Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2025

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

RE: CCN: 245271
Cycle Start Date: April 14, 2025

Dear Administrator:

On May 2, 2025, we notified you a remedy was imposed. On May 16, 2025 the Minnesota Department of Health 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 May 15, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 17, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 2, 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 April 14, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 3, 2025

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

Re: Reinspection Results
Event ID: DW1E12

Dear Administrator:

On May 16, 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 April 14, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
May 2, 2025

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

RE: CCN: 245271
Cycle Start Date: April 14, 2025

Dear Administrator:

On April 14, 2025, survey was completed at your facility by the Minnesota Department of Health 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 both substandard quality of care and 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 April 11, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices 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 May 17, 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 May 17, 2025, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 17, 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Providence Place is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 14, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 October 14, 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:

tamika.brown@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 tamika.brown@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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: DW1E11

Dear Administrator:

The above facility was surveyed on April 7, 2025 through April 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308   Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: ______ B. WING ______	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER: **PROVIDENCE PLACE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **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) COMPLETE DATE
2 000	Initial Comments	2 000		

*****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 4/7/25, 4/8/25, 4/9/25, 4/10/25, & 4/14/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H52712287C (MN00111778) with a licensing order issued at 0830. 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 surveyor ' s 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 14-01, available at <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 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. The facility is enrolled in ePOC and therefore a signature is	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	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 comprehensively assess supervision needs and develop individualized person-centered interventions to identify and mitigate risks and hazards for residents when out in the community and upon subsequent return to the facility. This failure resulted in the risk of serious harm, injury, or impairment for 3 of 3 residents (R2, R3, R1) reviewed for safety.	2 830	Corrected	5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 3	2 830		

The immediate jeopardy began on 2/27/25 when the facility failed to ensure a systematic process of an individualized community safety assessment to identify potential risks or establish prevention strategies to ensure resident safety for R2 who had vascular dementia and required supervision, R3 who had significant current alcoholism with impaired insight, judment, and memory, and R1 who had substance abuse disorder (SUD) with cognitive impairment and mobility limitation.

The IJ was identified on 4/10/25. The executive director (ED), director of nursing (DON), assistant executive director, and administrative intern were notified of the immediate jeopardy on 4/10/25 at 5:53 p.m. The immediate jeopardy was removed on 4/11/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R2's hospital discharge summary dated 11/5/24 to 11/8/24, indicated R2's past medical history included, abnormal urination (history of incarceration for public urination), aggressive behavior of child (history of physical fights), anxiety disorder, counseling on substance use and abuse (chemical dependency treatment 8 times), family history of suicide, history of psychiatric hospitalizations, intravenous (IV) drug user, self-mutilation, substance use disorder (SUD) - (history of IV heroin, cocaine and alcohol use), and suicidal behavior (R2 reported history of chronic suicidal ideations since 2005). Hospital course identified R2 had failure to thrive,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 04/14/2025

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

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2 830	Continued From page 4	2 830		

indicating R2 was reportedly altered, covered in feces, urine and had wandered into a shelter confused, according to the shelter. R2 was discharged to skilled nursing facility.

R2's Nurse Practitioner (NP) visit dated 1/6/25, identified R2 had a Saint Lewis University Mental Status (SLUMS) score of 23/30 showing moderate dementia. R2 could live in supportive housing, waiting on assisted living facility (ALF) setting which continues to be appropriate based on scoring. Assessment/Plan identified diagnosis of primary moderate vascular dementia with mood disturbance (moderate degree of cognitive impairment due to vascular disease, accompanied by mood changes with symptoms that may include difficulties with problem-solving, slowed thinking, and loss of focus): mood disturbances longstanding depressive disorder, history of homelessness, recommendation for assisted living setting for future housing.

R2's ACP visit dated 1/8/25, identified R2's mental status exam indicated short term memory and insight/judgement was impaired and thought content was blocked. R2's treatment recommendations/plan identified R2 would present as someone who would benefit from remaining in a secure structured setting to support best functioning and quality of life. Strategies to support him to maintain his sobriety area warranted including placement considerations given his history and level of cognition.

R2's quarterly Minimum Data Set (MDS) dated 2/11/25, indicated R2 admitted to the facility on 11/8/24 and identified R2 had moderate cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

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R2's care plan focus dated 2/21/25, identified R2 had cognitive loss/dementia or alteration in thought processes. Interventions included to cue and supervise as needed and observe/document/report to medical practitioner any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. The care plan lacked evidence of interventions related to safety in the community and did not identify if R2 was safe to be independent in the community or not.

R2's progress notes were reviewed in conjunction with facility sign out/sign in forms between 2/27/25 through 4/8/25. Progress notes identified multiple occurrences of R2 leaving the facility without indication that he was supervised. Further identified R2 did not complete the sign-out sheet, notify staff he was leaving, or inform staff of his whereabouts, who he was with/if he had supervision, his expected time of return, and his actual return.

R2's progress note dated 2/27/25 at 3:55 a.m., identified R2 was unable to be located, a thorough search of the entire facility including all common areas, rooms, bathrooms, outdoor areas was conducted. A missing person's report made to the police department and the facility DON/supervisor notified. At 4:38 a.m., police came to the facility and gathered more information for R2. At 8:00 a.m., R2 was at the ED with complaints of SOB. ER was assessing and send R2 back to the facility later this morning At 11:10 a.m., R2 returned to the facility via ambulance. The progress notes indicated staff did not know when he was last seen until 3:55

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a.m.; R2 was out of the facility and missing for at least 4 hours before the facility identified R2 was at the hospital. R2's record did not include a comprehensive community safety assessment that would identify individualized interventions for R2's safety in the community and/or ability to be unsupervised while out of the facility.

R2's progress note dated 3/3/25 at 2:55 p.m., per report R2 last seen at 12:25 p.m. R2 had left the facility. At 3:44 p.m., writer began petition for guardianship for R2. At 4:21 p.m., R2 had not returned to the facility, did not sign out when he departed at 12:25 p.m. At 8:53 p.m., R2 had not returned to the facility yet, last seen at 12:25 p.m., call placed to family with concerns of whereabouts. According to family they have no idea of R2's location. Calls placed to hospitals with no admission record for R2. At 10:50 p.m., R2 had not yet returned to the facility, oncoming night shift nurse updated to call police if not returned to facility by midnight. On 3/4/25 at 12:15 p.m., R2 had not returned yet to the facility ...a call placed to 911 about 12:15 a.m., to report R2 as missing. Police arrived at the facility around 12:55 a.m., gathered all necessary information about R2 missing. On 3/4/25 at 5:45 a.m., R2 was found lying in bed (at the facility) at this time. R2's progress notes identified R2 was gone for 17 hours and 15 minutes and R2's whereabouts were unknown.

R2's occupational therapy (OT) encounter note dated 3/14/25, identified R2 had a SLUMS assessment completed that he scored a 19/30 (score under 20 identified cognitive impairment or potential dementia). Most of R2's points were lost on recall of objects. R2 engaged in community outing involving indoor and outdoor ambulation, wheelchair management (pushes w/c in front of

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him like a walker), uneven surfaces, dressing, toileting (both independent), money management, social interaction, managing both his device and hot coffee (he did without spilling or burning himself) and general community safety. R2 was educated about therapy trying to get him out of memory care and into a more appropriate setting. Plan: continue functional cognitive assessments and functional mobility.

R2's progress note dated 3/14/25 at 11:16 a.m., met with R2 discussed sign out policy when leaving facility and calling if not making it back timely, R2 agreed, writer will assist with ordering a free cellphone. At 9:22 p.m., day shift nurse reported that R2 went outside to smoke. He signed out at approximately 5:30 p.m. However, R2 had not returned, writer called R2's family left message informed shift supervisor. Supervisor stated to wait until midnight if R2 does not return by then will report as a missing person. At 1:12 a.m., R2 did not return to facility, missing person report filed ...At 6:26 a.m., two police officers came to the facility, all necessary information given. On 3/15/25 at 9:33 a.m., hospital emergency room called and stated R2 was being admitted for respiratory difficulty ...At 8:35 p.m., R2 returned to the facility via ambulance. R2's progress notes indicated he was missing and whereabouts unknown for approximately 15 hours.

R2's progress note dated 3/17/25 at 12:45 p.m. staff seen R2 at bus stop, R2 stated he was going to the store via a bus and intended to be back by dinner time. At 5:57 p.m., received phone call from metro transit police said R2 was lost and unable to go back. R2 will be sent back. At 6:31 p.m., R2 was sent back by metro transit police, was found on Penn Avenue/Lowrey Avenue

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southbound bus stop shelter waiting for a bus. R2 was alert and oriented x 2, denied alcoholic drink, R2 stated he checked out before he left, writer unable to find where R2 signed. Progress note dated 3/18/25 at 12:45 p.m., writer applied for an assurance wireless phone for R2 should arrive within 7-10 business days. R2's progrss notes identified R2 was gone for approximately 5.5 hours whereabouts unknown, and identified R2 was lost and unable to make his way back to the facility and the police brought him back.

R2's progress notes dated 3/28/25 at 1:39 a.m., R2 was not in room for scheduled inhaler for COPD. At 2:02 a.m., writer got report from previous shift that R2 had not been seen in the facility since this morning. Writer checked around facility and not available. Writer called 911 and filed a missing person report with police. They will send police out as soon as possible. Writer called family and left message. At 2:50 a.m., police stopped at the facility requesting information regarding R2. Police stated to call and let them know when R2 returns so they can take him off the missing person report. At 10:33 a.m., identified R2 was on LOA. At 2:15 p.m., identified R2 returned to the unit between 1:00 p.m., and 1:30 p.m., R2 went to bed and was sleeping, message left with family that R2 was back. At 2:27 p.m., writer educated R2 on the importance of signing out, R2 stated, "okay..." R2's progress note identified on 3/28/25, R2 was missing for approximately 12 hours and his whereabouts unknown.

-On 4/4/25 at 7:09 p.m., identified R2 was not in the facility until dinner time and med pass time. Tried to contact him through cell phone but did not answer, will continue to follow up. At 11:47 p.m., R2 was not in the facility, called and left

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voice message incoming nurse updated. On 4/5/25 at 1:12 a.m., writer called R2's phone again and phone went to voicemail left message for call back. Called and filed a missing person report with police. Stated they would send officers to come to the facility, called family, left voicemail. At 1:30 a.m., police called to inform they will be sending an officer to the facility. At 6:00 a.m., police stopped by to see if R2 was back. At 3:02 p.m., R2 has not returned to the facility, family notified. On 4/6/25 at 12:08 a.m., R2 has not returned to the facility. At 6:42 a.m., R2 did not return to the facility will update incoming nurse. At 12:42 p.m., nurse received a call form the hospital regarding R2's admission due to COPD exacerbation and pneumonia will be arriving back to the facility with medications after 1:00 p.m. At 1:45 p.m., R2 returned from the hospital to the facility at 1:40 p.m., Temperature was 99.1, pulse 105, oxygen saturations 94% on room air and blood pressure was 112/67, no complaints of pain or discomfort.

R2's After Visit Summary (AVS) dated 4/5/25 to 4/6/25 identified R2 was in the hospital for treatment of COPD exacerbation. Summary included The patient presented to the ED due to new onset shortness of breath and mild cough over the past two days. R2 reported he was out of his as needed inhaler and R2 is most likely experiencing exacerbation of COPD due to lack of medication with a possible component of community acquired pneumonia. R2 was discharged with medications to treat this and will have an upcoming appointment with pulmonology on 6/3/25.

R2's medical record identified R2 was gone from facility from 4/4/25 at approximately 7:00 p.m., and returned to facility on 4/6/25 at 1:45 p.m.,

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2 830	Continued From page 10 gone for approximately 42 hours and 45 minutes. R2 was hospitalized from 4/5/25 at 3:11 p.m., and discharged from the hospital on 4/6/25 at 12:58 p.m., accounting for approximately 22 hours of hospitalization, with 22 hours of R2 missing and whereabouts unaccounted for. R2's progress notes dated 4/8/25 at 12:25 a.m., per PM nurse R2 was last seen around noon (on 4/7/25) on the floor ...R2 not on the floor/room. R2's personal cell phone was left in his room. At midnight a call was placed to police and hospital, was not found, filed missing person report. Night supervisor was updated. At 4:27 a.m., two police officers followed up on missing person report ...At 9:03 a.m., R2 returned to the facility, writer had conversation with R2 regarding the importance of signing out and ensuring he has his cell phone with them to keep the facility updated. R2 was in agreement. R2s progress notes identified R2 was gone from facility from 4/7/25 at approximately 12:00 p.m., and returned to facility on 4/8/25 at 9:03 a.m., gone for approximately 21 hours with whereabouts unknown. During an interview on 4/9/25 at 12:38 p.m., registered nurse (RN)-A stated all residents can leave the building anytime they want unless they reside on the secured unit. RN-A further stated all they must do is sign in/out on the sign out book. RN-A indicated they would not notice a resident was gone unless they went to go give their medications and could not find them. RN-A stated if a resident was not back by midnight, and we could not get a hold of them we would file a missing person's report with the police and document in the nurse's progress notes. During an interview on 4/9/25 at 4:28 p.m., OT-A stated a resident's cognition will be assessed on	2 830		

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2 830	Continued From page 11 admission, the social worker would first screen a resident to get a snapshot of their cognition by performing a Brief Interview for Mental Status (BIMS) assessment. OT-A stated this was used to assess for delirium and was not a true show of cognition. OT-A stated the SLUMS exam is a brief screening test for detecting mild cognitive impairment and dementia and assess for orientation, short term memory, calculation and language-verbal fluency. OT-A indicated if the SLUMS score is less than 20 it can indicate dementia and require further cognitive testing. OT-A stated she assessed R2's SLUMS on 3/13/25 and he scored a 19 out of 30 indicating dementia. OT-A stated the Cognitive Performance Test (CPT) assesses a person's cognitive abilities, like memory, attention, and reasoning, through various tasks and questions without being able to the cue the individual. OT-A stated the CPT assessment can be used to diagnose cognitive impairments like dementia and guides interventions and support for persons with cognitive challenges. OT-A indicated the CPT assessment takes about an hour to complete so rarely was utilized in the long-term care setting as it was unrealistic. OT-A was unable to articulate what staff at the facility would be responsible to assess a resident's safety in the community. OT-A identified R2 did not have a CPT assessment, stated she did assess R2 while he was in the community on 3/14/25, and completed a SLUMS assessment with a score of 19/30 that indicated cognitive impairment but was unable to articulate if R2 was able to be safe in the community independently while residing at the facility. OT-A stated R2's short-term memory was not intact and if she was doing a discharge to home assessment on R2, he would require supervision.	2 830		

