 would, at times, refuse cares but acknowledged staff should "look at everybody's skin with cares." ADON stated this was important to do as a skin condition could deteriorate and cause infection adding, "So much worse things that can happen." R158 R158's admission Minimum Dat Set (MDS) dated 1/21/25, identified R158 was cognitively intact and was diagnosed with diabetes mellitus. R158	F 684		

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F 684	Continued From page 36 was observed for one deep tissue injury in evolution and identified as at risk for pressure ulcers. R158's orders from 1/17/25, indicated nursing to complete a body audit every bath day and feet should be assessed weekly for skin integrity. R158's care plan revised on 1/28/25, included a diabetes focus area and instructed staff to observe feet daily for open areas, sores, pressure areas, blisters, edema or redness. The care plan also included R158 had a potential and actual impairment to skin integrity related to recent surgery and left heel deep tissue wound. The care plan indicated nursing assistants will keep linens dry, and wrinkle free, observe skin every shift and report changes to the nurse. Nurses were directed to perform weekly skin inspections and as needed. R158's Body Audit 11-15-V8 form included the following: 2/7/25- R158 received a bed bath, documented alterations in skin integrity of a left heel pressure and right thigh (front) o/a healing. 2/14/25- No Body Audit available. 2/21/25- R158 received a shower, documented alterations in skin integrity of a left heel pressure injury. The audit lacked documentation regarding right thigh or right foot. 2/28/25 R158 received a shower, documented alterations in skin integrity of a right thigh with an open lesion. The audit lacked documentation regarding an area on the right foot. R158's nursing assistant skin observation task documentation indicated R158 had no skin	F 684		

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F 684	Continued From page 37 concerns from 2/15/25 through 2/25/25. During observation and interview on 2/24/25 at 7:20 p.m., R158 stated she had a painful area on the bottom of her right foot and an open area on her right thigh, and she rubbed a prescribed skin barrier cream on her right thigh routinely. The tube was cut in half, open to air, and stored in an exam glove. R158 stated she self-administered the cream without hand hygiene and kept the cream on her side table. R158 stated staff was aware of the open area on the right thigh, but hadn't looked at the right foot. During interview on 2/25/25 1:41 p.m., R158 stated registered nurse (RN)-D was in her room and assessed her left toes that caused discomfort but overlooked the bottom of the right foot. RN-D was asked to return to the room by R158. When asked if there were any skin concerns RN-D touched the left toes. RN-D was not aware R158 felt discomfort on the bottom of the right foot or aware of the open area on her right thigh. RN-D assessed and measured both areas and announced the next step was to notify the nurse practitioner (NP)-B for treatment orders. RN-D informed R158 not to use the cream on her side table and tossed the cream in the trash can. RN-D verified there were no foot cushions or wedges to float heals for positioning and no orders stating to do so. R158's progress notes from 2/25/25 at 2:00 p.m., indicated skin on the bottom of the right foot was slightly raised with a firm area that measured 1.5 centimeter (cm) long by 0.5 cm wide. R158 reported sensation on the bottom of the right foot. The note indicated a second area on top of the right thigh measured 0.5 cm and was described	F 684		

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F 684	Continued From page 38 as a round, dry scab. R158 reported applying her own personal white cream that was discarded by the nurse. A message was left for the nurse practitioner with information regarding the skin concerns. During observation and interview on 2/26/25 at 7:46 a.m., RN-D entered R158's room and assessed her right foot, applied cream to the right thigh, and explained the cream to be a skin barrier. A cushion was observed in the corner of the room. RN-D verified it was for positioning, unopened and brand new. At 8:03 a.m., R158 asked RN-D to put a pillow under her right leg to elevate her foot off the bed. RN-D was not aware of any floating heels or wedges that were care planned for this resident, and confirmed NP-B had not entered orders regarding the two areas identified on 2/25/25. During interview on 2/26/25 at 8:17 a.m., nursing assistant (NA)-O stated they checked on R158 at 8:00 a.m. and offered to reposition and change resident. R158 refused because the night shift repositioned her before they went home. NA-O stated they understood what pressure relieving support devices were and why they were important but had not performed any cares for the resident, and was not aware of any skin concerns or positioning devices care planned for R158. During observation and interview on 2/26/25 at 11:37 a.m., R158's sheets were straightened, she was visibly repositioned with head of bed approximately at 75 degrees, and pillows were positioned under both feet. During interview on 2/27/25 at 10:08 a.m., RN-D stated only nurses did skin checks, not the	F 684		

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F 684	Continued From page 39 nursing assistants. During interview at 2/27/25 at 10:12 a.m., nursing assistant NA-P stated they were in R158's room a few times to offer morning cares and a bedding change, but R158 refused. NA-P confirmed they repositioined R158 today, moved her shoulder, and gave her a boost up in bed. NA-P stated, she rubbed lotion on both her feet because they were dry and sore. NA-P stated, she was not aware of any skin concerns or positioning care planned for R158 and would not provide cares differently for any of the assigned residents. NA-P further explained the care sheet indicated treatment plans and verified she was not aware of any skin concerns with R158. NA-P stated, R158 didn't have any skin concerns, only a callus on the bottom of her foot. R158 complained of dry skin, and no painful areas. During interview on 2/27/25 at 10:30 a.m., RN-D pointed to R158's right foot and stated, "this would be concerning". RN-D verified no assessments or notes pertaining to the right foot were documented prior to 2/25/25. RN-D verified with R158 her right foot has been hurting for over a week. R158 stated she couldn't see the bottom, and no one has looked at her foot. The open area on her right thigh has been present since she arrived at the facility. RN-D verified a verbal order was taken for both the right foot and right thigh. During interview on 2/27/25 at10:45 a.m., staff development, registered nurse (RN)-C stated, nursing assistants were trained to notice changes with residents and report those changes back to the nurse. The cares provided were not based on the resident's diagnosis. RN-C confirmed if a	F 684		

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F 684	Continued From page 40 nursing assistant rubbed lotion on a resident's foot with a sore area, it should be reported to the nurse and documented on their skin observation task sheet. R158's Progress Notes from 2/27/25 at 2:13 p.m., indicated a skin concern on the bottom of the right foot was pink, intact, and firm and had a pink area noted underneath. A small round area on top of the right thigh was cleansed with wound cleanser and no drainage was noted. Bacitracin and dressing applied to a shallow area. R158's orders transcribed from verbal order at 2/27/25 at 4:00 p.m., indicated right foot, monitor area twice a day and call nurse practitioner if area opens or changes. R158's orders transcribed 2/28/25 at 8:00 a.m., indicated right thigh wound care. Area should be cleansed with wound cleanser and apply bacitracin ointment, cover with a border dressing. R158's progress notes from 2/28/25 at 9:33 p.m., indicated resident received a shower and had no skin issues documented on the feet or thigh. Skin Management Program Policy, revised 9/22 indicated that body audits completed upon admission and weekly by licensed staff, preferable on bath day and as needed (PRN) for changes in skin integrity. Comprehensive skin and positioning evaluation completed upon admission quarterly, annually and with changes in condition. Interventions included daily skin observations with cares.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 41 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement planned fall interventions for 1 of 2 residents (R125) reviewed for falls. Findings include: R125's quarterly Minimum Data Set (MDS) dated 2/12/25, identified R125 had moderately impaired cognition and had diagnoses which included cancer, hip fracture, other fracture, personal history of traumatic brain injury, and history of falling. The MDS indicated R125 required substantial and/or maximal assistance with toileting hygiene and transfers. The MDS indicated R125 had two or more falls with no injury since prior assessment. R125's care plan printed 2/24/25, indicated R125 had limited physical mobility with fall risk related to history of falls, and falls were anticipated related to impulsivity, cognition, multiple attempts to self-transfer, and incontinence. Interventions included auto-locking brakes to wheelchair, gripper socks or shoes on at all times, keep wheelchair at bedside when in bed, and identified R125's mobility and transfer needs.	F 689	F689 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. R125 had care plan reviewed as well as NAR sheet reviewed to ensure fall interventions were noted. Facility staff were re-educated on following NAR sheets for fall care plan interventions. 2. The facility has determined that all residents have the potential to be affected. 3. The facilities Adverse Event guideline was reviewed to ensure it remains current. All facility staff received re-education on the Adverse Event Guideline. All residents had fall interventions reviewed and rooms audited	

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PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

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F 689	Continued From page 42 R125's nursing assistant care plan sheet updated 2/25/25, indicated R125 was a fall risk and required bilateral grab bars, auto lock brakes, gripper socks, and lock and keep wheelchair at bedside. Review of R125's most recent fall progress notes from 12/1/24 to 2/25/25, identified the following: -12/16/24 at 12:09 p.m., indicated R125 was found sitting on floor in room next to wheelchair with no sign of injuries. -12/17/24 at 8:22 a.m., indicated a Post Fall Data Collection for fall on 12/16/24 at "12:00 a.m.". R125 was found on the floor in their room next to transfer surface with no apparent injury. R125 attempted to self-transfer prior to the fall. Intervention: keep mobility device at bedside. -12/19/24 at 7:49 p.m., indicated R125 was found on floor in their room, and R125 stated they attempted to self-transfer and the floor was slippery. The bed was lowered to the lowest position, R125 was reminded to use call light for assistance, and the call light was placed within reach. -12/19/24 at 7:51 p.m., indicated a Post Fall Data Collection for fall on 12/19/24 at 6:45 p.m.. R125 was found on floor in their room next to transfer surface with wheelchair and/or bed brakes unlocked and no apparent injury. R125 did not activate call light and attempted to self-transfer prior to fall. Intervention: keep mobility device at bedside. -12/21/24 at 11:59 a.m., indicated a Post Fall Data Collection for fall on 12/21/24 at 8:45 a.m..	F 689	to ensure interventions remained in place. All care plans and NAR care guides were updated to reflect current need. 4. DNS or designee will complete random monthly audits x2 months will be completed to ensure facility Adverse Event guidelines are followed including ensuring appropriate interventions in place as per care plan. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 689	Continued From page 43 R125 was found on floor in their room next to transfer surface with no apparent injury. R125 rolled and/or slid out of bed prior to the fall. Intervention: bed adjusted to appropriate height. -12/21/24 at 12:22 p.m., indicated R125 was found on floor lying on their right side in the room by bedside. R125 stated they attempted to self-transfer and lost balance. Bed was in lowest position, call light was within reach, and resident re-educated to use call light for help. -12/26/24 at 8:53 p.m., indicated R125 was found sitting on the floor hanging onto their wheelchair with no apparent injury. Intervention: continue customer rounds. -12/26/24 at 8:56 p.m., indicated a Post Fall Data Collection for fall on 12/26/24 at 5:30 p.m.. R125 was observed on floor in their room with no apparent injury and attempted to self-transfer prior to fall. Intervention: "Other fall intervention: [nursing assistant] care plan sheets were reviewed and no changes indicated." -1/13/25 at 5:31 p.m., indicated R125 was found sitting on the floor next to their wheelchair around "4:59 pm" with no injury. R125 attempted to self-transfer to wheelchair. -1/13/25 at 5:38 p.m., indicated a Post Fall Data Collection for fall on 1/13/25 at "4:59 AM". R125 was observed on floor in their room next to transfer surface. R125 did not activate call light, had socks on, and was not wearing proper footwear. R125 attempted to self-transfer prior to fall. Intervention: "Other fall intervention: [nursing assistant] care plan sheets were reviewed and no changes indicated."	F 689		