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2 830	Continued From page 12 During a phone interview on 4/10/25 at 8:29 a.m., when asking nurse practitioner (NP)-A if the facility was responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address the risk. NP-A stated he was not involved in the process in the identifying and assessing the resident's risk for leaving the facility and the development of associated safety interventions. NP-A stated that all residents that do not reside on the locked unit are able to come and go into the community from the facility and would require the resident to put the date and time they are signing out, where they are going and what time the expected return is. NP-A further stated they cannot stop residents from coming and going as it is their right, stated, "this is not a prison." During an interview on 4/10/25 at 9:20 a.m., the medical director stated the process for a resident to leave the facility was all the residents that did not reside on the locked unit use a sign in and sign out process. Medical director stated, "we are not a prison, we cannot stop someone from coming and going unless they are in a locked unit." Medical director further stated if a resident was their own decision maker we are assuming they have capacity to go safely in the community unsupervised. Medical director further stated the BIMS assessment was not comprehensive in determining a resident's cognition and to determine true cognition it would be a combination of cognitive tests that include a CPT, SLUMS and the Allen Cognitive Level Screen (ACLS) assessment. Staff did not routinely assess cognition upon admission unless warranted. Medical Director was unable to articulate a facility process of how a resident was comprehensively assessed to be safe	2 830		

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2 830	Continued From page 13 independently in the community. During a phone interview on 4/10/25 at 10:51 a.m., licensed psychologist (LP)-A stated she performed a SLUMS assessment indicating R2 had cognitive impairment with short term memory impairment. LP-A stated residents with cognition concerns should be comprehensively assessed to be independent in the community several factors would need to be assessed to include cognition, diagnoses, capacity to create a contract and follow through, etc ...then IDT should discuss this to put a safety plan in place for each resident. During an interview on 4/10/25 at 11:16 a.m., when asking director of nursing (DON), if the facility was responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address the risk. DON explained the OT would be the professional to assess a resident to see if they would be safe to be in the community independently unsupervised. DON verified the OT that assessed R2 on 3/14/25, did not clearly state if R2 was safe to be independent in the community unsupervised. DON indicated their current process for a resident to leave the facility was if the resident did not reside on the locked unit the resident would utilize the sign in and sign out sheet located at each wing. The resident should write the time they leave and an expected return time along with where they are going. DON verified that residents do not always use the sign and sign out sheets and was unable to articulate what interventions the facility has in place to keep residents requiring supervision in the community safe. If a resident was missing, the staff call family and the resident to try and identify the resident's whereabouts and are to wait until midnight and call the police to file a	2 830		

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2 830	Continued From page 14 missing person's report and notify myself, the family and the supervisor. DON stated she received a report this morning that R2 went missing yesterday sometime and had not yet returned to the facility, a missing person's report was filed with the police at midnight, and she did not have any more information on R2. During an observation and interview on 4/14/25, at 9:48 a.m., R2 was observed dressed and lying in bed in his room. R2 stated he currently didn't feel good and has the sniffles, further stated he was put on the locked unit because he was smoking in his room, "rules are rules, don't bother me none." R2 stated he didn't come here to make friends and tried to stay to himself. R2 stated he was waiting to get out of here and get his own place. R2 stated he had been to the ED and hospital a few times recently due to his mental health. R2 did not wish to speak with surveyor any further and asked surveyor to leave. R3 R3's quarterly MDS dated 3/18/25, indicated R3 admitted to the facility on 11/2023. R3 was cognitively intact with a BIMS score of 15, was independent with activities of daily living and mobility, and utilized a wheelchair. R3's diagnosis report indicated R3 had diagnoses including alcohol [ETOH] abuse with withdrawal, alcohol dependence, alcoholic hepatitis (liver inflammation due to excessive ETOH consumption), alcoholic polyneuropathy (nerve damage from excess ETOH consumption), liver cirrhosis (scarring of the liver), opioid abuse, unspecified psychosis, major depressive disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, adjustment disorder with disturbance of conduct,	2 830		

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muscle weakness, unsteadiness on feet, history of falling, repeated falls.

R3's psychiatry note dated 12/20/24, indicated she had diagnoses including generalized anxiety disorder, alcohol use disorder, major depressive disorder, and opioid use disorder. Her mental status examination included "her insight, judgment, memory, and concentration are quite impaired."

R3's physician orders included naltrexone hydrochloride (HCl) 50 mg daily for substance use disorder (dated 2/14/25).

R3's care plan focus revised 3/25/25, identified she had limited physical mobility with fall risk related to ETOH abuse and noted she was independent with ambulation and utilized a wheelchair as needed. Interventions included: independent with bed mobility (dated 11/29/23), utilizes wheelchair as needed independently (dated 3/25/25), independent with toileting (dated 4/5/24), and independent with transfers (dated 4/5/24).

R3's care plan focus revised 3/25/25, identified she had suspected/actual illicit drug/ETOH use and previously declined treatment services but had started to talk with the LADC. Interventions dated 4/5/24 included: Doctor updated regarding actual/suspected abuse, hold all mood altering or all sedative medication when ETOH or marijuana use suspected; Ensure safety and observe for withdrawal symptoms; and a list of symptoms of a drug overdose including alcohol poisoning. R3's care plan did not identify the symptoms of alcohol withdrawal or identify her supervision needs in the community or related interventions for her safety in the community and upon subsequent return to

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the facility.

R3's physician note dated 1/8/25, indicated she had alcohol use disorder with recurrent episodes of alcohol use. She was most recently hospitalized 11/28/24 after being found intoxicated and "her blood alcohol level was 0.33."

R3's progress notes dated 1/9/25, 1/12/25, 1/13/25, 1/14/25, 2/8/25, and 2/9/25 indicated R3 was intoxicated and medications were refused and/or held. The notes did not indicate the provider was notified or identify what ongoing monitoring and interventions were implemented.

R3's progress notes dated 2/10/25, indicated R3 was intoxicated, medications were held, vital signs taken, and provider was notified. R3 later request transport to the hospital because she wasn't feeling well and reported vomiting all day.

R3's hospital notes between 2/11/25 through 2/13/25 identified R3 had a history of alcohol abuse and admitted to the hospital on 2/10/25 with nausea and vomiting. R3's principal diagnosis was alcoholic ketosis (buildup of acid in the blood caused by heavy alcohol use often in conjunction with poor nutrition) and she initially presented with tachycardia (elevated heart rate) to the 120's, hypertensive (elevated blood pressure) to 180's/100's, with numerous abnormal lab values. A hospital Social Work Initial Assessment indicated R3 reports she uses the w/c when at the facility, does not use an assistive device when she leaves the facility. She leaves the facility independently, usually via a cab ride she independently arranges. Patient reports her typical outing includes stops at Target and a liquor store. A progress note by hospitalist included R3

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reported the nursing home "don't really monitor where she goes so she regularly walks down to the bar on the corner of the street and drinks."

R3's progress note dated 2/13/25, indicated R3 returned from the hospital. R3's record did not identify the concerns in hospital documentation, including lack of assistive device when leaving the facility and purchase/consumption of alcohol while in the community, were addressed. Further, did not indicate that her need for supervision in the community was assessed.

R3's progress notes dated 2/25/25, indicated R3 was "extremely intoxicated" and found sleeping on the floor next to her bed with partially consumed bottles of alcohol at 3:00 a.m. Assessment and vital signs completed, assisted back to bed, and staff "kept monitoring her situation" with intervention of lowering her bed to the floor to prevent injuries in case she decided to get out of bed. The provider notification section of the note was blank and did not indicate the provider was notified. Further, progress notes indicated R3 remained intoxicated throughout the day, did not eat breakfast or lunch, refused all morning and afternoon medications, and refused assessment and vital signs.

R3's progress note dated 2/25/25 at 8:55 p.m., indicated nurse went to get R3 from front desk, R3 was intoxicated, R3 stated she fell while downtown and hit her head while trying to get on a bus. R3 refused vitals, neurological checks performed, provider notified. Additional progress note at 10:58 p.m., indicated R3 sustained a bruise and head hematoma from the fall, identified contributing factor of R3 was not using her wheelchair, and noted care plan and care sheets were reviewed with no changes indicated.

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It was not evident in R3's record that her supervision needs were assessed or interventions were developed to ensure her safety in the community after she fell and sustained a head injury while intoxicated in the community.

R3's record reviewed between 2/26/25 through 4/10/25 identified although R3 continued to be intoxicated almost daily, R3's record did not include a comprehensive assessments and/or monitoring of withdrawal symptoms nor assessments and/or monitoring of R3's medical condition while she intoxicated, nor safety interventions including the level of supervision while R3 was intoxicated inside the facility. Further there was no indication a monitoring system was developed to prevent and/or identify if/when R3 brought or had alcohol in room and not evident interventions were developed to keep R3 safe and other residents safe that may inadvertently have access to R3's alcohol. Additionally, R3's records did not include a comprehensive community safety assessment, despite R3's patterned history of leaving the facility, consuming alcohol while away, then returning intoxicated. R3's record did not include interventions that would prevent and/or mitigate R3's risks of serious injury or even death while in the community. Examples from the record include but are not limited to:

R3's progress notes dated 2/26/25, 2/27/25, 3/1/25, 3/4/25, 3/5/25, and 3/11/25, indicated R3 was intoxicated and medications were refused and/or held. On 3/4/25, alcohol was also found in R3's room and she was verbally abusive towards staff and refused cares.

R3's progress notes dated 3/12/25, indicated R3 was intoxicated, verbally aggressive to staff, and

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medications were refused and/or held. Note at 1:27 p.m., indicated she was sent to the hospital per provider order. Note at 8:06 p.m., indicated she was sent to the hospital for evaluation of a suspected gastrointestinal bleed after being found in her room intoxicated with black stool smeared in the bathroom. She returned to the facility at 6:30 p.m. and was still intoxicated, medications were held.

R3's emergency department (ED) After Visit Summary dated 3/12/25, indicated R3 was seen for an alcohol problem and blood in stool with diagnosis of alcoholic intoxication with complication.

R3's nurse practitioner note dated 3/14/25, indicated she was seen for evaluation following intoxication and concern for a gastrointestinal bleed two days ago. R3 "continues to drink," "had a blood alcohol level of 0.36," and "she states that her last drink was several weeks ago but this is not accurate."

R3's progress note dated 3/18/25, indicated R3's functional status abilities varied related to alcohol use. When intoxicated, she required supervision/touching assistance of one staff member for bed mobility, transfers, and ambulation for safety. When intoxicated, she required limited assistance of one staff member with toileting tasks and colostomy management. She was able to make her needs known but staff were to anticipate her needs as appropriate when intoxicated. R3's care plan did not identify individualized interventions that reflected the increased need for assistance when intoxicated.

R3's Comprehensive Nursing Data Collection assessment dated 3/18/25, identified R3 was

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2 830	Continued From page 20 vulnerable to self-abuse described as alcohol abuse, susceptible to abuse from others described as vulnerable adult, susceptible to abuse others, and had verbal behavioral symptoms directed at others described as a history of verbal aggression when intoxicated. The assessment identified R3 had alcohol use daily and history of substance/cannabis abuse was marked as never. The assessment failed to identify R3's diagnosed history of opioid abuse. The Data Collection included an elopement assessment with each 'yes' answer assigned one point and a score of 4 or greater indicating potential for elopement. R3 had an elopement risk score of 3 indicating no elopement risk. The questions "exhibits pacing or agitated behavior" and "has a diagnosis or OBS, dementia, psychosis, Alzheimer's, or other psychiatric diagnosis," were marked no. The assessment failed to identify R3's agitated behaviors where documented in provider and progress noted between 1/8/25 through 3/18/25, and further failed to identify R3's psychiatric diagnoses of unspecified psychosis, major depressive disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and adjustment disorder with disturbance of conduct. If the assessment identified these areas accurately, R3's score would have been 4 or greater, identifying her as an elopement risk. R3's progress notes dated 3/22/25 and 3/23/25, indicated R3 was intoxicated and medications were refused and/or held. Progress note dated 3/28/25, indicated R3 left the facility to go to the mall, walked out, and refused to sign out. Later returned in "good condition." R3's progress notes did not identify how long R3 was out of the facility and/or when R3 returned.	2 830		

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R3's progress notes dated 3/29/25, indicated she was missing from the unit at 8:00 a.m. and remained missing at 2:00 p.m. with supervisor to follow up. Note at 6:14 p.m., identified person in the community called the facility and stated resident was drunk and needed to be picked up, provided address, staff notified police. At 9:15 p.m. police dropped R3 off at the facility. She was intoxicated, non-compliant with cares, refused vital signs and assessment, and provider was notified. R3's record did not identify assessment of R3's supervision needs after she was found intoxicated in the community and returned to the facility by police. Further, did not identify what interventions were put in place to mitigate related risk while in the community and upon her return.

Progress note dated 3/30/25, indicated R3 was intoxicated the whole overnight shift and called emergency services at 6:00 a.m. and was taken to the hospital while still intoxicated. There was no assessment or indication why R2 was sent to the hospital.

R3's ED After Visit Summary dated 3/30/25, indicated R3 was seen for an alcohol problem with diagnosis of alcohol intoxication delirium with moderate or severe use disorder.

Progress notes dated 3/30/25, indicated R3 returned from the hospital around 12:00 p.m. R3 then requested a cab be called for a shopping trip, refused to sign out, and receptionist informed unit staff R3 did not wait for a cab and took the bus. R3 returned around 2:16 p.m., sounded slurred, and stated she never made it to the store.

R3's progress notes dated 3/31/25, indicated R3 was intoxicated and a partially consumed bottle of alcohol was found in her room. R3 refused cares,

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medications were held, and nurse noted "please continue to monitor closely."

R3's progress notes dated 4/1/25, indicated R3 was intoxicated and medications were refused and/or held. R3 refused assistance with cleaning her room, but staff removed items that could cause R3 to fall and placed wheelchair at bedside. At approximately 7:15 p.m., R3 went downstairs and called emergency services who transported her to the hospital per her request.

R3's ED Observation Discharge Summary physician note dated 4/2/25, indicated R3 was admitted from 4/1/25 and discharged back to the facility on 4/2/25 with diagnoses of altered mental status and ethyl alcohol poisoning. R3 had "risk of complication from severe intoxication requiring close observation." R3 "presented to the emergency department with altered mental status. Intoxication was suspected, and a breathalyzer for Ethyl alcohol was obtained. A legal hold was placed on the patient due to their inability to care for self which represented a danger to self in addition to their chemical dependency status that is in question due to intoxication." R3's initial breathalyzer result was 0.208 percent (concentration of alcohol in a person's breath to estimate their blood alcohol content. Results between 0.08 and 0.40 percent indicate legally intoxicated and very impaired).