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F 689	Continued From page 44 -2/23/25 at 12:15 a.m., indicated a Post Fall Data Collection for fall on 2/23/25 at 12:15 a.m.. R125 was found on floor at bedside, had bare feet, and had an abrasion (scrapes and scratches) and a laceration (deep cut). R125 was incontinent of urine when assessed following the fall, and attempted to self-transfer and rolled and/or slid out of bed. Intervention: bed adjusted to appropriate height and gripper socks or shoes at all times. -2/23/25 at 2:22 a.m., indicated R125 was found sitting on the floor by bedside and wheelchair and was holding onto the grab bar. R125 had a laceration by their eyebrow and right elbow. Intervention: 72 hour post fall vital signs and neurological exam (tests to monitor mental status, motor function, sensory function, reflexes, and coordination), gripper socks on, monitor eyebrow and elbow daily for signs and/or symptoms of any complication. During observation on 2/25/25 at 12:51 p.m., R125 was in their wheelchair near the dining area. R125 had on gripper socks, and the wheelchair did not appear to have anti-rollback brakes. During observation on 2/25/25 at 2:08 p.m., R125's wheelchair was not next to their bed and across the room out of reach, facing towards their dresser. R125's wheelchair did not appear to have anti-rollback brakes. During observation on 2/25/25 at 2:26 p.m., R125's wheelchair was in the same position. During observation on 2/25/25 at 2:55 p.m. to	F 689		

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F 689	Continued From page 45 2:56 p.m., R125's wheelchair was in the same position, and a nursing assistant walked by R125's room. During observation on 2/25/25 at 3:06 p.m., R125's wheelchair was in the same position. During observation and interview on 2/25/25 at 3:15 p.m., trained medication assistant (TMA)-A stated they notified the nurse when a resident fell, and the nurse completed documentation about the fall. TMA-A stated they monitored everyone for falls in the memory care area. TMA-A stated R125 was a fall risk and tried to self-transfer to use the bathroom by themselves, and fall interventions for R125 included to assist R125 to bed after lunch, check on R125, and ask if R125 needed to use the bathroom. TMA-A stated fall interventions were listed on care plan sheets. TMA-A entered R125's room, and R125 was standing up next to their bed with their back towards the bedside table and hands holding onto the bedside table. R125 had gripper socks on and shoes of a soft material. One of the shoes was not connected at a seam. TMA-A moved the wheelchair, which was next to the dresser, assisted R125 to sit in their wheelchair, and offered R125 to use the restroom. TMA-A assisted R125 to the hallway where other residents were, and R125's shoes remained on. TMA-A verified the wheelchair placement away from the bed and by the dresser and stated they kept the wheelchair away from the bed so R125 was not tempted to self-transfer. During observation and interview on 2/25/25 at 3:42 p.m., nursing assistant (NA)-J stated they pulled the emergency light, put a pillow under the resident's head, and called for help when they	F 689		

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F 689	Continued From page 46 found a resident on the floor. NA-J stated they know residents' fall interventions by the paper care plan and report from nursing staff. NA-J stated they had checked on R125 around 2:50 p.m., and R125 was in bed. NA-J stated R125 was a fall risk, attempted to self-transfer, and staff were supposed to keep the wheelchair at bedside. NA-J was not sure if R125 had auto-lock brakes on their wheelchair or not. NA-J brought R125 to their room to check for auto-lock brakes with R125's permission. NA-J and TMA-A applied a gait belt to R125, assisted R125 to stand, unlocked the wheelchair, and pushed the wheelchair backwards. NA-J confirmed R125's wheelchair did not have auto-lock brakes and assisted R125 back into their wheelchair. During interview and document review on 2/25/25 at 4:03 p.m., licensed practical nurse (LPN)-E stated they documented about falls and fall interventions in the electronic medical records' "Risk Management". LPN-E stated they checked residents for injuries, movement abilities, and vitals when a resident was found on the floor. LPN-E stated they called the doctor, family, supervisor, and DON. Staff collected information about what happened prior to the fall and created interventions. Nurses then continued taking vitals and neurological checks if needed. LPN-E stated they knew about fall interventions from their morning and evening meetings and reviewing documentation about falls. LPN-E stated managers and sometimes they health unit coordinator updated the care plans with fall interventions. LPN-E reviewed a care plan sheet updated 2/21/25, and indicated R125 as a fall risk with interventions which included bilateral grab bars, auto lock brakes, gripper socks, and lock and keep wheelchair at bedside. LPN-E	F 689		

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F 689	Continued From page 47 confirmed R125's wheelchair did not have auto-lock brakes. During observation on 2/26/25 at 7:35 a.m., R125's wheelchair was out of reach from the bed. During observation and interview on 2/26/25 at 7:41 a.m., LPN-E exited R125's room, and the wheelchair was now by R125's bed. LPN-E confirmed they moved the wheelchair to R125's bedside and stated staff forgot to keep the wheelchair at bedside. During interview on 2/27/25 at 2:26 p.m., the director of nursing (DON) reviewed fall interventions from the Risk Management documents. The DON expected staff to follow R125's care planned fall interventions, which included keeping R125's wheelchair at bedside when in bed and auto-locking brakes to wheelchair. A provided Adverse Event policy dated 2/2021, indicated falls were reviewed to ensure correct interventions occurred.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		3/31/25

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F 692	Continued From page 48 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assessed and ordered nutritional supplement interventions were followed for 1 of 1 resident (R18) reviewed for weight loss. Findings include: R18's annual Minimum Data Set (MDS) dated 11/27/24, identified R18 had severe cognitive impairment and required supervision or touching assistance with eating. R18 had diagnoses which included dementia, peripheral vascular disease, chronic viral hepatitis C, chronic obstructive pulmonary disease, dysphagia, constipation, hemiplegia (partial or total loss of voluntary movement on one side of the body) or hemiparesis (weakness on one side of the body), multiple sclerosis (chronic, autoimmune disease which affects the brain and spinal cord), and schizophrenia. The MDS identified R18 weighed 146 pounds, had sustained no substantial weight loss or weight gain in the previous six months, and had a mechanically altered diet. R18's comprehensive Nutritional Assessment	F 692	F692 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. R18 was given a supplement per order. Staff updated Dietary regarding need to maintain appropriate supplements in refrigerator for residents identified as having a need. 2. The facility has determined that all residents have the potential to be affected. 3. The facilities Weight Monitoring and Nutritional Risk guidelines were reviewed to ensure it remains current. All facility staff will receive re-education on the	

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F 692	Continued From page 49 dated 11/25/24, indicated R18's weight was 145.8 pounds, had a check next to "<5% [less than five percent] weight change in 30 days, <7.5% in 90 days or < 10% within 180 days", and indicated "sign [significant] weight loss noted at 90 days (-12.8# [pounds], -8%) in the description for "Interventions for unexpected/unintentional weight change". R18's Nutrition Progress Note dated 2/5/25 at 1:24 p.m., indicated the following: "Weight (2/3): 137.6#; 30 days (1/6): 146.2# (-8.6#, -5.8%); 180 days (8/1):158.3# (-20.7#, -13%); height: 64 inches; BMI:23.6. Sign weight loss noted at 30 and 180 days. Intake: 50-100%. Res [Resident] receives weekly weights and a fortified diet. Fortified food at meals to help maintain/ gain weight. Res food will have increased calorie and protein during meals by providing liquid butter/oils, cream, milks, and gravy. RD [registered dietician] recommends magic cup BID r/t [twice a day related to] sign weight loss" .... "RD updated [nurse practitioner] r/t weight loss. RD will continue to monitor weights, intakes, labs, and skin." R18's care plan printed 2/26/25, indicated R18 had a potential nutritional problem. The care plan indicated several interventions which included evaluate weight changes, determine percentage lost/gained and follow facility protocol for weight loss, observe fluid intake, observe/document/report to medical practitioner as needed for signs/symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss defined as 3 pounds in one week, greater than 5% in one month, greater than 7.5% in three months, or greater than 10% in six months, use of nosey cup and scoop plate,	F 692	facilities Weight Monitoring and Nutritional Risk policy. Dietitians will review current interventions on Nutritional Risk residents to ensure interventions remain appropriate. 4. Dietitians or designee will complete random monthly audit x2 months to ensure residents are receiving their identified nutritional supplement as ordered and the Weight Monitoring and Nutritional Risk guideline is being followed. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

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F 692	Continued From page 50	F 692		

fortified diet, observe weight per protocol or as ordered and record, registered dietician to evaluate and make diet change recommendations PRN (as needed), supervision during meals, etc.

R18's orders printed 2/26/25, indicated the following:
-8/27/24, regular diet, pureed texture, nectar consistency.
-10/1/24, weight weekly for nutritional risk per registered dietician in the morning every Monday.
-10/9/24, registered dietician recommends fortified diet for recent weight loss.
-2/5/25, magic cup supplement two times a day for routine signs of weight loss per dietician.

During breakfast observation on 2/26/25 at 8:22 a.m., R18 was up and dressed at the breakfast table. R18 had oatmeal, pureed breakfast items, and "nosey cups" with thickened liquids. Throughout breakfast observation, no supplement was given to R18.

During observation on 2/26/25 at 9:47 a.m., R18 was in the television room and was not drinking anything.

During observation on 2/26/25 at 11:50 a.m., R18 had a chocolate pudding cup before a pureed meal was provided to them.