R3's psychology note date 4/2/25, indicated R3 "continues to drink excessively and was hospitalized." It noted R3 identified triggers including her roommate, being more physically ill, falling often, and her family member not visiting much. R3 would benefit from a secure setting to support best functioning and quality of life along with a harm reduction approach for substance

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abuse management when she is drinking, staff striving to have a harm reduction plan and reproaching her as necessary may help. She may benefit from a safety plan which this psychologist can help draft. Further, "the care team identifying strategies to help keep her busy may help overall monitoring her for behavior can guide treatment goals. What might trigger her drinking and resulting behavior." R3's cognitive exam indicated her short-term memory, insight/judgement, and thought content were all impaired with dysthymic anxious mood, labile affect, and impaired behavior.

Review of R3's record did not identify a safety plan nor a harm reduction plan.

R3's progress notes dated 4/5/25, indicated R3 refused morning medications, left the facility around 10:30 a.m. and signed out after directed to do so, refused to state where she was going or when she would return, and the front desk called her a taxi per her request. At 11:40 a.m. R3 returned with no concerns. Additional note identified R3 returned to the facility at 1:30 p.m. It was not evident in R3's record if she left the facility again after returning at 11:40 a.m. Note at 5:51 p.m., indicated R3 smelled like alcohol and called emergency services who transferred her to the hospital, provider was notified. At 11:30 p.m., R3 returned to the facility with no concerns.

R3's ED Provider Note dated 4/5/25, indicated R3 presented via emergency medical services for evaluation of alcohol problem. R3 stated she drank some alcohol earlier that day but denied a history of alcohol withdrawal. R3 walked out informing staff and without having further workup completed reported R3 reported "she only needed a place to rest".

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R3's progress notes dated 4/6/25, indicated R3 was intoxicated and medications were refused and/or held.

R3's progress note dated 4/8/25, indicated R3 left the facility at 2:00 p.m. and did not sign out.

R3's progress notes dated 4/9/25, indicated R3 left the facility at 8:30 a.m. after harassing staff, went downstairs, and was seen outside waiting for a cab. R3 returned at 12:30 p.m. and seemed intoxicated, refused assessment, and medications were held. R3's record did not include an assessment of R3's condition prior to leaving the facility.

R3's nurse practitioner note dated 4/9/25, indicated she was in the ED on 4/2/25 for alcohol use and discharged back to the nursing home where she has continued to use alcohol periodically. Provider noted R3 "appears that she has been drinking alcohol but denies this." On exam, R3 was "alert somewhat belligerent calling out at times" and "appears sleepy and slightly impaired mental status." The assessment and plan for the diagnosis of alcohol use disorder noted "continues to have periodic alcohol use is not interested in further alcohol treatment continues on gabapentin." The note did not identify R3's repeated recent instances of leaving the facility unsupervised and without complete staff notification and then returning to the facility intoxicated or indicate that her needed level of supervision was assessed.

R3's progress note dated 4/10/25, indicated R3 was intoxicated, refused cares, refused vital signs, medications were held, and provider notified.

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Facility sign out/sign in forms titled Providence Place Release of Responsibility for Leave of Absence (LOA) dated 3/10/25 through 4/9/25 from R3's unit were reviewed. Records included one entry for R3, undated at 1:00 p.m., with R3's name and signature, destination of a fast food restaurant, and ETA 4:00 p.m. The sign-in section was blank.

During an interview on 4/9/25 at 12:46 p.m., NA-C stated R3 left the facility frequently and would not come back. NA-C stated she had seen R3 intoxicated before and this happened at least once a week.

During an interview on 4/8/25 at 11:11 a.m., RN-C stated for a resident with an SUD she would check orders to see what care they needed, like holding certain medications. RN-C stated "for [R3] there are no orders for interventions that need to be done." RN-C would check on R3 when she appeared intoxicated and get vital signs if R3 would allow, "but there are no interventions or orders for about what to do if she's drunk." When R3 was drunk, she's very angry, throws up, refuses her medications, and tends to try to leave the facility. RN-C noted SUD's should be on the care plan and interventions could be vital signs, keeping a resident hydrated, doing hourly checks if they seem intoxicated, and monitoring. RN-C would be concerned about someone with an SUD leaving the facility without supervision because they could leave and use their substance of choice or buy something illicit. For R3, "she isn't fully there" and "could end up somewhere and not know where she is, could be a risk to leave if she's intoxicated."

During an interview on 4/9/25 at 12:33 p.m.,

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RN-B identified monitoring should be done for intoxicated residents and identified signs of alcohol withdrawal, but was unsure of signs and symptoms of alcohol poisoning. RN-B was not aware of specific interventions in place for R3's alcohol use apart from holding meds. RN-B noted R3 frequently left the facility, was more likely to be intoxicated when she returned, was intoxicated at least twice a week, and did not always sign out. RN-B stated there were no specific safety interventions for R3 and he alcohol use, she had been offered treatment in the past and refused.

During an interview on 4/9/25 at 5:02 p.m., OT-A stated R3 has previously been on therapy's caseload, however, OT-A did not identify a community safety assessment in R3's record.

During an interview on 4/10/25 at 11:10 a.m., LP-A stated R3 often goes out from the facility and drinks. LP-A identified R3 was at risk when leaving the facility independently without notifying staff and was "so vulnerable in terms of potential assault or exploitation", became aggressive when intoxicated, and drank almost every time she was outside of the facility. LP-A would expect R3's care plan to include her SUD and that she might leave frequently. LP-A would further expect the care plan to include monitoring for patterns of when she is intoxicated and harm reduction like encouraging rest, vital signs and monitoring when intoxicated, removing alcohol from her room, identified triggers for substance use, and psychological consults. Additionally, she would expect a safety plan to be in place for when R3 does go into the community and consideration of how staff can intervene to try to distract her or encourage her to do something else.

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During an interview on 4/14/25 at 2:30 p.m., the DON stated R3 had not been comprehensively assessed to identify risks and hazards in the community and stated R3 "really needs supervision." The DON stated R3 did not have safety interventions in place to address risks and hazards when in the community and upon subsequent return that met her expectations. The DON identified R3 could fall, get hurt, or worse when in the community without supervision. The DON noted R3 was usually gone for an extended time and drinking when she went out of the facility and "she gets intoxicated and can't rationalize what's happening to her" and concerns included "getting lost, being taken advantage of, falling and getting hurt, passing out on the street." The DON would expect R3's SUD's to be care planned, would expect provider notification every time she was intoxicated, and would expect a community safety assessment to have been completed to identify R3's needed level of supervision in the community.

During an interview on 4/10/25 at 9:05 a.m., MD-A stated he was not aware of R3's recent alcohol use because the nurse practitioner would be the one notified. He was not aware of staff reports that she was intoxicated multiple times weekly. MD-A stated he would expect staff to do "some kind of monitoring" if she was intoxicated and did not expect staff to necessarily do anything else as long she was monitored "properly." MD-A could not articulate what constitutes "proper" monitoring. MD-A was asked if he expected the medical team to be notified if R3 returned from the community and appeared intoxicated and stated he did not know because it depended on the facility's framework for notification. MD-A stated he was not in a judgement role and could not identify if he was

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okay with a notification not being made in such a situation, though would expect provider notification for an alteration in a resident's condition. MD-A noted he relied on safety assessments completed by the facility to determine if a resident was safe in the community.

During an interview on 4/10/25 at 9:40 a.m., the medical director stated he had "obvious concerns" with a resident with an SUD leaving the facility without supervision. The medical director noted if a resident returned and staff suspected they were intoxicated or had used, the primary provider should be notified and a standing order to hold medications used. He would expect staff to monitor the resident per provider instruction and noted an inebriated resident was at increased risk for falls. A resident with a blood alcohol content of 0.3 could have acute alcohol intoxication or, in patients who were functional and walking around, this could be alcohol withdrawal self-treated with alcohol consumption. The medical director noted "any LPN or RN" should be aware of alcohol withdrawal symptoms and "it's dangerous, you could die, go into status epilepticus [prolonged seizures that are a medical emergency], blood pressure could go up and down with delirium tremens [life-threatening form of alcohol withdrawal]." When a resident leaves the facility there was no way for staff to know what they do, but staff would see such signs in a resident and contact the provider and send the resident to the hospital if needed.

R1
R1's quarterly Minimum Data Set (MDS) dated 2/21/25, indicated R1 admitted to the facility on 11/2024. R1 had verbal behaviors towards others on one to three days of the seven-day

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assessment period and had limited range of motion in one upper and lower extremity. R1 required maximal assistance with toileting, bathing, dressing, bed mobility, and transfers and was independent with wheelchair mobility.

R1's diagnosis report indicated R1's diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebral infarction (stroke), alcohol use, cocaine use, anxiety disorder, restlessness and agitation, cognitive communication deficit, muscle weakness, need for assistance with personal care, and unspecified fall.

R1's physician note dated 11/18/24, identified R1 admitted to the facility from a hospital after she was found down with a significant stroke and brain bleed "thought due to cocaine use."

R1's speech therapy note dated 11/19/24, indicated a cognitive test, the Montreal Cognitive Assessment (MoCA), was completed and R1 scored 11 out of 22, with scores of 18 or greater considered within normal limits. R1 was very impulsive, inattentive, and demanding throughout session.

R1's Diagnostic Assessment completed by licensed psychologist (LP)-A dated 11/20/24, indicated R1 had diagnoses including substance abuse of cocaine and alcohol and adjustment disorder with mixed disturbance of emotions and conduct. R1 presented with reduced insight and judgment and scored 17 out of 30 on the St. Louis University Mental Status examination (SLUMS), suggesting signs and symptoms of cognitive impairment. She presented with deficits in short-term memory, calculation, executive functioning, and comprehension. Treatment

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recommendations included "cognitive performance testing other assessments can also help identify functional support needs she will benefit from." Goals included "increased understanding of pattern of problematic substance use ... objectives include increasing knowledge of harm reduction strategies to reduce risk if drug use continues, reducing likelihood of relapse."

R1's care plan dated 3/14/25, identified a potential for communication problem with difficulty expressing ideas/wants and understanding verbal content. Interventions included "cue and supervise as needed." The care plan identified R1 was a vulnerable adult. The care plan did not identify the level of supervision R1 needed according the SLUMS assessment and occupational therapy recommendation dated 11/29/24. The care plan did not identify R1's cocaine and alcohol substance use disorders or associated interventions. The care plan did not identify R1's pattern of leaving the facility without complete staff notification, leaving without supervision, or associated interventions.

R1's occupational therapy note by occupational therapist (OT)-B dated 11/29/24, indicated a SLUMS cognitive assessment was completed with score of 15 out of 30 and deficits in short-term memory, executive functioning, visual processing, and numerics. The response to treatment section noted, "recommend 24/7 supervision per SLUMS assessment due to cognitive deficits."

During an interview on 4/8/25 at 10:06 a.m., occupational therapist (OT)-B stated she completed R1's SLUMS assessment dated 11/29/24. OT-B stated she would have safety

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concerns about R1 in the community, "I can imagine her getting lost, turned around in the community," and noted there were times R1 "wasn't understanding a lot of higher-level things." OT-B noted that if in the community unsupervised, R1 could fall, end up somewhere she shouldn't be, or end up in an unsafe situation with another person. OT-B stated there was a "higher level cognitive aspect that was a unique concern we had with her [R1]" including things like problem solving, understanding rules, and cause and effect. OT-B stated, "I think if I saw [R1] on the sidewalk in downtown Minneapolis I would be very concerned" and would expect to see her recommendation for 24/7 supervision to be followed through on by whoever was taking care of R1 and expect to see the supervision implemented and care planned. OT-B further stated making this recommendation was not something she took lightly.

R1's progress note dated 1/5/25, indicated, staff was notified by neighbor resident was couple blocks away from facility waiting for her son to come. Two staff went to get the resident and brought her back to the facility safely, resident went out earlier and took the bus with unknown destination.

R1's progress note dated 1/6/25, indicated staff confirmed R1 had signed out the previous day for her outing and understood the facility sign out process and leave of absence (LOA) guidelines. R1 confirmed she would talk with staff and family in the future prior to signing out "so we know she is safe."

R1's progress notes were reviewed in conjunction with facility sign out/sign in forms. Progress notes and sign in/sign out forms identified multiple

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occurrences of R1 leaving the facility without indication that she was supervised. Further identified R1 did not consistently complete the sign-out sheet, notify staff she was leaving, or inform staff of her whereabouts, who she was with/if she had supervision, her expected time of return, and her actual return.

Facility sign out/sign in forms titled Providence Place Release of Responsibility for Leave of Absence dated 3/10/25 through 4/9/25 included multiple entries for R1 with missing information and/or incorrectly completed and/or illegible. Forms included sign out section identifying date, time, name, signature of person accepting responsibility for resident, destination, and approximate time of return (ETA). Sign in section included date, time, and signature of person upon return. Review of the records identified the following entries for R1:
- Sign out on 3/17/25 with no sign in
- Sign out 3/18/25 with sign in on 3/18/25
- Sign out undated with sign in on 3/19/25
- Sign out undated with sign in on 3/19/25 a second time
- Sign out undated with sign in on 3/23/25
- Sign out 3/27/25 with undated sign in
- Sign out undated with no sign in
- Sign out undated with no sign in
- Sign out dated April (day illegible) with no sign in
- Sign out undated with no sign in
- Sign out undated with no sign in
- Sign out 4/4/25 with no sign in
- Sign out undated with no sign in

R1's progress note dated 3/18/25, indicated R1 called a taxi to go to a fast food restaurant, did not tell staff, and was seen outside waiting for her ride. Staff "convinced" R1 to go back inside and sign out. R1 then took the taxi "leaving

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independently," even though OT had recommended 24/7 supervision on 11/24/24, no indication of reassessment, and no indication safety interventions were put into place. R1's record did not identify when and/or if R1 returned to the facility on 3/18/25.

R1's progress note dated 3/19/25 at 5:52 p.m., indicated resident not on unit since start of this shift. Writer called resident to find out when she is returning to facility. Per resident she will return around 8 pm this evening. Additional progress note dated 3/19/25, indicated R1 returned at 9:00 p.m.

R1's psychology note dated 3/26/25, indicated R1 had impaired insight/judgement and thought content. Staff reported R1 had cognitive deficits "however is still her own decision maker and sometimes leaves the building." The note identified she had "limited insight into her health conditions as evidenced by not being able to explain why she couldn't walk."