During interview and document review on 2/26/25 at 12:02 p.m., registered nurse (RN)-F stated R18 did not have any scheduled supplements. RN-F checked R18's medication and treatment administration record and a documentation field which directed staff to give R18 a magic cup was marked as given. RN-F stated R18 usually

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F 692	Continued From page 51 received a magic cup in the morning with breakfast, and nursing staff usually delivered the magic cup to R18. When asked about whether R18 received their magic cup this morning, RN-F stated R18 must have gotten the supplement but was not sure. RN-F stated the nursing assistants knew about R18's supplement and usually provided the supplement to R18 at breakfast. During interview on 2/26/25 at 12:26 p.m., dietary aide (DA)-A stated they brought supplements from the main kitchen to the second-floor refrigerator in the dining area. DA-A stated the supplements brought up this morning were still in the refrigerator. During interview on 2/26/25 at 12:30 p.m., nursing assistant (NA)-H stated nursing assistants sometimes gave residents their supplements in the morning or as desserts. NA-H did not give any magic cups to residents during their shift thus far. During a joint interview on 2/26/25 at 12:33 p.m., NA-Q and NA-R stated supplements came from the kitchen, and nursing assistants gave supplements to residents if the supplement was labeled with the residents' name. NA-Q and NA-R stated they did not give any residents magic cups during their shift thus far. During interview on 2/26/25 at 12:34 p.m., DA-A stated they did not see any magic cups in the main kitchen so only brought up ensure, boost, and pudding this morning. DA-A stated no one had asked them about a magic cup so far during their shift. During interview on 2/27/25 at 11:05 a.m.,	F 692		

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F 692	Continued From page 52 licensed practical nurse (LPN)-E stated nurses gave residents supplements according to the orders written by the dietician. LPN-E stated the kitchen refrigerator had supplements labeled with residents' names and which shift the supplement should be given. LPN-E stated they had to go downstairs to the main kitchen when a resident's supplement was not in the second-floor refrigerator. During interview on 2/27/25 at 2:55 p.m., the director of nursing (DON) expected staff to give residents their ordered supplements or document if resident refused. DON expected nurses to ensure residents got their supplement, since they were the ones to sign the supplement as given. DON stated weight loss and not meeting nutritional needs were a risk when residents did not get their supplements as ordered. A provided Weight Monitoring and Nutrition-at-Risk policy dated 6/2023, indicated residents with undesired downward trends in their weight were monitored until the resident's condition resolved or stabilized and immediate interventions were implemented by the facility, as appropriate, to prevent further decline. The policy gave examples of interventions, which included supplements.	F 692		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		3/31/25

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F 880	Continued From page 53 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 54 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were consistently implemented in accordance with Centers for Disease Control (CDC) recommendations to reduce the risk of infection for 2 of 3 residents (R38, R25); and failed to ensure appropriate hand hygiene was completed during provision of personal care for 1 of 4 residents (R25) whose cares were observed. Findings include: EBP: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms	F 880	F880 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. R38 and R25 had rooms audited to ensure postings remained in place as well as infection control carts in place to promote the use of EBP. NA-A received	

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	245271	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 880	Continued From page 55 (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R38's care plan, printed 2/26/25, identified all of R38's actual or potential problems along with interventions to help R38 meet established goals of care. The care plan outlined, "[R38] has indwelling medical device requiring precautions - tube feeding - requiring enhanced barrier precautions." This had a date listed, "04/12/2024." The care plan directed further, "Requires enhanced [sic] barrier precautions." On 2/26/25 at approximately 7:15 a.m., R38's double room was observed from the hallway which had an orange-colored sign posted under the name plate which read, "[STOP SIGN] Enhanced Barrier Precautions [STOP SIGN] ... Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities ... Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assistance with toileting ..." The signage was provided from the	F 880	immediate re-education on hand hygiene. 2. The facility has determined that all residents have the potential to be affected. 3. The facility reviewed the hand hygiene and Enhanced Barrier Precautions guidelines to ensure they remain current. All staff received re-education on the guidelines. Infection Preventionist completed facility wide audit of all residents requiring precautions to ensure appropriate signage and infection control carts remained in place. All facility staff received re-education and competency testing on handwashing. 4. Infection Preventionist or designee will complete random audits 2months to ensure EBP are followed per facility guidelines and random monthly audits x2 months to ensure hand hygiene guidelines are followed. Results of audits will be brought to the monthly QAPI meeting for review and discussion. 5. POC date of completion: March 31, 2025	

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F 880	Continued From page 56 CDC, and underneath was a hard plastic cart with gowns and other PPE supplies inside. R38 was observed laying in bed but had visible tube feeding equipment at the bedside. Following, on 2/26/25 at 7:32 a.m., R38's room door was opened and nursing assistant (NA)-D and NA-E were inside the room; however, neither of them had a gown on as directed by the signage. NA-D was at R38's bedside and had R38 turned onto her right side as a mechanical lift sling was positioned underneath of her. NA-D stated they had just changed her and pointed to a soiled incontinence brief inside the small trash can next to her dresser. NA-D stated aloud, "We change her." NA-D was then assisted to transfer using the mechanical lift to her wheelchair. At 7:41 a.m., NA-D was questioned by the surveyor on the posted signage outside R38's double room which directed precautions should be used. NA-D observed the signage and expressed aloud, "It's for neither of them [R38 or her roommate]." NA-D stated if either of the residents needed the precautions, then they would have been wearing them. However, a few minutes later NA-D excused themselves from R38's room and was heard in the hallway asking other staff members about the posted signage for R38's room. Following, clinical support specialist (CSS)-A entered the room and verified R38 as being on EBP adding staff should be using a gown and PPE "anytime they are giving direct care." CSS-A explained R38 had a feeding tube which inserted into her skin and EBP were used with "any tubes" like such. NA-D and NA-E then both left the room and donned a disposable gown to finish the cares for R38.	F 880		

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F 880	Continued From page 57 On 2/26/25 at 10:27 a.m., registered nurse (RN)-C was interviewed and verified they were the campus' infection preventionist. RN-C stated education with direct care staff had started the year prior for EBP and continued on an ongoing basis. RN-C verified any residents with catheter, chronic wounds, or feeding tubes should have EBP used with direct, personal cares. RN-C verified R38 required EBP during cares due to her feeding tube adding R38 was "pretty vulnerable." RN-C stated use of EBP was important to help "protect her [R38] from getting an multi-drug resistant organism." R25's care plan printed 2/24/25, indicated R25 had a wound which required EBP. During observation on 2/24/25 at 3:35 p.m., nursing assistant (NA)-A had gloves on and registered nurse (RN)-F had no personal protective equipment on to use a full lift to transfer R25 from their wheelchair to bed. RN-F exited the room after the transfer. NA-A continued to wear the same gloves, opened R25's incontinent product, and performed peri-cares to clean bowel movement from R25. NA-A tucked the soiled brief and bed protector under R25, moved the wipes on R25's bed, and wiped R25 again. NA-A adjusted R25's clean brief, placed the incontinent spray product and incontinent wipes on R25's bedside table, removed gloves, did not perform hand hygiene, and applied new gloves. NA-A tucked i R25's clean incontinent product under them, assisted R25 to turn right, grabbed the soiled incontinent product and bed protector, threw away, and secured the clean incontinent product on R25. NA-A removed gloves, did not perform hand hygiene, and	F 880		

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F 880	Continued From page 58 applied a clean bed protector under R25. NA-A pulled up R25's blankets and left R25's room. NA-A threw the soiled trash from R25's room into the soiled utility room and went to the clean utility room to wash their hands. During observation and interview on 2/24/25 at 3:49 p.m., NA-A stated they washed their hands in the clean utility room because bins were in the way of the sink in the dirty utility room. NA-A confirmed they changed their gloves during peri-cares but did not perform hand hygiene between glove changes. NA-A stated there was hand sanitizer to use, but got a reaction from the alcohol in the hand sanitizer so they washed their hands instead. NA-A observed the sign and PPE cart outside of R25's room. NA-A stated neither R25 or their roommate were on enhanced barrier precautions and the sign and cart should be removed. NA-A stated the enhanced barrier precautions were for previously for R25's roommate but had since been cleared. The sign on R25's door indicated enhanced barrier precautions and directed staff to clean their hands before entering and when leaving the room. Further, the sign directed staff to wear gloves and gown for high-contact cares, which included transferring, changing linens, and changing briefs. During interview on 2/27/25 at 9:00 a.m., the RN-C confirmed R25 was on enhanced barrier precautions for a wound and expected staff to wear gloves and gowns for any direct care as listed on the sign outside resident's room. RN-C expected staff to change their gloves and perform hand hygiene after dirty tasks and before clean tasks to reduce the risk of infection and cross-contamination when hand hygiene was	F 880		

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F 880	Continued From page 59 missed. A provided Hand Hygiene Practice Guideline and Procedure dated 10/13/17, directed staff to complete handwashing after changing "diapers". The policy directed staff to complete hand washing before applying gloves and after removing gloves and to change gloves between cares to prevent cross-contamination. A facility' provided PPE Selection and Use policy, dated 9/2023, identified general guidelines to follow for PPE use along with various procedures to apply and remove the equipment. The policy included, "Enhanced Barrier Precautions: Gloves and gown prior to high contact care, change PPE before caring for another resident ...[EBP] fall between standard and contact precautions ... These may apply to wounds or indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy) regardless of MDRO colonization. These precautions are used during high contact resident care activities such as dressing, bathing, transfers, hygiene, incontinence care, device or wound care."	F 880		

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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: On 2/24/25 to 2/27/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000		

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52718023C (MN110825), H52718345C (MN110652), H52718343C (MN110626), H52718342C (MN110567), H52718344C (MN106287), H52718346C (MN105564), H52718304C (MN105284), H52718285C (MN104583) 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure developed skin conditions were identified, assessed and acted upon in a timely manner to promote healing and	2 830	Corrected	3/31/25

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2 830	Continued From page 3 reduce the risk of complication (i.e., infection, worsening) for 2 of 2 residents (R103, R158) reviewed who had skin impairments. Findings include: R103 R103's admission Minimum Data Set (MDS), dated 12/12/24, identified R103 had intact cognition, demonstrated no delusional thinking, and was dependent on staff for dressing and bed mobility. Further, the MDS identified R103 had several medical complications including cancer and diabetes mellitus, but had no current skin impairments (i.e., ulcers, surgical wounds, lesions on the foot). R103's care plan, printed 2/25/25, outlined all of R103's identified potential or actual problems along with corresponding interventions. The care plan outlined R103 had a self-care deficit and needed assistance with lower body dressing, bathing, and bed mobility; R103 had a history of false accusations against the staff along with exaggerated statements (i.e., they left me in bed for 10 days); and R103 was at risk for actual skin impairments due to her impaired mobility, incontinence and diabetes mellitus. The care plan directed to keep her linens dry and wrinkle free along with, "Skin Observation," and, "Observe skin during cares. Report any changes to nurse." On 2/24/25 at 1:22 p.m., R103 was observed lying in bed while in her room. R103 was interviewed and expressed multiple concerns about her care while at the nursing home. R103 stated she had dry skin on her feet which wasn't being addressed adding aloud, "I think they need to be looked at." R103's feet were observed and	2 830		

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2 830	Continued From page 4 both feet had visibly dry, flaking and, at times, cracked skin on the soles of the feet extending up towards the ankle. R103 stated her feet were sore and that she had asked staff about them "several weeks ago" but there was little response from them adding, "They feign interest and move on to something else." R103 stated there was no active treatment being done to them to her knowledge (i.e., lotion, medicated ointment) and reiterated she felt they needed to be addressed. R103's most recent Body Audit 11-15-V8, dated 2/19/25, identified R103 received a shower and had no skin impairments identified. R103's heels were recorded as, "a. Firm." When interviewed on 2/25/25 at 2:12 p.m., nursing assistant (NA)-C stated they had worked with R103 multiple times and explained R103 often, if not always, refused to get up from the bed. NA-C stated R103 only wanted female caregivers and the cares completed for her were mostly "briefs [change] and the meals." NA-C explained staff did reposition her, at times, but it required "always two people" due to R103 having pain and needing so much assistance with turning. NA-C verified they had helped R103 with morning cares that day (2/25/25), however, when asked about the dry skin on her feet, NA-C responded they had not looked at them. NA-C stated nobody had told them about R103's feet being dry or needing lotion, and verified they only applied lotion "when she [R103] ask." NA-C stated R103 had never asked them personally to apply lotion and reiterated they did not check the skin on her feet with morning cares adding aloud, "No." NA-C stated the nurses were responsible to check the skin on the feet. R103's Treatment Administration Record (TAR),	2 830		

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2 830	Continued From page 5 dated 2/2025, identified all of R103's current treatments ordered along with spaces for staff to record their administration or refusals. The TAR lacked any treatments or monitoring of R103's developed skin condition. On 2/25/25 at 2:19 p.m., licensed practical nurse (LPN)-D was interviewed. LPN-D stated they worked full-time during the week but had only "once or twice I think" seen R103's feet. LPN-D observed R103's feet and verified their condition but added aloud they were "not dry like that" last time they had seen them. LPN-D stated skin, including on the feet, should be checked weekly on "bath day." LPN-D stated R103's care plan intervention to monitor skin during cares should include checking her feet adding aloud, "It should, yes." LPN-D stated the medical record would have any assessed skin condition or subsequent interventions for them would be most likely in the Body Audit forms. LPN-D reiterated they had "not seen her feet dry like that" prior and expressed they were unsure how long they had been in such condition. LPN-D stated nobody had reported R103's feet skin condition to them, however, if they had then it would have been looked at and orders for treatment obtained. LPN-D reviewed R103's medical record, including TAR, and verified no active treatments or monitoring on R103's feet were being done. LPN-D stated they would update the medical provider and get an order for it. LPN-D stated they were unsure why a shower had been recorded (Body Audit 02/25/25) as R103 remained mostly in bed; however, expressed it was important to ensure a skin condition was acted upon timely as R103 was bariatric and had "more possibilities for breakdown." R103's medical record was reviewed and lacked	2 830		

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2 830	Continued From page 6 evidence R103's dry skin on her feet had been identified or acted upon until 2/25/25 despite R103 saying the condition had been present for several weeks, nor despite the care plan directing staff to check R103's skin with cares and direct care staff saying this had not been completed. On 2/26/25 at 1:03 p.m., the assistant director of nursing (ADON) was interviewed. ADON stated skin should be inspected daily while the NA is doing cares. If something "abnormal" was spotted, then it should be reported to the nurse. ADON stated R103 would, at times, refuse cares but acknowledged staff should "look at everybody's skin with cares." ADON stated this was important to do as a skin condition could deteriorate and cause infection adding, "So much worse things that can happen." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for routine skin checks and/or monitoring; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days Based on observation, interview, and document review, the facility failed to implement planned fall interventions for 1 of 2 residents (R125) reviewed for falls. Findings include: R125's quarterly Minimum Data Set (MDS) dated 2/12/25, identified R125 had moderately impaired	2 830		

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2 830	Continued From page 7 cognition and had diagnoses which included cancer, hip fracture, other fracture, personal history of traumatic brain injury, and history of falling. The MDS indicated R125 required substantial and/or maximal assistance with toileting hygiene and transfers. The MDS indicated R125 had two or more falls with no injury since prior assessment. R125's care plan printed 2/24/25, indicated R125 had limited physical mobility with fall risk related to history of falls, and falls were anticipated related to impulsivity, cognition, multiple attempts to self-transfer, and incontinence. Interventions included auto-locking brakes to wheelchair, gripper socks or shoes on at all times, keep wheelchair at bedside when in bed, and identified R125's mobility and transfer needs. R125's nursing assistant care plan sheet updated 2/25/25, indicated R125 was a fall risk and required bilateral grab bars, auto lock brakes, gripper socks, and lock and keep wheelchair at bedside. Review of R125's most recent fall progress notes from 12/1/24 to 2/25/25, identified the following: -12/16/24 at 12:09 p.m., indicated R125 was found sitting on floor in room next to wheelchair with no sign of injuries. -12/17/24 at 8:22 a.m., indicated a Post Fall Data Collection for fall on 12/16/24 at "12:00 a.m.". R125 was found on the floor in their room next to transfer surface with no apparent injury. R125 attempted to self-transfer prior to the fall. Intervention: keep mobility device at bedside. -12/19/24 at 7:49 p.m., indicated R125 was found	2 830		

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2 830	Continued From page 8 on floor in their room, and R125 stated they attempted to self-transfer and the floor was slippery. The bed was lowered to the lowest position, R125 was reminded to use call light for assistance, and the call light was placed within reach. -12/19/24 at 7:51 p.m., indicated a Post Fall Data Collection for fall on 12/19/24 at 6:45 p.m.. R125 was found on floor in their room next to transfer surface with wheelchair and/or bed brakes unlocked and no apparent injury. R125 did not activate call light and attempted to self-transfer prior to fall. Intervention: keep mobility device at bedside. -12/21/24 at 11:59 a.m., indicated a Post Fall Data Collection for fall on 12/21/24 at 8:45 a.m.. R125 was found on floor in their room next to transfer surface with no apparent injury. R125 rolled and/or slid out of bed prior to the fall. Intervention: bed adjusted to appropriate height. -12/21/24 at 12:22 p.m., indicated R125 was found on floor lying on their right side in the room by bedside. R125 stated they attempted to self-transfer and lost balance. Bed was in lowest position, call light was within reach, and resident re-educated to use call light for help. -12/26/24 at 8:53 p.m., indicated R125 was found sitting on the floor hanging onto their wheelchair with no apparent injury. Intervention: continue customer rounds. -12/26/24 at 8:56 p.m., indicated a Post Fall Data Collection for fall on 12/26/24 at 5:30 p.m.. R125 was observed on floor in their room with no apparent injury and attempted to self-transfer prior to fall. Intervention: "Other fall intervention:	2 830		

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2 830	Continued From page 9 [nursing assistant] care plan sheets were reviewed and no changes indicated." -1/13/25 at 5:31 p.m., indicated R125 was found sitting on the floor next to their wheelchair around "4:59 pm" with no injury. R125 attempted to self-transfer to wheelchair. -1/13/25 at 5:38 p.m., indicated a Post Fall Data Collection for fall on 1/13/25 at "4:59 AM". R125 was observed on floor in their room next to transfer surface. R125 did not activate call light, had socks on, and was not wearing proper footwear. R125 attempted to self-transfer prior to fall. Intervention: "Other fall intervention: [nursing assistant] care plan sheets were reviewed and no changes indicated." -2/23/25 at 12:15 a.m., indicated a Post Fall Data Collection for fall on 2/23/25 at 12:15 a.m.. R125 was found on floor at bedside, had bare feet, and had an abrasion (scrapes and scratches) and a laceration (deep cut). R125 was incontinent of urine when assessed following the fall, and attempted to self-transfer and rolled and/or slid out of bed. Intervention: bed adjusted to appropriate height and gripper socks or shoes at all times. -2/23/25 at 2:22 a.m., indicated R125 was found sitting on the floor by bedside and wheelchair and was holding onto the grab bar. R125 had a laceration by their eyebrow and right elbow. Intervention: 72 hour post fall vital signs and neurological exam (tests to monitor mental status, motor function, sensory function, reflexes, and coordination), gripper socks on, monitor eyebrow and elbow daily for signs and/or symptoms of any complication.	2 830		

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2 830	Continued From page 10 During observation on 2/25/25 at 12:51 p.m., R125 was in their wheelchair near the dining area. R125 had on gripper socks, and the wheelchair did not appear to have anti-rollback brakes. During observation on 2/25/25 at 2:08 p.m., R125's wheelchair was not next to their bed and across the room out of reach, facing towards their dresser. R125's wheelchair did not appear to have anti-rollback brakes. During observation on 2/25/25 at 2:26 p.m., R125's wheelchair was in the same position. During observation on 2/25/25 at 2:55 p.m. to 2:56 p.m., R125's wheelchair was in the same position, and a nursing assistant walked by R125's room. During observation on 2/25/25 at 3:06 p.m., R125's wheelchair was in the same position. During observation and interview on 2/25/25 at 3:15 p.m., trained medication assistant (TMA)-A stated they notified the nurse when a resident fell, and the nurse completed documentation about the fall. TMA-A stated they monitored everyone for falls in the memory care area. TMA-A stated R125 was a fall risk and tried to self-transfer to use the bathroom by themselves, and fall interventions for R125 included to assist R125 to bed after lunch, check on R125, and ask if R125 needed to use the bathroom. TMA-A stated fall interventions were listed on care plan sheets. TMA-A entered R125's room, and R125 was standing up next to their bed with their back towards the bedside table and hands holding onto the bedside table. R125 had gripper socks on and shoes of a soft material. One of the shoes was	2 830		