R1's physician note dated 4/1/25, indicated R1 had a history of alcohol and cocaine abuse and was found down on a welfare check with an intraparenchymal hemorrhage (brain bleed) prior to admission and "cocaine was the most likely cause of the intracranial hemorrhage." The note identified R1 was seen by psychiatry on 3/14/25 with psychiatrist "noting adjustment disorder with mixed disturbance of emotions and conduct in addition to substance use disorders." The physician visit did not address R1's the cognitive assessments (MoCA dated 11/19/24, SLUMS dated 11/20/24, or SLUMS dated 11/29/24) that all identified R1 was cognitively impaired and unable to make decisions nor address R1's safety related to her cognition while out in the

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community unsupervised.

R1's progress note dated 4/2/25 at 2:40 p.m., indicated "Resident not on unit at start of shift. Resident signed herself out." Progress note dated 4/2/25 at 9:27 p.m., indicated R1 returned to the facility.

R1's speech therapy note dated 4/7/25, indicated a MoCA assessment was completed and results included deficits in scores for visuospatial/executive functioning, naming, delayed recall, attention, language, and orientation. The score was 17 out of 30 indicating moderate cognitive impairment.

Although the assessment dated 4/7/25 identified R1 had cognitive impairment in addition to documentation of substance use disorders and impaired mobility, it was not evident there had been a comprehensive assessment completed to identify R1's risk factors/vulnerabilities in the community nor evident safety interventions and/or level of supervision needed was determined and implemented even though she frequently left the facility without supervision.

R1's progress note dated 4/8/25 at 3:29 p.m., indicated "per report resident left facility on day shift around 1:00 p.m. Progress note dated 4/8/25 at 5:17 p.m., indicated a nursing assistant (NA) reported R1 said she would return tomorrow. Progress note dated 4/8/25 at 7:02 p.m., indicated R1 returned to the facility.

During an interview on 4/8/25 at 9:14 a.m., speech language pathologist (SLP)-A stated she completed a cognitive assessment, the MoCA, with R1 yesterday and "her cognition is definitely impaired." SLP-A identified R1's MoCA score of

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17 out of 30 indicated "moderate to moderate severe cognitive impairment" in cognitive skills including visuospatial, executive functioning, attention, delayed recall, and abstraction. SLP-A noted cognitive assessments like the SLUMS are repeated infrequently because people can learn them and they become ineffective. She had repeated R1's assessment because it had been five months which was an appropriate time period for reassessment. SLP-A noted, "it would scare me to see her [R1] go into a public place" independently and identified concerns as R1 lashing out at someone, being unpredictable, not bringing her phone, self-propelling in her wheelchair backwards with a lack of safety awareness, left-sided hemiparesis, needing assistance with toileting, and difficulty problem solving.

During an interview on 4/8/25 at 10:40 a.m., certified occupational therapy assistant (COTA)-A stated R1 lacked safety awareness, needed assistance getting around, was cognitively impaired, and impulsive. COTA-A would be concerned if R1 was out in the community unsupervised as R1 could get lost or not return, have difficulty navigating and maneuvering, get hurt, or hurt someone else. COTA-A noted R1 tended to self-propel in her wheelchair backwards because of her flaccid left leg, lacked awareness of where she was going, had run into walls before, and needed frequent staff reminders to watch where she was going. COTA-A stated R1 was not safe on her own in the community and needed supervision because of impaired cognition, mobility, impulsivity, problem solving, and mood.

During an interview on 4/7/25 at 11:56 a.m., the DON stated R1 could leave the facility

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independently and she didn't have to have supervision. The DON could not a identify a date and/or completed assessment that identified R1 did not need 24/7 supervision as per the OT recommendation dated 11/29/24. DON stated it was determined that R1 was safe to go into the community independently because "she is 100% cognitively intact," alert and oriented, not incompetent, and aware of her limitations however, the DON could not identify a date and/or assessment that conflicted with the cognitive assessments completed on 11/19/24, 11/20/24, 11/29/24, and 4/7/25. The DON noted if R1 wanted to go into the community by herself she would be assessed by therapy for community safety, but R1 only went out with family. The DON did not identify R1's history of not properly completing the sign-out sheet, notifying staff she was leaving, or informing staff of her whereabouts, who she was with/if she had supervision, her expected time of return, and her actual return.

During an interview on 4/7/25 at 12:45 p.m., the director of rehabilitation (DOR) confirmed a community safety assessment had not been completed for R1 and did not recommend R1 leave the facility without supervision based on her cognitive testing. The DOR stated he was aware of at least one time when R1 had left the facility without supervision.

On 4/8/25 at 11:24 a.m., health unit coordinator (HUC)-A stated R1 signed out that morning and did not complete the sign-out form fully or accurately. R1 did not tell HUC-A details about her plans and HUC-A was on the phone when R1 signed out. HUC-A stated, "no one was with her when she left." HUC-A did not indicate further action or interventions were needed to confirm

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R1's whereabouts or safety.

During an interview on 4/8/25 at 11:28 a.m., nursing assistant (NA)-D stated on 4/8/25, R1 had told her she was leaving for the day and did not tell NA-D where she was going, but HUC-A said she had signed out. NA-D stated when R1 said she was leaving NA-D did not tell her anything, "I don't have authority to tell her where she can or cannot go" NA-D confirmed she did not ask R1 for further details about her trip into the community. NA-D did not identify actions or interventions needed to confirm R1's plans or current safety.

During an interview on 4/7/25 at 10:47 a.m., NA-B stated she knew if a resident was okay to leave the facility and go into the community independently based on care plans, how they transfer, if they were independent, and would decide based on that. NA-B would be worried about R1 going into the community without supervision because she was a vulnerable adult and required staff assistance of one for getting up and transfers. NA-B noted if R1 was her own family member, she would not want R1 in the community unsupervised.

On 4/8/25 at 3:06 p.m., NA-A stated she had seen R1 leave the building independently and not come back until the next day multiple times. NA-A stated R1 had recently left the facility on 3/17/25 with family to celebrate her birthday at the casino, was gone overnight, police and family had been contacted. R1 finally returned the next morning and "it seemed like she was on something [illicit drug]." When R1 was talking, her mouth was twitching, she wasn't making eye contact like normal, seemed like she was in a different space. NA-A noted other times R1 would go into the

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community she would come back different. NA-A was unaware of R1's substance use history until she learned of it from family on 3/17/25. NA-A did not think R1 was safe in the community by herself. During a subsequent observation and interview at 3:28 p.m. on 4/8/25, NA-A confirmed R1 was not present in her room and stated she was not aware of R1's whereabouts as she was not told. NA-A went to check the resident sign out/sign in sheet and noted it stated R1's name with destination of "fresh air downtown" and return time of 8:00 p.m., but there was not a date identified. Licensed practical nurse (LPN)-C informed NA-A that she had seen R1 leave the facility around 1:30 p.m. LPN-C nor NA-A identified interventions needed to confirm R1's safety at this time after it was noted that she was absent from the facility.

During an interview on 4/7/25 at 4:44 p.m., licensed practical nurse (LPN)-A noted R1 could go out but needed someone to check on her. LPN-A stated he had smelled marijuana on R1 before. When this happened LPN-A would "keep an eye on her" and hold scheduled medications if she appeared under the influence.

During an interview on 4/7/25 at 4:54 p.m., LPN-B stated, "there is a concern with her [R1's] decision making," concern with her mobility, and the potential for a bad outcome if she left the facility unsupervised. LPN-B expressed concerns about R1's cognition, coordinating, and communicating because she could be erratic and spontaneous. Someone who is erratic is not safe to be in the community without supervision. LPN-B noted R1 did not always sign out or communicate with staff when leaving the facility. When staff noticed she was missing they would call her family, call her, and update their

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supervisor. LPN-B noted if a resident was out past the time they were supposed to return and staff were looking for them and couldn't find them in the community, they would update the police.

During an interview on 4/7/25 at 10:25 a.m., registered nurse (RN)-C stated she was not sure how residents were assessed for safety in the community independently, but care plans usually said if a resident was independent or required assistance. She had not seen care plans identify if a resident was okay to leave the facility independently and did not know where this would be identified in a resident's record. She noted there was a safety assessment that could be completed but she did not know who completed them.

During an interview on 4/7/25 at 11:02 a.m., RN-A noted residents were assessed to determine if they were safe to leave the facility independently based on physical and cognitive status. RN-A stated, "If family is taking them it is something different, but if they are going by themselves, they have to be able to go physically and cognitively." RN-A would check the care plan and physician orders for this information.

During an interview on 4/8/25 at 2:52 p.m., RN-D stated R1 goes out a lot and most times goes by herself. When RN-D would ask R1 for details about her outings R1 would not provide them. RN-D had concerns about R1 going into the community unsupervised due to her one-sided weakness, need for staff assistance, being a vulnerable adult, and refusing help when she needs help.

During an interview on 4/7/25 at 11:41 a.m., the social services director (SSD) stated resident

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safety in the community was assessed based on cognition and mobility. SSD noted social services performed the Brief Interview for Mental Status (BIMS) assessments, but therapy did more cognitive performance testing, SLUMS assessments, and community assessments. The SSD stated staff relied on therapy to do testing. The SSD noted safety in the community was care planned by exception when there was an issue like a resident not signing out or leaving and not coming back.

During an interview on 4/7/25 at 9:38 a.m., the director of rehabilitation (DOR) stated therapy was responsible for completing community safety assessments. They were completed if a resident was discharging home soon or upon facility request. DOR noted the facility requested the assessment when a resident wanted to go out and hadn't been out before, if staff knew a resident was going out frequently and using public transportation, or if a resident wanted to go out without family supervision. The DOR stated SLUMS scores, cognitive performance testing (CPT), ambulation status, and community assessments were part of therapy's recommendation for a resident's needed level of supervision in the community.

In an interview an 4/8/25 at 11:45 a.m., licensed alcohol and drug counselor (LADC), stated he had received a referral for R1 but R1 declined services. The LADC noted there were always safety concerns for someone with a substance use disorder (SUD) going out into the community. He noted it was important for staff to know if a resident had a SUD because there are certain things and behaviors to look for. Further, it would be important for staff to know withdrawal symptoms and what being under the influence

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looks like because withdrawal is very dangerous. The LADC noted he was sure nurses had education on drug-seeking behaviors, but there was more to it, like being manipulative, behavior changes, isolating, little signs.

During an interview on 4/10/25 at 11:10 a.m., licensed psychologist (LP)-A stated R1 had a moderate level of cognitive impairment with score of 17 out of 30 on a SLUMS assessment in November 2024. LP-A noted R1's history of cocaine and alcohol abuse and likely use within the last year. LP-A was not aware of staff concerns about R1 potentially using substances while out in the community but noted it could be occurring. LP-A noted R1 was vulnerable and she would want her to have an escort in the community for safety. LP-A noted R1 showed poor insight and a lack of judgement and staff should be watching her and when she comes and goes, what triggers her, and when does she tend to leave. She would expect to see R1's SUD care planned with monitoring of patterns like when she leaves, does she leave alone, when does she come back as well as checking vital signs, assessing to see if she seems more impaired or is acting off, and contacting providers as needed. LP-A noted care plans should be comprehensive and individualized to minimize risk but still provide quality of life.

During an interview on 4/10/25 at 9:05 a.m., medical doctor (MD)-A stated he had possible concerns about R1's safety in the community and identified her history as part of the concern, as she could potentially leave the facility and use illicit substances. MD-A stated a community safety assessment should be done and, if one had not been completed, he would ask for one. MD-A would rely on assessments completed by

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2 830	Continued From page 42 the facility to determine if a resident was safe to be in the community. During an interview on 4/10/25 at 9:40 a.m., the medical director stated he had "obvious concerns" about residents with an SUD going into the community unsupervised because "they may be using, that's a concern." If a resident returned from the community and seemed impaired, he would expect the primary doctor to be notified and staff to follow provider recommendations for monitoring. The immediate jeopardy that began on 2/27/25 was removed on 4/11/25 and was verified through observation, interview, and document review when the facility implemented the following interventions: - Reviewed/revised elopement and missing persons policies and procedures in conjunction with the resident sign-out/sign-in protocols. - Developed and implemented a system to assess and monitor residents with an SUD when they return to the facility from the community. - Educated staff on procedures pertaining to residents leaving the facility, missing persons, elopement, comprehensively assessing residents for safety in the community, and monitoring/assessing for substance usage upon return. - Completed a comprehensive safe community assessment to identify appropriate levels of supervision, possible risk factors and hazards, and corresponding individualized interventions or safety plans for residents who leave the facility independently. - Updated care plans with individualized interventions. Facility policies and procedures regarding	2 830		

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	00096	A. BUILDING: ______ B. WING ______	C 04/14/2025

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2 830	Continued From page 43	2 830		

resident sign-in/sign-out, missing persons, behavioral health, and substance use disorders requested but not received.

Facility policy titled Elopement Risk dated 5/2024, indicated all admissions, hospital returns, and change of conditions are assessed for elopement risk within the nursing assessment with residents in Minnesota assessed every 90 days. A score of 4 of more indicated risk. A score of 10 or more required an intervention which could include an Electronic Monitoring Device (EMD) i.e. wanderguard. Potential interventions can include but not limited to: 1. Resides in secure memory unit 2. EMD/wanderguard placement 3. Place on elopement list 4. Apply appropriate system to prevent elopement 5. Resident agrees not to leave facility without staff or family member.

Facility policy titled Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting (626.557) dated 8/2019, included "Providence Place shall ensure that the resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, should review/revise policies and procedures related to supervision needs and community safety, and develop individualized person-centered interventions to identify and mitigate risks and hazards for residents when out in the community and upon subsequent return to the facility. The DON or designee should ensure appropriate comprehensive assessments and interventions are developed and implemented for

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2 830	Continued From page 44 all residents with the potential to be affected. The DON or designee should re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk. The DON or designee should develop a system for evaluating and monitoring consistent implementation of policies and procedures and perform measurable audits to monitor for supervision needs. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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F 000	INITIAL COMMENTS	F 000		

On 4/7/25, 4/8/25, 4/9/25, 4/10/25, & 4/14/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 2/27/25, when the facility failed to comprehensively assess appropriate supervision needs and develop individualized person-centered interventions to identify and mitigate risks and hazards for residents when out in the community and upon subsequent return to the facility. The administrator and director of nursing (DON) were notified of the IJ on 4/10/25 at 5:53 p.m. The IJ was removed on 4/11/25.

The above findings constituted Substandard Quality of Care and an extended survey was conducted on 4/14/25.

The following complaint was reviewed: H52712287C (MN00111778) with deficiencies cited at F689.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/06/2025

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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 comprehensively assess supervision needs and develop individualized person-centered interventions to identify and mitigate risks and hazards for residents when out in the community and upon subsequent return to the facility. This failure resulted in the risk of serious harm, injury, or impairment for 3 of 3 residents (R2, R3, R1) reviewed for safety. The immediate jeopardy began on 2/27/25 when the facility failed to ensure a systematic process of an individualized community safety assessment to identify potential risks or establish prevention strategies to ensure resident safety for R2 who had vascular dementia and required supervision, R3 who had significant current alcoholism with impaired insight, judment, and memory, and R1 who had substance abuse disorder (SUD) with cognitive impairment and mobility limitation.	F 689	May 9, 2025 F689 1. R1, R2, R3 will have a comprehensive community assessment completed to identify the level of supervision required when out of facility, risk factors and hazards, and interventions or safety plans needed. In addition, R1, R2, and R3 will have cognitive testing completed. Results of all assessments will be reviewed with interdisciplinary team and care plans updated to reflect everyone’s personalized needs. 2. The Social Service Director and designee will review all residents in the facility and identify those residents that have an active substance abuse concern. All identified residents with an active SUD will have a comprehensive community	5/12/25

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Continued From page 2

The IJ was identified on 4/10/25. The executive director (ED), director of nursing (DON), assistant executive director, and administrative intern were notified of the immediate jeopardy on 4/10/25 at 5:53 p.m. The immediate jeopardy was removed on 4/11/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R2's hospital discharge summary dated 11/5/24 to 11/8/24, indicated R2's past medical history included, abnormal urination (history of incarceration for public urination), aggressive behavior of child (history of physical fights), anxiety disorder, counseling on substance use and abuse (chemical dependency treatment 8 times), family history of suicide, history of psychiatric hospitalizations, intravenous (IV) drug user, self-mutilation, substance use disorder (SUD) - (history of IV heroin, cocaine and alcohol use), and suicidal behavior (R2 reported history of chronic suicidal ideations since 2005). Hospital course identified R2 had failure to thrive, indicating R2 was reportedly altered, covered in feces, urine and had wandered into a shelter confused, according to the shelter. R2 was discharged to skilled nursing facility.

R2's Nurse Practitioner (NP) visit dated 1/6/25, identified R2 had a Saint Lewis University Mental Status (SLUMS) score of 23/30 showing moderate dementia. R2 could live in supportive housing, waiting on assisted living facility (ALF) setting which continues to be appropriate based

F 689

assessment completed to identify the level of supervision required when out of facility, risk factors and hazards, and interventions or safety plans needed. In addition, cognitive testing will be completed. Results of all assessments will be reviewed with the interdisciplinary team and care plans updated to reflect everyone's personalized needs. Any current residents identified as having a history of substance abuse will have a CAGE-AID assessment completed to determine current status. Results of assessment will be discussed with the interdisciplinary team and interventions placed as needed. Care plans will be updated to reflect any current need.
Facility will complete CAGE-AID assessment on all new admission, quarterly, annually, and with significant changes on anyone identified as having a SUD or a history of a SUD. All interventions will be care planned per facility policy.

3. Facilities policy regarding elopement and missing resident was reviewed and updated to ensure it included all necessary parts.
Facilities sign out protocol was reviewed and updated.
Facility will develop and implement "Safety for Residents with Substance Use Disorder" policy.
Facility will develop and implement a system to assess/monitor residents that have a SUD when they return to the facility.

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F 689	Continued From page 3 on scoring. Assessment/Plan identified diagnosis of primary moderate vascular dementia with mood disturbance (moderate degree of cognitive impairment due to vascular disease, accompanied by mood changes with symptoms that may include difficulties with problem-solving, slowed thinking, and loss of focus): mood disturbances longstanding depressive disorder, history of homelessness, recommendation for assisted living setting for future housing. R2's ACP visit dated 1/8/25, identified R2's mental status exam indicated short term memory and insight/judgement was impaired and thought content was blocked. R2's treatment recommendations/plan identified R2 would present as someone who would benefit from remaining in a secure structured setting to support best functioning and quality of life. Strategies to support him to maintain his sobriety area warranted including placement considerations given his history and level of cognition. R2's quarterly Minimum Data Set (MDS) dated 2/11/25, indicated R2 admitted to the facility on 11/8/24 and identified R2 had moderate cognitive impairment. R2's care plan focus dated 2/21/25, identified R2 had cognitive loss/dementia or alteration in thought processes. Interventions included to cue and supervise as needed and observe/document/report to medical practitioner any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. The	F 689	CAGE-AID assessment for newly admitted residents and current residents was implemented All Nursing staff, front desk staff, Medical Records, and administration will be educated on the policy and procedures for missing persons/elopement, Safety for Residents with Substance Abuse Disorder policy, the comprehensive assessment of residents for safety in the community, and monitoring/assessing for substance usage upon return. Education will be provided in large group settings, 1:1, or via telephone conference. Social Services will receive education on the CAGE-AID assessment, assessment schedule, and care planning of the assessment. 4. ED or designee will complete random weekly audits x3 months to ensure all policies and procedures surrounding residents with an active SUD are completed and follow up notifications are made per facility guidelines. Director of Social Services or designee will complete random weekly audits x3 months to ensure CAGE-AID has been completed on all new admissions and with each quarterly, annual, an sig change MDS and that interventions are implemented and care planned per facility guidelines. 5. Audit results and the data collected will be presented to the QAPI Committee monthly by the ED, Social Service Director, or designee. QAPI committee will review and make any necessary	

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F 689	Continued From page 4 care plan lacked evidence of interventions related to safety in the community and did not identify if R2 was safe to be independent in the community or not. R2's progress notes were reviewed in conjunction with facility sign out/sign in forms between 2/27/25 through 4/8/25. Progress notes identified multiple occurrences of R2 leaving the facility without indication that he was supervised. Further identified R2 did not complete the sign-out sheet, notify staff he was leaving, or inform staff of his whereabouts, who he was with/if he had supervision, his expected time of return, and his actual return. R2's progress note dated 2/27/25 at 3:55 a.m., identified R2 was unable to be located, a thorough search of the entire facility including all common areas, rooms, bathrooms, outdoor areas was conducted. A missing person's report made to the police department and the facility DON/supervisor notified. At 4:38 a.m., police came to the facility and gathered more information for R2. At 8:00 a.m., R2 was at the ED with complaints of SOB. ER was assessing and send R2 back to the facility later this morning At 11:10 a.m., R2 returned to the facility via ambulance. The progress notes indicated staff did not know when he was last seen until 3:55 a.m.; R2 was out of the facility and missing for at least 4 hours before the facility identified R2 was at the hospital. R2's record did not include a comprehensive community safety assessment that would identify individualized interventions for R2's safety in the community and/or ability to be unsupervised while out of the facility. R2's progress note dated 3/3/25 at 2:55 p.m., per	F 689	recommendations. Plan of correction will be completed by 5/12/2025	

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F 689	Continued From page 5	F 689		

report R2 last seen at 12:25 p.m. R2 had left the facility. At 3:44 p.m., writer began petition for guardianship for R2. At 4:21 p.m., R2 had not returned to the facility, did not sign out when he departed at 12:25 p.m. At 8:53 p.m., R2 had not returned to the facility yet, last seen at 12:25 p.m., call placed to family with concerns of whereabouts. According to family they have no idea of R2's location. Calls placed to hospitals with no admission record for R2. At 10:50 p.m., R2 had not yet returned to the facility, oncoming night shift nurse updated to call police if not returned to facility by midnight. On 3/4/25 at 12:15 p.m., R2 had not returned yet to the facility ...a call placed to 911 about 12:15 a.m., to report R2 as missing. Police arrived at the facility around 12:55 a.m., gathered all necessary information about R2 missing. On 3/4/25 at 5:45 a.m., R2 was found lying in bed (at the facility) at this time. R2's progress notes identified R2 was gone for 17 hours and 15 minutes and R2's whereabouts were unknown.

R2's occupational therapy (OT) encounter note dated 3/14/25, identified R2 had a SLUMS assessment completed that he scored a 19/30 (score under 20 identified cognitive impairment or potential dementia). Most of R2's points were lost on recall of objects. R2 engaged in community outing involving indoor and outdoor ambulation, wheelchair management (pushes w/c in front of him like a walker), uneven surfaces, dressing, toileting (both independent), money management, social interaction, managing both his device and hot coffee (he did without spilling or burning himself) and general community safety. R2 was educated about therapy trying to get him out of memory care and into a more appropriate setting. Plan: continue functional cognitive assessments

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F 689 Continued From page 6
and functional mobility.

R2's progress note dated 3/14/25 at 11:16 a.m., met with R2 discussed sign out policy when leaving facility and calling if not making it back timely, R2 agreed, writer will assist with ordering a free cellphone. At 9:22 p.m., day shift nurse reported that R2 went outside to smoke. He signed out at approximately 5:30 p.m. However, R2 had not returned, writer called R2's family left message informed shift supervisor. Supervisor stated to wait until midnight if R2 does not return by then will report as a missing person. At 1:12 a.m., R2 did not return to facility, missing person report filed ...At 6:26 a.m., two police officers came to the facility, all necessary information given. On 3/15/25 at 9:33 a.m., hospital emergency room called and stated R2 was being admitted for respiratory difficulty ...At 8:35 p.m., R2 returned to the facility via ambulance. R2's progress notes indicated he was missing and whereabouts unknown for approximately 15 hours.

R2's progress note dated 3/17/25 at 12:45 p.m. staff seen R2 at bus stop, R2 stated he was going to the store via a bus and intended to be back by dinner time. At 5:57 p.m., received phone call from metro transit police said R2 was lost and unable to go back. R2 will be sent back. At 6:31 p.m., R2 was sent back by metro transit police, was found on Penn Avenue/Lowrey Avenue southbound bus stop shelter waiting for a bus. R2 was alert and oriented x 2, denied alcoholic drink, R2 stated he checked out before he left, writer unable to find where R2 signed. Progress note dated 3/18/25 at 12:45 p.m., writer applied for an assurance wireless phone for R2 should arrive within 7-10 business days. R2's progrss notes

F 689

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F 689	Continued From page 7	F 689		

identified R2 was gone for approximately 5.5 hours whereabouts unknown, and identified R2 was lost and unable to make his way back to the facility and the police brought him back.

R2's progress notes dated 3/28/25 at 1:39 a.m., R2 was not in room for scheduled inhaler for COPD. At 2:02 a.m., writer got report from previous shift that R2 had not been seen in the facility since this morning. Writer checked around facility and not available. Writer called 911 and filed a missing person report with police. They will send police out as soon as possible. Writer called family and left message. At 2:50 a.m., police stopped at the facility requesting information regarding R2. Police stated to call and let them know when R2 returns so they can take him off the missing person report. At 10:33 a.m., identified R2 was on LOA. At 2:15 p.m., identified R2 returned to the unit between 1:00 p.m., and 1:30 p.m., R2 went to bed and was sleeping, message left with family that R2 was back. At 2:27 p.m., writer educated R2 on the importance of signing out, R2 stated, "okay..." R2's progress note identified on 3/28/25, R2 was missing for approximately 12 hours and his whereabouts unknown.

-On 4/4/25 at 7:09 p.m., identified R2 was not in the facility until dinner time and med pass time. Tried to contact him through cell phone but did not answer, will continue to follow up. At 11:47 p.m., R2 was not in the facility, called and left voice message incoming nurse updated. On 4/5/25 at 1:12 a.m., writer called R2's phone again and phone went to voicemail left message for call back. Called and filed a missing person report with police. Stated they would send officers to come to the facility, called family, left voicemail.

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F 689	Continued From page 8	F 689		

At 1:30 a.m., police called to inform they will be sending an officer to the facility. At 6:00 a.m., police stopped by to see if R2 was back. At 3:02 p.m., R2 has not returned to the facility, family notified. On 4/6/25 at 12:08 a.m., R2 has not returned to the facility. At 6:42 a.m., R2 did not return to the facility will update incoming nurse. At 12:42 p.m., nurse received a call form the hospital regarding R2's admission due to COPD exacerbation and pneumonia will be arriving back to the facility with medications after 1:00 p.m. At 1:45 p.m., R2 returned from the hospital to the facility at 1:40 p.m., Temperature was 99.1, pulse 105, oxygen saturations 94% on room air and blood pressure was 112/67, no complaints of pain or discomfort.

R2's After Visit Summary (AVS) dated 4/5/25 to 4/6/25 identified R2 was in the hospital for treatment of COPD exacerbation. Summary included The patient presented to the ED due to new onset shortness of breath and mild cough over the past two days. R2 reported he was out of his as needed inhaler and R2 is most likely experiencing exacerbation of COPD due to lack of medication with a possible component of community acquired pneumonia. R2 was discharged with medications to treat this and will have an upcoming appointment with pulmonology on 6/3/25.

R2's medical record identified R2 was gone from facility from 4/4/25 at approximately 7:00 p.m., and returned to facility on 4/6/25 at 1:45 p.m., gone for approximately 42 hours and 45 minutes. R2 was hospitalized from 4/5/25 at 3:11 p.m., and discharged from the hospital on 4/6/25 at 12:58 p.m., accounting for approximately 22 hours of hospitalization, with 22 hours of R2 missing and

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whereabouts unaccounted for.

R2's progress notes dated 4/8/25 at 12:25 a.m., per PM nurse R2 was last seen around noon (on 4/7/25) on the floor ...R2 not on the floor/room. R2's personal cell phone was left in his room. At midnight a call was placed to police and hospital, was not found, filed missing person report. Night supervisor was updated. At 4:27 a.m., two police officers followed up on missing person report ...At 9:03 a.m., R2 returned to the facility, writer had conversation with R2 regarding the importance of signing out and ensuring he has his cell phone with them to keep the facility updated. R2 was in agreement. R2s progress notes identified R2 was gone from facility from 4/7/25 at approximately 12:00 p.m., and returned to facility on 4/8/25 at 9:03 a.m., gone for approximately 21 hours with whereabouts unknown.

During an interview on 4/9/25 at 12:38 p.m., registered nurse (RN)-A stated all residents can leave the building anytime they want unless they reside on the secured unit. RN-A further stated all they must do is sign in/out on the sign out book. RN-A indicated they would not notice a resident was gone unless they went to go give their medications and could not find them. RN-A stated if a resident was not back by midnight, and we could not get a hold of them we would file a missing person's report with the police and document in the nurse's progress notes.