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2 830	Continued From page 11 not connected at a seam. TMA-A moved the wheelchair, which was next to the dresser, assisted R125 to sit in their wheelchair, and offered R125 to use the restroom. TMA-A assisted R125 to the hallway where other residents were, and R125's shoes remained on. TMA-A verified the wheelchair placement away from the bed and by the dresser and stated they kept the wheelchair away from the bed so R125 was not tempted to self-transfer. During observation and interview on 2/25/25 at 3:42 p.m., nursing assistant (NA)-J stated they pulled the emergency light, put a pillow under the resident's head, and called for help when they found a resident on the floor. NA-J stated they know residents' fall interventions by the paper care plan and report from nursing staff. NA-J stated they had checked on R125 around 2:50 p.m., and R125 was in bed. NA-J stated R125 was a fall risk, attempted to self-transfer, and staff were supposed to keep the wheelchair at bedside. NA-J was not sure if R125 had auto-lock brakes on their wheelchair or not. NA-J brought R125 to their room to check for auto-lock brakes with R125's permission. NA-J and TMA-A applied a gait belt to R125, assisted R125 to stand, unlocked the wheelchair, and pushed the wheelchair backwards. NA-J confirmed R125's wheelchair did not have auto-lock brakes and assisted R125 back into their wheelchair. During interview and document review on 2/25/25 at 4:03 p.m., licensed practical nurse (LPN)-E stated they documented about falls and fall interventions in the electronic medical records' "Risk Management". LPN-E stated they checked residents for injuries, movement abilities, and vitals when a resident was found on the floor. LPN-E stated they called the doctor, family,	2 830		

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2 830	Continued From page 12 supervisor, and DON. Staff collected information about what happened prior to the fall and created interventions. Nurses then continued taking vitals and neurological checks if needed. LPN-E stated they knew about fall interventions from their morning and evening meetings and reviewing documentation about falls. LPN-E stated managers and sometimes they health unit coordinator updated the care plans with fall interventions. LPN-E reviewed a care plan sheet updated 2/21/25, and indicated R125 as a fall risk with interventions which included bilateral grab bars, auto lock brakes, gripper socks, and lock and keep wheelchair at bedside. LPN-E confirmed R125's wheelchair did not have auto-lock brakes. During observation on 2/26/25 at 7:35 a.m., R125's wheelchair was out of reach from the bed. During observation and interview on 2/26/25 at 7:41 a.m., LPN-E exited R125's room, and the wheelchair was now by R125's bed. LPN-E confirmed they moved the wheelchair to R125's bedside and stated staff forgot to keep the wheelchair at bedside. During interview on 2/27/25 at 2:26 p.m., the director of nursing (DON) reviewed fall interventions from the Risk Management documents. The DON expected staff to follow R125's care planned fall interventions, which included keeping R125's wheelchair at bedside when in bed and auto-locking brakes to wheelchair. A provided Adverse Event policy dated 2/2021, indicated falls were reviewed to ensure correct interventions occurred.	2 830		

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2 830	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene cares (i.e., nail care, showering, facial hair removal, personal cares, dressing assistance) were offered and/or completed for 4 of 6 residents (R62, R37, R112, R64) reviewed for activities of daily living (ADLs) and whom were dependent on staff for such cares. Findings include:	2 920	Corrected	3/31/25

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2 920	Continued From page 14 R62 R62's annual MDS, dated 1/8/25, identified R62 had intact cognition and had multiple medical conditions including progressive neurological disease, multiple sclerosis (MS), and malnutrition. Further, the MDS identified R62 demonstrated no rejection of care behaviors and required substantial/maximal assistance with personal hygiene cares. R62's most recent Body Audit 11-15-V8, dated 2/21/25, identified R62 had a bed bath completed and listed a section which read, "Nails." The section had questions to be answered by staff about what, if any, cares were completed. This identified R62's fingernails were clean and trimmed, and R62 had allowed the care to be completed. However, on 2/24/25 at 12:51 p.m., R62 was observed lying in bed while in his room. R62 was dressed in a hospital-style gown and had a bedside table pulled over himself at waist level with an opened can of Dr. Pepper on top. R62 had visibly long, soiled fingernails present on both hands with his left hand having black-colored debris around each nail fold (where skin meets nail), and several nails being multiple millimeters (mm) in length. R62 was asked about his nails and looked at them, then expressed aloud, "I want them cleaned." R62 stated he was unsure when his nails were last clipped but expressed he got a weekly bed bath. R62 reiterated he wanted his nails clipped and cleaned when asked. R62's care plan, printed 2/26/25, identified all of R62's actual or potential problem statements along with corresponding interventions for them.	2 920		

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2 920	Continued From page 15 The care plan identified R62 had an ADL self-care deficit and was on hospice care. The care plan outlined R62 preferred to have a bed bath twice weekly and directed, "PERSONAL HYGIENE: Requires substantial/maximal assistance of 1 staff to complete." The care plan lacked any information on R62's nails, including any identified length preference, or evidence R62 refused nail care to be completed. On 2/26/25 at 9:33 a.m., R62 was again observed in bed. R62's nails remained long on both hands, however, the debris which had been present on 2/24/25 (two days prior) appeared lessened. R62 was again asked about his nail length and responded aloud, "They could take care of it [clip them]." Following, on 2/26/25 at 9:34 a.m., nursing assistant (NA)-B was interviewed and stated R62 needed total help with cares. NA-B explained the unit had a bathing schedule but NA-B stated they had not helped him with bathing recently. NA-B stated they were unsure where nail care, if offered and refused, would be documented adding aloud, "I don't know." NA-B then observed R62's fingernails and described them as "long and kinda dirty," adding further, "It needs work." NA-B stated R62's wife visited a few times each week and also, at times, would clip them and clean them. R62's medical record was reviewed and lacked evidence R62 had been offered or had his nails clipped and/or cleaned since 2/21/25, despite having visibly long and soiled nails on both hands which was verified by staff observation. On 2/26/25 at 9:38 a.m., licensed practical nurse (LPN)-D was interviewed, and stated R62 was	2 920		

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2 920	Continued From page 16 "total care" and on hospice services. LPN-D stated they had noticed R62 seemed to be refusing more cares "more recently" and observed R62's fingernails at the request of the surveyor. LPN-D stated R62 had been eating chocolate and that was the reason for them to appear soiled, and expressed they believed hospice had just clipped them the week prior. However, LPN-D acknowledged their appearance and expressed aloud, "They look like they need to be trimmed." LPN-D stated nail care should be completed "with baths" adding "and PRN [as needed]." LPN-D verified if nails were long, they could be clipped whenever needed. LPN-D continued and explained another NA had noticed them long the day prior, however, was unable to locate a clippers to address them. LPN-D then stated they felt R62's nails were not "extremely long for him" and thought they were "looking fine on Monday [2/24/25; also when observed by the surveyor]." LPN-D stated nail care wasn't charted by the NA staff but staff should "look at everybody, everyday." LPN-D stated nails should be kept clean and trimmed "so they [resident] don't scratch themselves." Later, on 2/26/25 at 10:17 a.m., LPN-D approached the surveyor and expressed nail care was charted in the completed Body Audit forms and, again, reiterated someone had clipped them the week prior to their recall. However, LPN-D stated they had just clipped R62's nails prior, and he allowed some of the nails to be addressed. R62's corresponding progress note, dated 2/26/25 at 10:07 a.m., identified text which read, "[R]esident allowed staff to cut nails on left hand and refused nails to be cut on the left [sic] hand." On 2/26/25 at 1:14 p.m., the assistant director of nursing (ADON) was interviewed. ADON	2 920		

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2 920	Continued From page 17 explained nail care should be completed on bath days or when needed. ADON stated the NA should be checking nails with provision of cares and addressing it then, if needed, adding aloud such was "part of the daily cares." ADON stated if R62 consumed chocolate regularly causing his nails to be soiled, then they could also outlined such within his care plan. ADON stated nails should be kept trimmed and clean as someone could scratch themselves or cause infection. ADON added, "Dignity is number one [reason]." A facility' provided Standards Of Care Guidelines policy, dated 7/2019, identified a section labeled, "Care of Body," which directed bathing should be completed as scheduled along with, "G. Assure fingernails are kept clean." R37 R37's annual Minimum Data Set (MDS) dated 12/19/24, indicated R37 had moderately impaired cognition, delusions, verbal behavioral symptoms directed towards others and not directed towards others, and did not reject cares. The MDS indicated diagnoses which included dementia, anxiety, depression, bipolar disease, and psychotic disorder. The MDS indicated R37 required partial and/or moderate assistance with shower and/or bathing self and setup or clean-up assistance with personal hygiene, which included shaving. R37's care plan printed 2/25/25, indicated R37 required assistance with bathing and was setup/clean-up assistance for personal hygiene. R37's care plan lacked information regarding R37's preference on chin hair and did not indicate R37 refused cares, besides wearing hearing aids appropriately.	2 920		

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2 920	Continued From page 18 During observation and interview on 2/25/25 at 2:14 p.m., R37 had approximately 10 gray and brown colored hairs on their chin and stated "I do not like it" about the hair on their chin. During observation on 2/26/25 at 11:00 a.m., R37's chin hair remained the same. During observation on 2/27/25 at 10:27 a.m., R37's chin hair remained the same. R112 R112's quarterly MDS dated 12/19/24, indicated R112 had short and long-term memory problems, severely impaired cognitive skills for daily decision making, inattention, and disorganized thinking. The MDS indicated R112 had verbal behavioral symptoms directed toward others and not directed toward others and rejected cares daily. The MDS indicated R112 had Alzheimer's disease, dementia, depression, and post-polio syndrome (condition which can affect people who have had polio and causes gradual muscle weakness and muscle loss). The MDS indicated R37 had impairment to both lower extremities, used a wheelchair, and was dependent on staff for shower/bathing self and required substantial/maximal assistance with personal hygiene. R112's care plan printed 2/27/25, indicated R112 required assistance with personal hygiene and showers/bathing. The care plan indicated R112 refused cares, showers, and yelled and swore at staff when they attempted to change R112's clothing or visibly soiled brief. The care plan directed staff to provide redirection when R112 had behaviors. The care plan lacked direction or preferences about R112's facial hair. R112's electronic medical record recorded R112	2 920		