During an interview on 4/9/25 at 4:28 p.m., OT-A stated a resident's cognition will be assessed on admission, the social worker would first screen a resident to get a snapshot of their cognition by performing a Brief Interview for Mental Status (BIMS) assessment. OT-A stated this was used

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to assess for delirium and was not a true show of cognition. OT-A stated the SLUMS exam is a brief screening test for detecting mild cognitive impairment and dementia and assess for orientation, short term memory, calculation and language-verbal fluency. OT-A indicated if the SLUMS score is less than 20 it can indicate dementia and require further cognitive testing. OT-A stated she assessed R2's SLUMS on 3/13/25 and he scored a 19 out of 30 indicating dementia. OT-A stated the Cognitive Performance Test (CPT) assesses a person's cognitive abilities, like memory, attention, and reasoning, through various tasks and questions without being able to the cue the individual. OT-A stated the CPT assessment can be used to diagnose cognitive impairments like dementia and guides interventions and support for persons with cognitive challenges. OT-A indicated the CPT assessment takes about an hour to complete so rarely was utilized in the long-term care setting as it was unrealistic. OT-A was unable to articulate what staff at the facility would be responsible to assess a resident's safety in the community. OT-A identified R2 did not have a CPT assessment, stated she did assess R2 while he was in the community on 3/14/25, and completed a SLUMS assessment with a score of 19/30 that indicated cognitive impairment but was unable to articulate if R2 was able to be safe in the community independently while residing at the facility. OT-A stated R2's short-term memory was not intact and if she was doing a discharge to home assessment on R2, he would require supervision.

During a phone interview on 4/10/25 at 8:29 a.m., when asking nurse practitioner (NP)-A if the facility was responsible for identifying and

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assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address the risk. NP-A stated he was not involved in the process in the identifying and assessing the resident's risk for leaving the facility and the development of associated safety interventions. NP-A stated that all residents that do not reside on the locked unit are able to come and go into the community from the facility and would require the resident to put the date and time they are signing out, where they are going and what time the expected return is. NP-A further stated they cannot stop residents from coming and going as it is their right, stated, "this is not a prison."

During an interview on 4/10/25 at 9:20 a.m., the medical director stated the process for a resident to leave the facility was all the residents that did not reside on the locked unit use a sign in and sign out process. Medical director stated, "we are not a prison, we cannot stop someone from coming and going unless they are in a locked unit." Medical director further stated if a resident was their own decision maker we are assuming they have capacity to go safely in the community unsupervised. Medical director further stated the BIMS assessment was not comprehensive in determining a resident's cognition and to determine true cognition it would be a combination of cognitive tests that include a CPT, SLUMS and the Allen Cognitive Level Screen (ACLS) assessment. Staff did not routinely assess cognition upon admission unless warranted. Medical Director was unable to articulate a facility process of how a resident was comprehensively assessed to be safe independently in the community.

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F 689	Continued From page 12 During a phone interview on 4/10/25 at 10:51 a.m., licensed psychologist (LP)-A stated she performed a SLUMS assessment indicating R2 had cognitive impairment with short term memory impairment. LP-A stated residents with cognition concerns should be comprehensively assessed to be independent in the community several factors would need to be assessed to include cognition, diagnoses, capacity to create a contract and follow through, etc ...then IDT should discuss this to put a safety plan in place for each resident. During an interview on 4/10/25 at 11:16 a.m., when asking director of nursing (DON), if the facility was responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address the risk. DON explained the OT would be the professional to assess a resident to see if they would be safe to be in the community independently unsupervised. DON verified the OT that assessed R2 on 3/14/25, did not clearly state if R2 was safe to be independent in the community unsupervised. DON indicated their current process for a resident to leave the facility was if the resident did not reside on the locked unit the resident would utilize the sign in and sign out sheet located at each wing. The resident should write the time they leave and an expected return time along with where they are going. DON verified that residents do not always use the sign and sign out sheets and was unable to articulate what interventions the facility has in place to keep residents requiring supervision in the community safe. If a resident was missing, the staff call family and the resident to try and identify the resident's whereabouts and are to wait until midnight and call the police to file a missing person's report and notify myself, the	F 689		

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family and the supervisor. DON stated she received a report this morning that R2 went missing yesterday sometime and had not yet returned to the facility, a missing person's report was filed with the police at midnight, and she did not have any more information on R2.

During an observation and interview on 4/14/25, at 9:48 a.m., R2 was observed dressed and lying in bed in his room. R2 stated he currently didn't feel good and has the sniffles, further stated he was put on the locked unit because he was smoking in his room, "rules are rules, don't bother me none." R2 stated he didn't come here to make friends and tried to stay to himself. R2 stated he was waiting to get out of here and get his own place. R2 stated he had been to the ED and hospital a few times recently due to his mental health. R2 did not wish to speak with surveyor any further and asked surveyor to leave.

R3
R3's quarterly MDS dated 3/18/25, indicated R3 admitted to the facility on 11/2023. R3 was cognitively intact with a BIMS score of 15, was independent with activities of daily living and mobility, and utilized a wheelchair.

R3's diagnosis report indicated R3 had diagnoses including alcohol [ETOH] abuse with withdrawal, alcohol dependence, alcoholic hepatitis (liver inflammation due to excessive ETOH consumption), alcoholic polyneuropathy (nerve damage from excess ETOH consumption), liver cirrhosis (scarring of the liver), opioid abuse, unspecified psychosis, major depressive disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, adjustment disorder with disturbance of conduct,

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muscle weakness, unsteadiness on feet, history of falling, repeated falls.

R3's psychiatry note dated 12/20/24, indicated she had diagnoses including generalized anxiety disorder, alcohol use disorder, major depressive disorder, and opioid use disorder. Her mental status examination included "her insight, judgment, memory, and concentration are quite impaired."

R3's physician orders included naltrexone hydrochloride (HCl) 50 mg daily for substance use disorder (dated 2/14/25).

R3's care plan focus revised 3/25/25, identified she had limited physical mobility with fall risk related to ETOH abuse and noted she was independent with ambulation and utilized a wheelchair as needed. Interventions included: independent with bed mobility (dated 11/29/23), utilizes wheelchair as needed independently (dated 3/25/25), independent with toileting (dated 4/5/24), and independent with transfers (dated 4/5/24).

R3's care plan focus revised 3/25/25, identified she had suspected/actual illicit drug/ETOH use and previously declined treatment services but had started to talk with the LADC. Interventions dated 4/5/24 included: Doctor updated regarding actual/suspected abuse, hold all mood altering or all sedative medication when ETOH or marijuana use suspected; Ensure safety and observe for withdrawal symptoms; and a list of symptoms of a drug overdose including alcohol poisoning. R3's care plan did not identify the symptoms of alcohol withdrawal or identify her supervision needs in the community or related interventions for her safety

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in the community and upon subsequent return to the facility.

R3's physician note dated 1/8/25, indicated she had alcohol use disorder with recurrent episodes of alcohol use. She was most recently hospitalized 11/28/24 after being found intoxicated and "her blood alcohol level was 0.33."

R3's progress notes dated 1/9/25, 1/12/25, 1/13/25, 1/14/25, 2/8/25, and 2/9/25 indicated R3 was intoxicated and medications were refused and/or held. The notes did not indicate the provider was notified or identify what ongoing monitoring and interventions were implemented.

R3's progress notes dated 2/10/25, indicated R3 was intoxicated, medications were held, vital signs taken, and provider was notified. R3 later request transport to the hospital because she wasn't feeling well and reported vomiting all day.

R3's hospital notes between 2/11/25 through 2/13/25 identified R3 had a history of alcohol abuse and admitted to the hospital on 2/10/25 with nausea and vomiting. R3's principal diagnosis was alcoholic ketosis (buildup of acid in the blood caused by heavy alcohol use often in conjunction with poor nutrition) and she initially presented with tachycardia (elevated heart rate) to the 120's, hypertensive (elevated blood pressure) to 180's/100's, with numerous abnormal lab values. A hospital Social Work Initial Assessment indicated R3 reports she uses the w/c when at the facility, does not use an assistive device when she leaves the facility. She leaves the facility independently, usually via a cab ride she independently arranges. Patient reports her

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typical outing includes stops at Target and a liquor store. A progress note by hospitalist included R3 reported the nursing home "don't really monitor where she goes so she regularly walks down to the bar on the corner of the street and drinks."

R3's progress note dated 2/13/25, indicated R3 returned from the hospital. R3's record did not identify the concerns in hospital documentation, including lack of assistive device when leaving the facility and purchase/consumption of alcohol while in the community, were addressed. Further, did not indicate that her need for supervision in the community was assessed.

R3's progress notes dated 2/25/25, indicated R3 was "extremely intoxicated" and found sleeping on the floor next to her bed with partially consumed bottles of alcohol at 3:00 a.m. Assessment and vital signs completed, assisted back to bed, and staff "kept monitoring her situation" with intervention of lowering her bed to the floor to prevent injuries in case she decided to get out of bed. The provider notification section of the note was blank and did not indicate the provider was notified. Further, progress notes indicated R3 remained intoxicated throughout the day, did not eat breakfast or lunch, refused all morning and afternoon medications, and refused assessment and vital signs.

R3's progress note dated 2/25/25 at 8:55 p.m., indicated nurse went to get R3 from front desk, R3 was intoxicated, R3 stated she fell while downtown and hit her head while trying to get on a bus. R3 refused vitals, neurological checks performed, provider notified. Additional progress note at 10:58 p.m., indicated R3 sustained a bruise and head hematoma from the fall,

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identified contributing factor of R3 was not using her wheelchair, and noted care plan and care sheets were reviewed with no changes indicated. It was not evident in R3's record that her supervision needs were assessed or interventions were developed to ensure her safety in the community after she fell and sustained a head injury while intoxicated in the community.

R3's record reviewed between 2/26/25 through 4/10/25 identified although R3 continued to be intoxicated almost daily, R3's record did not include a comprehensive assessments and/or monitoring of withdrawal symptoms nor assessments and/or monitoring of R3's medical condition while she intoxicated, nor safety interventions including the level of supervision while R3 was intoxicated inside the facility. Further there was no indication a monitoring system was developed to prevent and/or identify if/when R3 brought or had alcohol in room and not evident interventions were developed to keep R3 safe and other residents safe that may inadvertently have access to R3's alcohol. Additionally, R3's records did not include a comprehensive community safety assessment, despite R3's patterned history of leaving the facility, consuming alcohol while away, then returning intoxicated. R3's record did not include interventions that would prevent and/or mitigate R3's risks of serious injury or even death while in the community. Examples from the record include but are not limited to:

R3's progress notes dated 2/26/25, 2/27/25, 3/1/25, 3/4/25, 3/5/25, and 3/11/25, indicated R3 was intoxicated and medications were refused and/or held. On 3/4/25, alcohol was also found in R3's room and she was verbally abusive towards

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staff and refused cares.

R3's progress notes dated 3/12/25, indicated R3 was intoxicated, verbally aggressive to staff, and medications were refused and/or held. Note at 1:27 p.m., indicated she was sent to the hospital per provider order. Note at 8:06 p.m., indicated she was sent to the hospital for evaluation of a suspected gastrointestinal bleed after being found in her room intoxicated with black stool smeared in the bathroom. She returned to the facility at 6:30 p.m. and was still intoxicated, medications were held.

R3's emergency department (ED) After Visit Summary dated 3/12/25, indicated R3 was seen for an alcohol problem and blood in stool with diagnosis of alcoholic intoxication with complication.

R3's nurse practitioner note dated 3/14/25, indicated she was seen for evaluation following intoxication and concern for a gastrointestinal bleed two days ago. R3 "continues to drink," "had a blood alcohol level of 0.36," and "she states that her last drink was several weeks ago but this is not accurate."

R3's progress note dated 3/18/25, indicated R3's functional status abilities varied related to alcohol use. When intoxicated, she required supervision/touching assistance of one staff member for bed mobility, transfers, and ambulation for safety. When intoxicated, she required limited assistance of one staff member with toileting tasks and colostomy management. She was able to make her needs known but staff were to anticipate her needs as appropriate when intoxicated. R3's care plan did not identify

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individualized interventions that reflected the increased need for assistance when intoxicated.

R3's Comprehensive Nursing Data Collection assessment dated 3/18/25, identified R3 was vulnerable to self-abuse described as alcohol abuse, susceptible to abuse from others described as vulnerable adult, susceptible to abuse others, and had verbal behavioral symptoms directed at others described as a history of verbal aggression when intoxicated. The assessment identified R3 had alcohol use daily and history of substance/cannabis abuse was marked as never. The assessment failed to identify R3's diagnosed history of opioid abuse. The Data Collection included an elopement assessment with each 'yes' answer assigned one point and a score of 4 or greater indicating potential for elopement. R3 had an elopement risk score of 3 indicating no elopement risk. The questions "exhibits pacing or agitated behavior" and "has a diagnosis or OBS, dementia, psychosis, Alzheimer's, or other psychiatric diagnosis," were marked no. The assessment failed to identify R3's agitated behaviors where documented in provider and progress noted between 1/8/25 through 3/18/25, and further failed to identify R3's psychiatric diagnoses of unspecified psychosis, major depressive disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and adjustment disorder with disturbance of conduct. If the assessment identified these areas accurately, R3's score would have been 4 or greater, identifying her as an elopement risk.

R3's progress notes dated 3/22/25 and 3/23/25, indicated R3 was intoxicated and medications were refused and/or held. Progress note dated

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3/28/25, indicated R3 left the facility to go to the mall, walked out, and refused to sign out. Later returned in "good condition." R3's progress notes did not identify how long R3 was out of the facility and/or when R3 returned.

R3's progress notes dated 3/29/25, indicated she was missing from the unit at 8:00 a.m. and remained missing at 2:00 p.m. with supervisor to follow up. Note at 6:14 p.m., identified person in the community called the facility and stated resident was drunk and needed to be picked up, provided address, staff notified police. At 9:15 p.m. police dropped R3 off at the facility. She was intoxicated, non-compliant with cares, refused vital signs and assessment, and provider was notified. R3's record did not identify assessment of R3's supervision needs after she was found intoxicated in the community and returned to the facility by police. Further, did not identify what interventions were put in place to mitigate related risk while in the community and upon her return.

Progress note dated 3/30/25, indicated R3 was intoxicated the whole overnight shift and called emergency services at 6:00 a.m. and was taken to the hospital while still intoxicated. There was no assessment or indication why R2 was sent to the hospital.

R3's ED After Visit Summary dated 3/30/25, indicated R3 was seen for an alcohol problem with diagnosis of alcohol intoxication delirium with moderate or severe use disorder.