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2 920	Continued From page 19 had a shower on 2/13/25, and lacked documentation of R112's chin hair. R112's record further lacked information on whether R112 had a shower or any refusals of shower or chin hair removal after 2/13/25. During observation on 2/24/25 at 5:08 p.m., R112 was in their wheelchair and had a thick amount of multiple chin hairs. R112 was not interviewable. During observation on 2/25/25 at 8:26 a.m., R112's chin hairs were unchanged. A second interview was attempted, and R112 was not interviewable. During observation on 2/27/25 at 10:26 a.m., R112's chin hairs were unchanged. During interview on 2/27/25 at 10:42 a.m., nursing assistant (NA)-I stated if staff saw chin hair on female residents, they took care of it since most residents were not able to shave themselves in the memory care area. NA-I stated they reapproached, reassured, and asked another staff person to help if a resident refused care. NA-I stated they reported to the nurse if reapproaching and reassuring did not work. NA-I stated they did not work with R37 often and had never shaved R37. NA-I confirmed R37's chin hair and stated staff should document if R37 refused shaving when showered, and R37 did not refuse cares. NA-I stated R112 did not refuse cares but had behaviors of yelling and screaming while staff assisted with cares. NA-I stated staff can shave R112 and did not work with R112 this morning. NA-I confirmed R112's chin hair, and stated staff could shave R112. During interview on 2/27/25 at 11:12 a.m., licensed practical nurse (LPN)-E stated staff	2 920		

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2 920	Continued From page 20 documented in resident's medical record if a shower was refused, and staff were to shave female residents' chin hair when noticed. LPN-E confirmed R112's chin hair and stated R112 tried to kick and hit staff away when they helped with cares. LPN-E confirmed R37's chin hair and stated LPN-E did not notice the chin hair from a distance away and did not think R37 would refuse to shave. During interview on 2/27/25 at 12:55 p.m., NA-H stated they reapproached residents who refused care one or two times, asked another coworker to try, and then told the nurse. NA-H stated the facility had an electric shaver and blade they used for shaving. NA-H stated R112 refused cares, screamed and yelled at staff. NA-H stated they tried to shave R112 yesterday, and R112 refused. NA-H was not sure why R112 refused and stated cares depended on R112's mood. NA-H confirmed R37 had a shower yesterday and stated staff were supposed to shave residents on their shower day. NA-H stated R37 refused cares some days. During interview on 2/27/25 at 1:28 p.m., registered nurse (RN)-E stated they documented in resident's body audits if they refused shower or shaving. RN-E confirmed R112 did not have a documented body audit or documentation R112 refused shaving after 2/13/25. RN-E stated R37 had a body audit documented on 2/26/25, and did not indicate if R37 refused shaving. During observation and interview on 2/27/25 at 1:49 p.m., R112 did not have chin hairs. NA-G stated R112 yelled during cares but was cooperative. NA-G stated R112 tried to push their hand away, and then R112 allowed NA-G to shave them. NA-G stated R112 allowed cares if	2 920		

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2 920	Continued From page 21 staff started the cares and did not approach R112 from the front or explain the cares to R112. During joint interview on 2/27/25 at 2:14 p.m. with the director of nursing (DON) and assistant director of nursing (ADON), the DON expected staff to give residents showers weekly and shave female chin hair. The DON expected staff to document refusals, and care planned those who refused cares or shaving of chin hairs. The ADON stated staff followed R112 while R112 wheeled self in wheelchair and R112 refused cares. The ADON expected staff to reapproach R112 when cares refused. The DON expected staff to document if R37 refused to shave chin hair when showered, and residents needed to look clean and presentable. A facility provided Standards of Care Guidelines policy dated 7/2019, identified a section labeled, "Care of Body," which directed bathing should be completed as scheduled along with, "E. Female residents should be assisted as needed with shaving." R64 R64's Minimum Data Set (MDS) dated 12/18/24, indicated moderate impaired cognition, diagnoses of dementia, schizoaffective disorder, bipolar and received antipsychotics on a routine basis. R64 needed substantial/maximal assistance with toileting hygiene and self-cares, and had no documented rejection of cares. R64's care plan printed 2/27/25, indicated a self-care deficit and he was to be dressed and groomed according to personal preference daily as conditions allows. R64 required	2 920		

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2 920	Continued From page 22 partial/moderate assist of one with upper and lower body dressing and supervision/touching assistance of one for personal hygiene. R64 preferred showers at 3:00 p.m., and required assist of one to wash/dry. Nursing assistants were to provide sponge bath on days shower cannot be tolerated, and observe and report changes in skin conditions. Nurse was to provide nail care. Furthermore, the care plan indicated R64 was continent of bowel and bladder, and independent with toileting and hygiene. R64's progress notes dated 2/6/25, indicated resident received a shower, but did not require nail care. R64's progress notes dated 2/7/25, indicated resident walked out of the dining room to the carpeted area, pulled down his pants, and defecated on the floor. When staff intervened, R64 asked where the bathroom was. R64's progress notes skin audit dated 2/13/25, indicated R64 was showered, and that nails were clean and trimmed. Nail care was not needed. R64's nursing assistant task documentation lacked evidence of shower, sponge bath, or nail care from 2/14/25, through 2/26/25. R64's progress notes with nurse practitioner (NP)-A dated 2/19/25 indicated, "writer also noticed pretty long nails and offered to trim, but patient declined". R64's progress notes skin audit dated 2/20/25, indicated resident was not given a shower and that nails were clean and trimmed, and nail care was not needed.	2 920		

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2 920	Continued From page 23 R64's progress notes dated 2/26/25, indicated that registered nurse (RN)-D offered to trim nails, but resident refused nail care and resident would be added to the podiatry list. R64's Toileting task documentation dated 2/26/25, indicated he needed extensive assistance for bladder incontinence twice, at 3:02 a.m. and 12:46 p.m. No other toileting was documented this day. On 2/25/25 at 9:48 a.m., R64 was observed on the couch in the commons area with television turned on. His sweatshirt hood was pulled up, and he appeared to have full facial hair, and ungroomed nails one inch long with debris under the thumb and several fingernails on both hands. His long- sleeved blue hooded sweatshirt had wet or stained areas, his grey sweatpants had tears on the bottom, and his shoes were off and placed under table. R64 wore blue gripper socks and paced from the couch to the hallway. On 2/25/25 at 11:54 a.m., R64 was observed seated at the lunch table. His left leg was wet from groin to knee. On 2/25/25 at 1:07 p.m., R64 continued to pace unit, sweatpants continued to have darkened areas down his left leg. R64 smelled of urine. Staff were present around R64, but did not offer to toilet or assist R64. On 2/25/25 at 1:20 p.m., R64 was observed to lay/sit on couch. His right blue gripper sock had a hole in heel the size of a plum. On 2/25/25 at 2:13 p.m., R64 continued to pace the unit.	2 920		

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2 920	Continued From page 24 During interview on 2/25/25 at 2:18 p.m., RN-D verified R64's bath day was Thursday afternoon., and had not noticed R64's torn sock. On 2/26/25 at 7:12 a.m., R64 was dressed in the same gray sweatpants tears on bottom of pant legs and a long sleeve, navy hooded sweatshirt as the previous day. His fingernails remained as previously described. On 2/26/25 at 11:22 a.m., R64 observed to be dressed in same outfit. No personal cares were documented. During interview on 2/26/25 at 11:35 a.m., with RN-D stated nursing assistants should be charting refused for nail care or not needed. She stated she would talk with the primary nurse this afternoon regarding nail care, and will also attempt to offer nail care after lunch. On 02/26/25 at 11:54 a.m., R64 was observed at lunch table wearing the same clothing and his left leg appeared wet. On 2/26/25 at 1:11 p.m., R64 was observed back on the couch after lunch wearing the same clothes and smelling of urine. The pant leg appeared almost dry, and his fingernails were approximate one inch long. During interview on 2/26/25 at 1:28 p.m., (NA)-F stated R64 was given a bath yesterday 2/25/25, however, nail care was not offered because it was not his regular bath day. NA-F stated, "not gonna [sic] offer all the things" as this shower was extra. NA-F verified that he changed R64's briefs this morning right before breakfast. NA-F stated the resident had a large bowel movement and was incontinent, put his hands up wide, and	2 920		

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2 920	Continued From page 25 stated "boom". NA-F verified that R64 didn't get his clothes changed every day because he refused, and he didn't have many clothes or allow for dressing. NA-F verified the shower was not documented. When asked what should be done if a resident refused to change clothes, NA-F stated there was nothing they could do about that. NA-F verified that he did not report R64 had been in the same clothes from 2/25-2/26 to the nurse, and stated nail care would be done on Thursday evenings by the nurse. During interview on 2/26/25 at 1:31 p.m., RN-D stated she was not aware a shower was given on 2/25, and confirmed R64 was dressed in the same clothing and had a urine odor. During interview on 2/26/25 at 1:47 p.m., assistant director of nursing (ADON) stated the expectation was that staff change residents' clothes if they were soiled or had an odor. If the resident would not allow clothes to be changed the staff member should re-approach. If it was a laundry issue the staff should talk with social work, and if the resident lacked clothing they would get the family involved. If a resident refused to change clothes, the staff member should get someone else to try and maybe there was a reason the resident didn't want that person offering to help. If the resident could not make the decision, it was the staff's responsibility to change them out of odorous and dirty clothes, and to explain to the resident the risk/benefits of being in soiled clothes if they refused. If the nursing assistant could not get the resident in clean clothes, next step is to talk to the nurse who could also get the family involved. It is the expectation that nursing assistant will ask the resident if they want a shower on designated bath day, and if the resident refused or was not	2 920		

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2 920	Continued From page 26 available to receive a shower on designated day, the staff member would offer the shower at the next opportunity. Nail care should be offered with every shower and if resident refused nail care it should be documented as refused. If shower or nail care was completed it was also expected to be documented. On 2/27/25 at 8:18 a.m., R64 was observed to be seated at dining room table in flannel pajama pants, a blue shirt, and blue grip socks. At 10:10 a.m., R64 was seated at the couch. Fingernails continues to appear approximately one inch long with brown colored substance under more than half of the fingernails. No odor was present. Policy-Standard of Care Guidelines dated July 2019 directed, on page two under Care of Body-Part A. Cleanliness-bath/showers as scheduled. This includes body, nails ears, hair. Nails are to be trimmed weekly or more often as needed. Part G. Assure fingernails are kept clean. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for routine bathing, nail care, and facial hair removal; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet	2 965		3/31/25

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2 965	Continued From page 27 which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assessed and ordered nutritional supplement interventions were followed for 1 of 1 resident (R18) reviewed for weight loss. Findings include: R18's annual Minimum Data Set (MDS) dated 11/27/24, identified R18 had severe cognitive impairment and required supervision or touching assistance with eating. R18 had diagnoses which included dementia, peripheral vascular disease, chronic viral hepatitis C, chronic obstructive pulmonary disease, dysphagia, constipation, hemiplegia (partial or total loss of voluntary movement on one side of the body) or hemiparesis (weakness on one side of the body), multiple sclerosis (chronic, autoimmune disease which affects the brain and spinal cord), and schizophrenia. The MDS identified R18 weighed 146 pounds, had sustained no substantial weight loss or weight gain in the previous six months, and had a mechanically altered diet. R18's comprehensive Nutritional Assessment dated 11/25/24, indicated R18's weight was 145.8 pounds, had a check next to "<5% [less than five percent] weight change in 30 days, <7.5% in 90	2 965	Corrected	

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2 965	Continued From page 28 days or < 10% within 180 days", and indicated "sign [significant] weight loss noted at 90 days (-12.8# [pounds], -8%) in the description for "Interventions for unexpected/unintentional weight change". R18's Nutrition Progress Note dated 2/5/25 at 1:24 p.m., indicated the following: "Weight (2/3): 137.6#; 30 days (1/6): 146.2# (-8.6#, -5.8%); 180 days (8/1):158.3# (-20.7#, -13%); height: 64 inches; BMI:23.6. Sign weight loss noted at 30 and 180 days. Intake: 50-100%. Res [Resident] receives weekly weights and a fortified diet. Fortified food at meals to help maintain/ gain weight. Res food will have increased calorie and protein during meals by providing liquid butter/oils, cream, milks, and gravy. RD [registered dietician] recommends magic cup BID r/t [twice a day related to] sign weight loss" .... "RD updated [nurse practitioner] r/t weight loss. RD will continue to monitor weights, intakes, labs, and skin." R18's care plan printed 2/26/25, indicated R18 had a potential nutritional problem. The care plan indicated several interventions which included evaluate weight changes, determine percentage lost/gained and follow facility protocol for weight loss, observe fluid intake, observe/document/report to medical practitioner as needed for signs/symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss defined as 3 pounds in one week, greater than 5% in one month, greater than 7.5% in three months, or greater than 10% in six months, use of nosey cup and scoop plate, fortified diet, observe weight per protocol or as ordered and record, registered dietician to evaluate and make diet change recommendations PRN (as needed), supervision	2 965		

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2 965	Continued From page 29 during meals, etc. R18's orders printed 2/26/25, indicated the following: -8/27/24, regular diet, pureed texture, nectar consistency. -10/1/24, weight weekly for nutritional risk per registered dietician in the morning every Monday. -10/9/24, registered dietician recommends fortified diet for recent weight loss. -2/5/25, magic cup supplement two times a day for routine signs of weight loss per dietician. During breakfast observation on 2/26/25 at 8:22 a.m., R18 was up and dressed at the breakfast table. R18 had oatmeal, pureed breakfast items, and "nosey cups" with thickened liquids. Throughout breakfast observation, no supplement was given to R18. During observation on 2/26/25 at 9:47 a.m., R18 was in the television room and was not drinking anything. During observation on 2/26/25 at 11:50 a.m., R18 had a chocolate pudding cup before a pureed meal was provided to them. During interview and document review on 2/26/25 at 12:02 p.m., registered nurse (RN)-F stated R18 did not have any scheduled supplements. RN-F checked R18's medication and treatment administration record and a documentation field which directed staff to give R18 a magic cup was marked as given. RN-F stated R18 usually received a magic cup in the morning with breakfast, and nursing staff usually delivered the magic cup to R18. When asked about whether R18 received their magic cup this morning, RN-F stated R18 must have gotten the supplement but	2 965		

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2 965	Continued From page 30 was not sure. RN-F stated the nursing assistants knew about R18's supplement and usually provided the supplement to R18 at breakfast. During interview on 2/26/25 at 12:26 p.m., dietary aide (DA)-A stated they brought supplements from the main kitchen to the second-floor refrigerator in the dining area. DA-A stated the supplements brought up this morning were still in the refrigerator. During interview on 2/26/25 at 12:30 p.m., nursing assistant (NA)-H stated nursing assistants sometimes gave residents their supplements in the morning or as desserts. NA-H did not give any magic cups to residents during their shift thus far. During a joint interview on 2/26/25 at 12:33 p.m., NA-Q and NA-R stated supplements came from the kitchen, and nursing assistants gave supplements to residents if the supplement was labeled with the residents' name. NA-Q and NA-R stated they did not give any residents magic cups during their shift thus far. During interview on 2/26/25 at 12:34 p.m., DA-A stated they did not see any magic cups in the main kitchen so only brought up ensure, boost, and pudding this morning. DA-A stated no one had asked them about a magic cup so far during their shift. During interview on 2/27/25 at 11:05 a.m., licensed practical nurse (LPN)-E stated nurses gave residents supplements according to the orders written by the dietician. LPN-E stated the kitchen refrigerator had supplements labeled with residents' names and which shift the supplement should be given. LPN-E stated they had to go	2 965		

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2 965	Continued From page 31 downstairs to the main kitchen when a resident's supplement was not in the second-floor refrigerator. During interview on 2/27/25 at 2:55 p.m., the director of nursing (DON) expected staff to give residents their ordered supplements or document if resident refused. DON expected nurses to ensure residents got their supplement, since they were the ones to sign the supplement as given. DON stated weight loss and not meeting nutritional needs were a risk when residents did not get their supplements as ordered. A provided Weight Monitoring and Nutrition-at-Risk policy dated 6/2023, indicated residents with undesired downward trends in their weight were monitored until the resident's condition resolved or stabilized and immediate interventions were implemented by the facility, as appropriate, to prevent further decline. The policy gave examples of interventions, which included supplements. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items and/or nutritional supplements given, offered, or consumed by residents are implemented as identified or ordered. The facility should report	2 965		

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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) COMPLETE DATE
2 965	Continued From page 32 those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who required assistance during mealtime on a locked dementia unit had a dignified dining experience. Findings include: During observation on 2/24/25 at 5:18 p.m., nursing assistant (NA)-A and NA-N prepared the dining area and residents for a meal. NA-A was passing out desserts and drinks to a table with two residents, and NA-N was approximately ten feet away near the steam table. NA-A stated to NA-N, with two tables of residents in between them, to set-up all the "feeders" first. During interview on 2/24/25 at 5:38 p.m., NA-N stated they usually served residents who needed assistance last so they could assist them right away, but they had extra help so could assist	21805	Corrected	3/31/25

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	00096	A. BUILDING: _____ B. WING _____	C 02/27/2025

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21805	Continued From page 33 those who needed help first. NA-N acknowledged NA-A used the term "feeders" and stated the term was wrong to use and they could have used a better term instead. NA-N stated private information was usually discussed one to one and not across the room but sometimes comments were made from across the room in the memory care area. NA-N stated there were approximately five residents who needed assistance with eating. During interview on 2/27/25 at 10:36 a.m., NA-I stated "feeders" was a term for babies and did not use the term. NA-I stated residents on the memory care area may not respond to someone who used the term "feeders" but it may make the residents feel like they were babies. During interview on 2/27/25 at 11:00 a.m., licensed practical nurse (LPN)-E stated the term "feeders" was not a "good one", and the term would make residents "feel bad". LPN-E compared the term to how staff used "clothing protector" instead of "bib". During interview on 2/27/25 at 2:43 p.m., the director of nursing (DON) agreed use of the term "feeders" was not dignified. A provided care sheet dated 2/25/25, identified a total of six residents needed assistance of one with eating. A provided Standards of Care Guidelines dated 7/2019, directed staff to care for residents in a manner which promoted maintenance, dignity, or enhancement of each person's quality of life.	21805		

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21805	Continued From page 34 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's advance directives was accurately and consistently	21840	Corrected	3/25/25

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21840	Continued From page 35 documented in the resident's electronic health record (EHR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the residents wishes would be followed in the event of a cardiac arrest for 1 of 33 residents (R84) whose code status was not accurately documented and was reviewed for advanced directives. Findings include: R84's admission Minimum Data Set (MDS) dated 2/4/25, indicated R84 had intact cognition and had been admitted to the facility on 1/29/25. R84's Transfer/Admission orders dated 1/29/25, indicated R84's code status was a full code with the page signed by the provider on 1/28/25. The report then indicated a copy of a signed POLST was still needed and this would need to be done by a provider, with the page signed on 1/29/25. R84's POLST dated 1/29/25, indicated DNR/allow natural death and was signed by R84 and nurse practitioner (NP)-A on 1/29/25. This POLST was found in both the EHR and paper chart with no further POLSTs found. R84's progress note dated: -1/29/25 at 3:20 p.m., indicated data was collected for R84's admission by nursing staff and R84's code status was DNR. -2/3/25 at 3:17 p.m., indicated R84's advanced directive could be found on her POLST and had the code status was DNR. -1/29/25 through 2/24/25 were reviewed and lacked documentation to support the resident wished to receive CPR if she was found with no pulse and was not breathing.	21840		

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21840	Continued From page 36 R84's provider note dated 2/5/25, indicated R84 had recently moved to the facility from her home in the community due to an increased level of care need. The note indicated R84 was a Jehovah's Witness and was excited to talk with another "Witness" who lived in the building. The note listed R84's code status as DNR. The note indicated R84 was diagnosed with diabetes, a heart arrhythmia (the heart beats with an abnormal rhythm), and obstructive sleep apnea (OSA, repeatedly stopping and starting breathing while sleeping). R84's care plan dated 2/5/24, indicated R84's code status could be found on her POLST and the goal of the care plan was to have her code status wishes honored. The care plan indicated that code status would be reviewed quarterly and as needed with the resident/resident representative. The care plan indicated R84 followed Jehovah's Witness practices, and the facility would help to coordinate visits with spiritual leaders from the same faith. R84's Care Conference Summary dated 2/12/25, indicated a care conference was held with R84 attending. The note indicated R84's advance directives were reviewed with her, and no changes were needed to the "DNR" status. R84's order summary dated 2/23/25, included an order, "code status: full code", that was dated 1/29/25. R84's EHR banner, printed on 2/24/25, indicated R84's code status was full code. R84's clinical profile in the EHR, printed on 2/26/25, indicated R84 was her own representative.	21840		