Progress notes dated 3/30/25, indicated R3 returned from the hospital around 12:00 p.m. R3 then requested a cab be called for a shopping trip, refused to sign out, and receptionist informed

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unit staff R3 did not wait for a cab and took the bus. R3 returned around 2:16 p.m., sounded slurred, and stated she never made it to the store.

R3's progress notes dated 3/31/25, indicated R3 was intoxicated and a partially consumed bottle of alcohol was found in her room. R3 refused cares, medications were held, and nurse noted "please continue to monitor closely."

R3's progress notes dated 4/1/25, indicated R3 was intoxicated and medications were refused and/or held. R3 refused assistance with cleaning her room, but staff removed items that could cause R3 to fall and placed wheelchair at bedside. At approximately 7:15 p.m., R3 went downstairs and called emergency services who transported her to the hospital per her request.

R3's ED Observation Discharge Summary physician note dated 4/2/25, indicated R3 was admitted from 4/1/25 and discharged back to the facility on 4/2/25 with diagnoses of altered mental status and ethyl alcohol poisoning. R3 had "risk of complication from severe intoxication requiring close observation." R3 "presented to the emergency department with altered mental status. Intoxication was suspected, and a breathalyzer for Ethyl alcohol was obtained. A legal hold was placed on the patient due to their inability to care for self which represented a danger to self in addition to their chemical dependency status that is in question due to intoxication." R3's initial breathalyzer result was 0.208 percent (concentration of alcohol in a person's breath to estimate their blood alcohol content. Results between 0.08 and 0.40 percent indicate legally intoxicated and very impaired).

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R3's psychology note date 4/2/25, indicated R3 "continues to drink excessively and was hospitalized." It noted R3 identified triggers including her roommate, being more physically ill, falling often, and her family member not visiting much. R3 would benefit from a secure setting to support best functioning and quality of life along with a harm reduction approach for substance abuse management when she is drinking, staff striving to have a harm reduction plan and reproaching her as necessary may help. She may benefit from a safety plan which this psychologist can help draft. Further, "the care team identifying strategies to help keep her busy may help overall monitoring her for behavior can guide treatment goals. What might trigger her drinking and resulting behavior." R3's cognitive exam indicated her short-term memory, insight/judgement, and thought content were all impaired with dysthymic anxious mood, labile affect, and impaired behavior.

Review of R3's record did not identify a safety plan nor a harm reduction plan.

R3's progress notes dated 4/5/25, indicated R3 refused morning medications, left the facility around 10:30 a.m. and signed out after directed to do so, refused to state where she was going or when she would return, and the front desk called her a taxi per her request. At 11:40 a.m. R3 returned with no concerns. Additional note identified R3 returned to the facility at 1:30 p.m. It was not evident in R3's record if she left the facility again after returning at 11:40 a.m. Note at 5:51 p.m., indicated R3 smelled like alcohol and called emergency services who transferred her to the hospital, provider was notified. At 11:30 p.m., R3 returned to the facility with no concerns.

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R3's ED Provider Note dated 4/5/25, indicated R3 presented via emergency medical services for evaluation of alcohol problem. R3 stated she drank some alcohol earlier that day but denied a history of alcohol withdrawal. R3 walked out informing staff and without having further workup completed reported R3 reported "she only needed a place to rest".

R3's progress notes dated 4/6/25, indicated R3 was intoxicated and medications were refused and/or held.

R3's progress note dated 4/8/25, indicated R3 left the facility at 2:00 p.m. and did not sign out.

R3's progress notes dated 4/9/25, indicated R3 left the facility at 8:30 a.m. after harassing staff, went downstairs, and was seen outside waiting for a cab. R3 returned at 12:30 p.m. and seemed intoxicated, refused assessment, and medications were held. R3's record did not include an assessment of R3's condition prior to leaving the facility.

R3's nurse practitioner note dated 4/9/25, indicated she was in the ED on 4/2/25 for alcohol use and discharged back to the nursing home where she has continued to use alcohol periodically. Provider noted R3 "appears that she has been drinking alcohol but denies this." On exam, R3 was "alert somewhat belligerent calling out at times" and "appears sleepy and slightly impaired mental status." The assessment and plan for the diagnosis of alcohol use disorder noted "continues to have periodic alcohol use is not interested in further alcohol treatment continues on gabapentin." The note did not

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identify R3's repeated recent instances of leaving the facility unsupervised and without complete staff notification and then returning to the facility intoxicated or indicate that her needed level of supervision was assessed.

R3's progress note dated 4/10/25, indicated R3 was intoxicated, refused cares, refused vital signs, medications were held, and provider notified.

Facility sign out/sign in forms titled Providence Place Release of Responsibility for Leave of Absence (LOA) dated 3/10/25 through 4/9/25 from R3's unit were reviewed. Records included one entry for R3, undated at 1:00 p.m., with R3's name and signature, destination of a fast food restaurant, and ETA 4:00 p.m. The sign-in section was blank.

During an interview on 4/9/25 at 12:46 p.m., NA-C stated R3 left the facility frequently and would not come back. NA-C stated she had seen R3 intoxicated before and this happened at least once a week.

During an interview on 4/8/25 at 11:11 a.m., RN-C stated for a resident with an SUD she would check orders to see what care they needed, like holding certain medications. RN-C stated "for [R3] there are no orders for interventions that need to be done." RN-C would check on R3 when she appeared intoxicated and get vital signs if R3 would allow, "but there are no interventions or orders for about what to do if she's drunk." When R3 was drunk, she's very angry, throws up, refuses her medications, and tends to try to leave the facility. RN-C noted SUD's should be on the care plan and interventions could be vital signs,

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keeping a resident hydrated, doing hourly checks if they seem intoxicated, and monitoring. RN-C would be concerned about someone with an SUD leaving the facility without supervision because they could leave and use their substance of choice or buy something illicit. For R3, "she isn't fully there" and "could end up somewhere and not know where she is, could be a risk to leave if she's intoxicated."

During an interview on 4/9/25 at 12:33 p.m., RN-B identified monitoring should be done for intoxicated residents and identified signs of alcohol withdrawal, but was unsure of signs and symptoms of alcohol poisoning. RN-B was not aware of specific interventions in place for R3's alcohol use apart from holding meds. RN-B noted R3 frequently left the facility, was more likely to be intoxicated when she returned, was intoxicated at least twice a week, and did not always sign out. RN-B stated there were no specific safety interventions for R3 and he alcohol use, she had been offered treatment in the past and refused.

During an interview on 4/9/25 at 5:02 p.m., OT-A stated R3 has previously been on therapy's caseload, however, OT-A did not identify a community safety assessment in R3's record.

During an interview on 4/10/25 at 11:10 a.m., LP-A stated R3 often goes out from the facility and drinks. LP-A identified R3 was at risk when leaving the facility independently without notifying staff and was "so vulnerable in terms of potential assault or exploitation", became aggressive when intoxicated, and drank almost every time she was outside of the facility. LP-A would expect R3's care plan to include her SUD and that she might

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leave frequently. LP-A would further expect the care plan to include monitoring for patterns of when she is intoxicated and harm reduction like encouraging rest, vital signs and monitoring when intoxicated, removing alcohol from her room, identified triggers for substance use, and psychological consults. Additionally, she would expect a safety plan to be in place for when R3 does go into the community and consideration of how staff can intervene to try to distract her or encourage her to do something else.

During an interview on 4/14/25 at 2:30 p.m., the DON stated R3 had not been comprehensively assessed to identify risks and hazards in the community and stated R3 "really needs supervision." The DON stated R3 did not have safety interventions in place to address risks and hazards when in the community and upon subsequent return that met her expectations. The DON identified R3 could fall, get hurt, or worse when in the community without supervision. The DON noted R3 was usually gone for an extended time and drinking when she went out of the facility and "she gets intoxicated and can't rationalize what's happening to her" and concerns included "getting lost, being taken advantage of, falling and getting hurt, passing out on the street." The DON would expect R3's SUD's to be care planned, would expect provider notification every time she was intoxicated, and would expect a community safety assessment to have been completed to identify R3's needed level of supervision in the community.

During an interview on 4/10/25 at 9:05 a.m., MD-A stated he was not aware of R3's recent alcohol use because the nurse practitioner would be the one notified. He was not aware of staff

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reports that she was intoxicated multiple times weekly. MD-A stated he would expect staff to do "some kind of monitoring" if she was intoxicated and did not expect staff to necessarily do anything else as long she was monitored "properly." MD-A could not articulate what constitutes "proper" monitoring. MD-A was asked if he expected the medical team to be notified if R3 returned from the community and appeared intoxicated and stated he did not know because it depended on the facility's framework for notification. MD-A stated he was not in a judgement role and could not identify if he was okay with a notification not being made in such a situation, though would expect provider notification for an alteration in a resident's condition. MD-A noted he relied on safety assessments completed by the facility to determine if a resident was safe in the community.

During an interview on 4/10/25 at 9:40 a.m., the medical director stated he had "obvious concerns" with a resident with an SUD leaving the facility without supervision. The medical director noted if a resident returned and staff suspected they were intoxicated or had used, the primary provider should be notified and a standing order to hold medications used. He would expect staff to monitor the resident per provider instruction and noted an inebriated resident was at increased risk for falls. A resident with a blood alcohol content of 0.3 could have acute alcohol intoxication or, in patients who were functional and walking around, this could be alcohol withdrawal self-treated with alcohol consumption. The medical director noted "any LPN or RN" should be aware of alcohol withdrawal symptoms and "it's dangerous, you could die, go into status

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epilepticus [prolonged seizures that are a medical emergency], blood pressure could go up and down with delirium tremens [life-threatening form of alcohol withdrawal]." When a resident leaves the facility there was no way for staff to know what they do, but staff would see such signs in a resident and contact the provider and send the resident to the hospital if needed.

R1
R1's quarterly Minimum Data Set (MDS) dated 2/21/25, indicated R1 admitted to the facility on 11/2024. R1 had verbal behaviors towards others on one to three days of the seven-day assessment period and had limited range of motion in one upper and lower extremity. R1 required maximal assistance with toileting, bathing, dressing, bed mobility, and transfers and was independent with wheelchair mobility.

R1's diagnosis report indicated R1's diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebral infarction (stroke), alcohol use, cocaine use, anxiety disorder, restlessness and agitation, cognitive communication deficit, muscle weakness, need for assistance with personal care, and unspecified fall.

R1's physician note dated 11/18/24, identified R1 admitted to the facility from a hospital after she was found down with a significant stroke and brain bleed "thought due to cocaine use."

R1's speech therapy note dated 11/19/24, indicated a cognitive test, the Montreal Cognitive Assessment (MoCA), was completed and R1 scored 11 out of 22, with scores of 18 or greater considered within normal limits. R1 was very

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impulsive, inattentive, and demanding throughout session.

R1's Diagnostic Assessment completed by licensed psychologist (LP)-A dated 11/20/24, indicated R1 had diagnoses including substance abuse of cocaine and alcohol and adjustment disorder with mixed disturbance of emotions and conduct. R1 presented with reduced insight and judgment and scored 17 out of 30 on the St. Louis University Mental Status examination (SLUMS), suggesting signs and symptoms of cognitive impairment. She presented with deficits in short-term memory, calculation, executive functioning, and comprehension. Treatment recommendations included "cognitive performance testing other assessments can also help identify functional support needs she will benefit from." Goals included "increased understanding of pattern of problematic substance use ... objectives include increasing knowledge of harm reduction strategies to reduce risk if drug use continues, reducing likelihood of relapse."

R1's care plan dated 3/14/25, identified a potential for communication problem with difficulty expressing ideas/wants and understanding verbal content. Interventions included "cue and supervise as needed." The care plan identified R1 was a vulnerable adult. The care plan did not identify the level of supervision R1 needed according the SLUMS assessment and occupational therapy recommendation dated 11/29/24. The care plan did not identify R1's cocaine and alcohol substance use disorders or associated interventions. The care plan did not identify R1's pattern of leaving the facility without complete staff notification, leaving without

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supervision, or associated interventions.

R1's occupational therapy note by occupational therapist (OT)-B dated 11/29/24, indicated a SLUMS cognitive assessment was completed with score of 15 out of 30 and deficits in short-term memory, executive functioning, visual processing, and numerics. The response to treatment section noted, "recommend 24/7 supervision per SLUMS assessment due to cognitive deficits."

During an interview on 4/8/25 at 10:06 a.m., occupational therapist (OT)-B stated she completed R1's SLUMS assessment dated 11/29/24. OT-B stated she would have safety concerns about R1 in the community, "I can imagine her getting lost, turned around in the community," and noted there were times R1 "wasn't understanding a lot of higher-level things." OT-B noted that if in the community unsupervised, R1 could fall, end up somewhere she shouldn't be, or end up in an unsafe situation with another person. OT-B stated there was a "higher level cognitive aspect that was a unique concern we had with her [R1]" including things like problem solving, understanding rules, and cause and effect. OT-B stated, "I think if I saw [R1] on the sidewalk in downtown Minneapolis I would be very concerned" and would expect to see her recommendation for 24/7 supervision to be followed through on by whoever was taking care of R1 and expect to see the supervision implemented and care planned. OT-B further stated making this recommendation was not something she took lightly.

R1's progress note dated 1/5/25, indicated, staff was notified by neighbor resident was couple

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blocks away from facility waiting for her son to come. Two staff went to get the resident and brought her back to the facility safely, resident went out earlier and took the bus with unknown destination.

R1's progress note dated 1/6/25, indicated staff confirmed R1 had signed out the previous day for her outing and understood the facility sign out process and leave of absence (LOA) guidelines. R1 confirmed she would talk with staff and family in the future prior to signing out "so we know she is safe."

R1's progress notes were reviewed in conjunction with facility sign out/sign in forms. Progress notes and sign in/sign out forms identified multiple occurrences of R1 leaving the facility without indication that she was supervised. Further identified R1 did not consistently complete the sign-out sheet, notify staff she was leaving, or inform staff of her whereabouts, who she was with/if she had supervision, her expected time of return, and her actual return.