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21840	Continued From page 37 During an interview on 2/24/25 at 4:01 p.m., R84 confirmed she would not want to be resuscitated if she was found with no pulse and was not breathing. R84 stated she was one of Jehovah's Witnesses as part of her religious belief she would want to enter the "future world" if it was her time and would not want "to suffer" by being resuscitated. During an interview on 2/24/25 at 4:09 p.m., licensed practical nurse (LPN)-B stated he was not R84's nurse but if a resident was found pulseless and not breathing, he would look at the POLST in the "hard chart" to determine if CPR should be initiated. During an interview on 2/24/25 at 4:37 p.m., LPN-A stated she was R84's nurse this shift and although both the POLST or the EHR banner could be referenced to determine code status, she would reference the EHR banner to see if R84 needed to be resuscitated because it was easier to access. LPN-A stated that R84 was a full code per the EHR banner and the provider order so she would initiate CPR if R84 was found pulseless and not breathing. When asked to review R84's POLST, LPN-A exclaimed "ooooh" and stated the POLST indicated R84's code status was DNR and believed this was the accurate code status. LPN-A stated she would be "worried" staff would perform CPR on R84 against her wishes because of the mismatch. During an interview on 2/24/25 at 5:09 p.m., health unit coordinator (HUC)-A stated when a resident was admitted, she would reference the hospital paperwork or admit orders to determine the code status to enter into the EHR until a POLST was reviewed with the resident and	21840		

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21840	Continued From page 38 signed by the provider. HUC-A stated she was in charge of uploading POLSTs to the EHR and updating the physician order/EHR banner after reviewing the POLST. HUC-A confirmed R84's EHR banner/provider order did not match R84's most recent POLST. HUC-A stated she thought R84's accurate code status was DNR. HUC-A stated she was unsure how updating the EHR banner/provider order was missed after R84's POLST was completed. HUC-A stated she was supposed to be completing audits every two weeks to ensure resident code status in the EHR matched the POLST. HUC-A stated these audits had not been completed since R84 had been admitted in January as she felt they were "pretty short-staffed" and did not feel she had time. During an interview on 2/24/25 at 5:09 p.m., LPN-C stated if a resident was found pulseless and not breathing, she would check their code status on the EHR banner, and if the banner said Full code, she would start CPR. During an interview on 2/24/25 at 6:19 p.m. with the director of nursing (DON) and the administrator, the DON stated if a resident was found pulseless and not breathing, staff could look at either the POLST or the EHR banner/provider order as they should all match, to determine if CPR should be initiated. The administrator stated that R84's profile or face sheet could be referenced to determine if the resident was her own representative and confirmed that she was. The DON stated that the HUCs were in charge of completing audits to ensure the POLST and the EHR banner/provider order indicating code status, matched. The DON stated as this was an informal process, the frequency of these audits did change based on results and the DON thought audits were being	21840		

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21840	Continued From page 39 completed monthly. The DON stated the health information system supervisor (HISS) oversaw ensuring these audits were being completed. On 2/24/25 at 7:27 p.m., the DON stated she had reviewed her emails and confirmed that code status audits were to be completed every two weeks, not monthly, and these were not completed for the floor R84 resided so far this month. During an interview on 2/24/25 at 6:42 p.m., the HISS stated the HUCs were supposed to complete audits or resident code status every two weeks. HISS stated he and the DON had decided on the audit frequency when the HUC checklist was updated in January and confirmed that audits were to be completed every two weeks to ensure EHR code status accuracy. During an interview on 2/24/25 at 7:29 p.m., the social services director (SSD) stated social workers reviewed code status wishes with residents at their care conferences and would review the POLST to see if it needed to be updated to honor the resident wishes. The SSD confirmed that R84 had wished to be DNR on her care conference on 2/12/25 and was her own decision-maker. During an interview on 2/25/25 at 1:30 p.m., registered nurse (RN)-C, the staff development coordinator stated she had assisted in educating staff members on the advance directive process. RN-C stated either the HUC, if working, or the nurse on duty would be in charge of ensuring when a new POLST was obtained, that the EHR banner/provider order matched the updated POLST. During an interview on 2/26/25 at 9:42 p.m., NP-A	21840		

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21840	Continued From page 40 stated that on 1/29/25, she had a conversation with R84, as she was her own decision-maker, about her wishes in the circumstance that her heart stopped beating and she stopped breathing. NP-A stated R84 indicated she would not want to be resuscitated related to her religious beliefs. NP-A stated that it was important that R84's wishes to allow a natural death were honored as CPR would be a "violent death" for R84 and R84 had made it clear she did not want a "violent death". NP-A stated once she completed a POLST with a resident she would attach it to the resident's hard chart for the HUC to upload but did not go in herself and verify that the provider order matched the updated POLST as she expected the HUC to do this. NP-A stated after the "communication error" involving R84's code status order being a full code instead of being updated to a DNR, she would now ensure the EHR provider order matched the POLST after she completed a POLST with a resident. The undated HUC Job Description, indicated the HUC would complete daily, weekly, and monthly audits as directed. The HUC Duties Checklist revised on 1/2/25, indicated POLSTs were to be audited every two weeks, on the first and third Friday of every month. The facility's Advanced Care Planning and POLST policy dated 12/18, indicated when the need for resuscitation occurred, the physician order, CPR/DNR section of the health care directive, and/or the POLST would be followed. The policy indicated if a resident was admitted with a signed POLST, it would be honored during the initial assessment period and a designated staff member must review the POLST with the	21840		

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21840	Continued From page 41 resident as soon as possible to ensure its accuracy. The policy indicated the physician would review the POLST with the resident within the 14-day assessment period as part of the comprehensive assessment. The facility's Cardiopulmonary Resuscitation policy dated 12/18, indicated that if a resident experienced cardiac arrest, facility staff would provide basic life support, including CPR in accordance with the resident's advanced directives. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review the facility policy related to advanced directives and provide education to all staff. The quality assurance designee could monitor records for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	21840		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal	21860		3/31/25

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21860	Continued From page 42 interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This had the potential to affect all 72 residents of the second and third floor whose personal information was listed on exposed care sheets. Findings include: During continuous observation on 2/24/25 starting at 3:24 p.m., licensed practical nurse (LPN)-A locked the medication cart, closed the laptop screen, and left the medication cart with 2 North nurses' worksheet unattended face up. Information included name, room number, sleep/wake preferences, assistance needed with dressing, grooming bathing, toileting, including continence of bowel and bladder, turning assistance needed, mobility devices, diet, assistance needed with meals, skin integrity issues such as wounds, and personal interests such as puzzles, music, religious services, and reading books. -at 3:31 p.m., two staff members walked past the	21860	Corrected	

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21860	Continued From page 43 unattended care sheet. During observation and interview at 3:43 p.m., LPN-A walked back to the medication cart with unattended care sheet and stated, "the care sheet should not be left like that because people could look at the private information" and "care sheet has their [resident] name and it has patient identifying information. HIPAA problem." During continuous observation on 2/25/25 at 8:12 a.m., a medication cart was observed with 2 South nurses' worksheet unattended face up. Information included name, room number, sleep/wake preferences, assistance needed with dressing, grooming bathing, toileting, including continence of bowel and bladder, turning assistance needed, mobility devices, diet, assistance needed with meals, skin integrity issues such as wounds, and personal interests such as puzzles, music, religious services, and reading books. -at 8:14 a.m., a housekeeper pushing a cart walked past the unattended worksheet. -at 8:15 a.m., a resident with wheeled walker walked past the unattended worksheet. -at 8:18 a.m., a staff member walked past the unattended worksheet. -at 8:26 a.m., another staff member walked past the unattended worksheet. During observation and interview at 8:32 a.m., registered nurse (RN)-B walked up to the medication cart with unattended worksheet and stated, "[care sheet] should not be left like that because it has private information that should not	21860		

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21860	Continued From page 44 be seen by anyone except me." During interview with director of nursing on 2/27/25 at 10:35 a.m., DON stated the nursing care sheets, "should be flipped [sic] over" and not visible to unauthorized staff. DON stated, "it's a constant battle" and facility was "leaving reminders around" to staff to cover unattended patient identifying information. Facility policy on privacy practices was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of complaince with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860		

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K 000	INITIAL COMMENTS Initial Comments Section FIRE SAFETY An annual Life Safety Code survey was conducted on 02/25/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Providence Place was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2025**

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K 000	Continued From page 2 one building. The building is fully protected throughout by an automatic fire sprinkler system. 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 capacity of 190 beds and had a census of 154 at the time of the survey.	K 000		
K 311 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include:	K 311	K311 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	3/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2025**

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

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K 311	Continued From page 3 On 02/25/2025, between 10:00 AM and 12:30 PM, observations and staff interview revealed that there was a ceiling tile missing in the hallway near room 36 in the basement. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Executive Director and the Assistant Executive Director verified this deficient finding at the time of discovery.	K 311	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. The affected area immediately received the missing ceiling tile. 2. Facility completed audit of basement hallways for ceiling tiles. 3. Maintenance staff re-educated on fire code and ensuring proper ceiling tiles are in place. All staff educated on importance of ceiling tiles and to notify maintenance team if any areas are in need of replacement. Maintenance Director of designee will conduct random monthly audits of facility ceiling tiles x3 months. Results will be brought to monthly QAPI meetings for further review. 4. Maintenance Director or designee. 5. Date of completion: March 31, 2025	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101	K 345	K345 The preparation of the following plan of correction for this deficiency does not	3/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 4 (2012 edition), Life Safety Code, sections 33.2.3.4.1, 9.6, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 10:00 AM and 12:30 PM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review at the time of the survey. An interview with the Executive Director and the Assistant Executive Director verified this deficient finding at the time of discovery.	K 345	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. Facility immediately reached out to contracted fire protection company to obtain completed reports from the fire panel. 2. Facility completed audit to ensure that no fire alarm sensitivity test results are missing from the most current service. Maintenance Director or designee will obtain all fire alarm sensitivity reports moving forward. 3. Maintenance Director or Designee. 4. Date of completion: March 31, 2025	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 9, 2025

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: February 27, 2025

Dear Administrator:

On March 11, 2025, we notified you a remedy was imposed. On April 2, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 31, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 26, 2025 be discontinued as of March 31, 2025. (42 CFR 488.417 (b))

In our letter of March 11, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 26, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 9, 2025

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

Re: Reinspection Results
Event ID: DLFO12

Dear Administrator:

On April 2, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us