Facility sign out/sign in forms titled Providence Place Release of Responsibility for Leave of Absence dated 3/10/25 through 4/9/25 included multiple entries for R1 with missing information and/or incorrectly completed and/or illegible. Forms included sign out section identifying date, time, name, signature of person accepting responsibility for resident, destination, and approximate time of return (ETA). Sign in section included date, time, and signature of person upon return. Review of the records identified the following entries for R1:
- Sign out on 3/17/25 with no sign in
- Sign out 3/18/25 with sign in on 3/18/25

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- Sign out undated with sign in on 3/19/25
- Sign out undated with sign in on 3/19/25 a second time
- Sign out undated with sign in on 3/23/25
- Sign out 3/27/25 with undated sign in
- Sign out undated with no sign in
- Sign out undated with no sign in
- Sign out dated April (day illegible) with no sign in
- Sign out undated with no sign in
- Sign out undated with no sign in
- Sign out 4/4/25 with no sign in
- Sign out undated with no sign in

R1's progress note dated 3/18/25, indicated R1 called a taxi to go to a fast food restaurant, did not tell staff, and was seen outside waiting for her ride. Staff "convinced" R1 to go back inside and sign out. R1 then took the taxi "leaving independently," even though OT had recommended 24/7 supervision on 11/24/24, no indication of reassessment, and no indication safety interventions were put into place. R1's record did not identify when and/or if R1 returned to the facility on 3/18/25.

R1's progress note dated 3/19/25 at 5:52 p.m., indicated resident not on unit since start of this shift. Writer called resident to find out when she is returning to facility. Per resident she will return around 8 pm this evening. Additional progress note dated 3/19/25, indicated R1 returned at 9:00 p.m.

R1's psychology note dated 3/26/25, indicated R1 had impaired insight/judgement and thought content. Staff reported R1 had cognitive deficits "however is still her own decision maker and sometimes leaves the building." The note identified she had "limited insight into her health

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conditions as evidenced by not being able to explain why she couldn't walk."

R1's physician note dated 4/1/25, indicated R1 had a history of alcohol and cocaine abuse and was found down on a welfare check with an intraparenchymal hemorrhage (brain bleed) prior to admission and "cocaine was the most likely cause of the intracranial hemorrhage." The note identified R1 was seen by psychiatry on 3/14/25 with psychiatrist "noting adjustment disorder with mixed disturbance of emotions and conduct in addition to substance use disorders." The physician visit did not address R1's the cognitive assessments (MoCA dated 11/19/24, SLUMS dated 11/20/24, or SLUMS dated 11/29/24) that all identified R1 was cognitively impaired and unable to make decisions nor address R1's safety related to her cognition while out in the community unsupervised.

R1's progress note dated 4/2/25 at 2:40 p.m., indicated "Resident not on unit at start of shift. Resident signed herself out." Progress note dated 4/2/25 at 9:27 p.m., indicated R1 returned to the facility.

R1's speech therapy note dated 4/7/25, indicated a MoCA assessment was completed and results included deficits in scores for visuospatial/executive functioning, naming, delayed recall, attention, language, and orientation. The score was 17 out of 30 indicating moderate cognitive impairment.

Although the assessment dated 4/7/25 identified R1 had cognitive impairment in addition to documentation of substance use disorders and impaired mobility, it was not evident there had

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been a comprehensive assessment completed to identify R1's risk factors/vulnerabilities in the community nor evident safety interventions and/or level of supervision needed was determined and implemented even though she frequently left the facility without supervision.

R1's progress note dated 4/8/25 at 3:29 p.m., indicated "per report resident left facility on day shift around 1:00 p.m. Progress note dated 4/8/25 at 5:17 p.m., indicated a nursing assistant (NA) reported R1 said she would return tomorrow. Progress note dated 4/8/25 at 7:02 p.m., indicated R1 returned to the facility.

During an interview on 4/8/25 at 9:14 a.m., speech language pathologist (SLP)-A stated she completed a cognitive assessment, the MoCA, with R1 yesterday and "her cognition is definitely impaired." SLP-A identified R1's MoCA score of 17 out of 30 indicated "moderate to moderate severe cognitive impairment" in cognitive skills including visuospatial, executive functioning, attention, delayed recall, and abstraction. SLP-A noted cognitive assessments like the SLUMS are repeated infrequently because people can learn them and they become ineffective. She had repeated R1's assessment because it had been five months which was an appropriate time period for reassessment. SLP-A noted, "it would scare me to see her [R1] go into a public place" independently and identified concerns as R1 lashing out at someone, being unpredictable, not bringing her phone, self-propelling in her wheelchair backwards with a lack of safety awareness, left-sided hemiparesis, needing assistance with toileting, and difficulty problem solving.

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During an interview on 4/8/25 at 10:40 a.m., certified occupational therapy assistant (COTA)-A stated R1 lacked safety awareness, needed assistance getting around, was cognitively impaired, and impulsive. COTA-A would be concerned if R1 was out in the community unsupervised as R1 could get lost or not return, have difficulty navigating and maneuvering, get hurt, or hurt someone else. COTA-A noted R1 tended to self-propel in her wheelchair backwards because of her flaccid left leg, lacked awareness of where she was going, had run into walls before, and needed frequent staff reminders to watch where she was going. COTA-A stated R1 was not safe on her own in the community and needed supervision because of impaired cognition, mobility, impulsivity, problem solving, and mood.

During an interview on 4/7/25 at 11:56 a.m., the DON stated R1 could leave the facility independently and she didn't have to have supervision. The DON could not a identify a date and/or completed assessment that identified R1 did not need 24/7 supervision as per the OT recommendation dated 11/29/24. DON stated it was determined that R1 was safe to go into the community independently because "she is 100% cognitively intact," alert and oriented, not incompetent, and aware of her limitations however, the DON could not identify a date and/or assessment that conflicted with the cognitive assessments completed on 11/19/24, 11/20/24, 11/29/24, and 4/7/25. The DON noted if R1 wanted to go into the community by herself she would be assessed by therapy for community safety, but R1 only went out with family. The DON did not identify R1's history of not properly completing the sign-out sheet, notifying staff she

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was leaving, or informing staff of her whereabouts, who she was with/if she had supervision, her expected time of return, and her actual return.

During an interview on 4/7/25 at 12:45 p.m., the director of rehabilitation (DOR) confirmed a community safety assessment had not been completed for R1 and did not recommend R1 leave the facility without supervision based on her cognitive testing. The DOR stated he was aware of at least one time when R1 had left the facility without supervision.

On 4/8/25 at 11:24 a.m., health unit coordinator (HUC)-A stated R1 signed out that morning and did not complete the sign-out form fully or accurately. R1 did not tell HUC-A details about her plans and HUC-A was on the phone when R1 signed out. HUC-A stated, "no one was with her when she left." HUC-A did not indicate further action or interventions were needed to confirm R1's whereabouts or safety.

During an interview on 4/8/25 at 11:28 a.m., nursing assistant (NA)-D stated on 4/8/25, R1 had told her she was leaving for the day and did not tell NA-D where she was going, but HUC-A said she had signed out. NA-D stated when R1 said she was leaving NA-D did not tell her anything, "I don't have authority to tell her where she can or cannot go" NA-D confirmed she did not ask R1 for further details about her trip into the community. NA-D did not identify actions or interventions needed to confirm R1's plans or current safety.

During an interview on 4/7/25 at 10:47 a.m., NA-B stated she knew if a resident was okay to leave

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the facility and go into the community independently based on care plans, how they transfer, if they were independent, and would decide based on that. NA-B would be worried about R1 going into the community without supervision because she was a vulnerable adult and required staff assistance of one for getting up and transfers. NA-B noted if R1 was her own family member, she would not want R1 in the community unsupervised.

On 4/8/25 at 3:06 p.m., NA-A stated she had seen R1 leave the building independently and not come back until the next day multiple times. NA-A stated R1 had recently left the facility on 3/17/25 with family to celebrate her birthday at the casino, was gone overnight, police and family had been contacted. R1 finally returned the next morning and "it seemed like she was on something [illicit drug]." When R1 was talking, her mouth was twitching, she wasn't making eye contact like normal, seemed like she was in a different space. NA-A noted other times R1 would go into the community she would come back different. NA-A was unaware of R1's substance use history until she learned of it from family on 3/17/25. NA-A did not think R1 was safe in the community by herself. During a subsequent observation and interview at 3:28 p.m. on 4/8/25, NA-A confirmed R1 was not present in her room and stated she was not aware of R1's whereabouts as she was not told. NA-A went to check the resident sign out/sign in sheet and noted it stated R1's name with destination of "fresh air downtown" and return time of 8:00 p.m., but there was not a date identified. Licensed practical nurse (LPN)-C informed NA-A that she had seen R1 leave the facility around 1:30 p.m. LPN-C nor NA-A identified interventions needed to confirm R1's

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safety at this time after it was noted that she was absent from the facility.

During an interview on 4/7/25 at 4:44 p.m., licensed practical nurse (LPN)-A noted R1 could go out but needed someone to check on her. LPN-A stated he had smelled marijuana on R1 before. When this happened LPN-A would "keep an eye on her" and hold scheduled medications if she appeared under the influence.

During an interview on 4/7/25 at 4:54 p.m., LPN-B stated, "there is a concern with her [R1's] decision making," concern with her mobility, and the potential for a bad outcome if she left the facility unsupervised. LPN-B expressed concerns about R1's cognition, coordinating, and communicating because she could be erratic and spontaneous. Someone who is erratic is not safe to be in the community without supervision. LPN-B noted R1 did not always sign out or communicate with staff when leaving the facility. When staff noticed she was missing they would call her family, call her, and update their supervisor. LPN-B noted if a resident was out past the time they were supposed to return and staff were looking for them and couldn't find them in the community, they would update the police.

During an interview on 4/7/25 at 10:25 a.m., registered nurse (RN)-C stated she was not sure how residents were assessed for safety in the community independently, but care plans usually said if a resident was independent or required assistance. She had not seen care plans identify if a resident was okay to leave the facility independently and did not know where this would be identified in a resident's record. She noted there was a safety assessment that could be

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completed but she did not know who completed them.

During an interview on 4/7/25 at 11:02 a.m., RN-A noted residents were assessed to determine if they were safe to leave the facility independently based on physical and cognitive status. RN-A stated, "If family is taking them it is something different, but if they are going by themselves, they have to be able to go physically and cognitively." RN-A would check the care plan and physician orders for this information.

During an interview on 4/8/25 at 2:52 p.m., RN-D stated R1 goes out a lot and most times goes by herself. When RN-D would ask R1 for details about her outings R1 would not provide them. RN-D had concerns about R1 going into the community unsupervised due to her one-sided weakness, need for staff assistance, being a vulnerable adult, and refusing help when she needs help.

During an interview on 4/7/25 at 11:41 a.m., the social services director (SSD) stated resident safety in the community was assessed based on cognition and mobility. SSD noted social services performed the Brief Interview for Mental Status (BIMS) assessments, but therapy did more cognitive performance testing, SLUMS assessments, and community assessments. The SSD stated staff relied on therapy to do testing. The SSD noted safety in the community was care planned by exception when there was an issue like a resident not signing out or leaving and not coming back.

During an interview on 4/7/25 at 9:38 a.m., the director of rehabilitation (DOR) stated therapy

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was responsible for completing community safety assessments. They were completed if a resident was discharging home soon or upon facility request. DOR noted the facility requested the assessment when a resident wanted to go out and hadn't been out before, if staff knew a resident was going out frequently and using public transportation, or if a resident wanted to go out without family supervision. The DOR stated SLUMS scores, cognitive performance testing (CPT), ambulation status, and community assessments were part of therapy's recommendation for a resident's needed level of supervision in the community.

In an interview an 4/8/25 at 11:45 a.m., licensed alcohol and drug counselor (LADC), stated he had received a referral for R1 but R1 declined services. The LADC noted there were always safety concerns for someone with a substance use disorder (SUD) going out into the community. He noted it was important for staff to know if a resident had a SUD because there are certain things and behaviors to look for. Further, it would be important for staff to know withdrawal symptoms and what being under the influence looks like because withdrawal is very dangerous. The LADC noted he was sure nurses had education on drug-seeking behaviors, but there was more to it, like being manipulative, behavior changes, isolating, little signs.

During an interview on 4/10/25 at 11:10 a.m., licensed psychologist (LP)-A stated R1 had a moderate level of cognitive impairment with score of 17 out of 30 on a SLUMS assessment in November 2024. LP-A noted R1's history of cocaine and alcohol abuse and likely use within the last year. LP-A was not aware of staff

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concerns about R1 potentially using substances while out in the community but noted it could be occurring. LP-A noted R1 was vulnerable and she would want her to have an escort in the community for safety. LP-A noted R1 showed poor insight and a lack of judgement and staff should be watching her and when she comes and goes, what triggers her, and when does she tend to leave. She would expect to see R1's SUD care planned with monitoring of patterns like when she leaves, does she leave alone, when does she come back as well as checking vital signs, assessing to see if she seems more impaired or is acting off, and contacting providers as needed. LP-A noted care plans should be comprehensive and individualized to minimize risk but still provide quality of life.

During an interview on 4/10/25 at 9:05 a.m., medical doctor (MD)-A stated he had possible concerns about R1's safety in the community and identified her history as part of the concern, as she could potentially leave the facility and use illicit substances. MD-A stated a community safety assessment should be done and, if one had not been completed, he would ask for one. MD-A would rely on assessments completed by the facility to determine if a resident was safe to be in the community.

During an interview on 4/10/25 at 9:40 a.m., the medical director stated he had "obvious concerns" about residents with an SUD going into the community unsupervised because "they may be using, that's a concern." If a resident returned from the community and seemed impaired, he would expect the primary doctor to be notified and staff to follow provider recommendations for monitoring.

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The immediate jeopardy that began on 2/27/25 was removed on 4/11/25 and was verified through observation, interview, and document review when the facility implemented the following interventions:
- Reviewed/revised elopement and missing persons policies and procedures in conjunction with the resident sign-out/sign-in protocols.
- Developed and implemented a system to assess and monitor residents with an SUD when they return to the facility from the community.
- Educated staff on procedures pertaining to residents leaving the facility, missing persons, elopement, comprehensively assessing residents for safety in the community, and monitoring/assessing for substance usage upon return.
- Completed a comprehensive safe community assessment to identify appropriate levels of supervision, possible risk factors and hazards, and corresponding individualized interventions or safety plans for residents who leave the facility independently.
- Updated care plans with individualized interventions.

Facility policies and procedures regarding resident sign-in/sign-out, missing persons, behavioral health, and substance use disorders requested but not received.

Facility policy titled Elopement Risk dated 5/2024, indicated all admissions, hospital returns, and change of conditions are assessed for elopement risk within the nursing assessment with residents in Minnesota assessed every 90 days. A score of 4 of more indicated risk. A score of 10 or more required an intervention which could include an

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F 689	Continued From page 43 Electronic Monitoring Device (EMD) i.e. wanderguard. Potential interventions can include but not limited to: 1. Resides in secure memory unit 2. EMD/wanderguard placement 3. Place on elopement list 4. Apply appropriate system to prevent elopement 5. Resident agrees not to leave facility without staff or family member. Facility policy titled Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting (626.557) dated 8/2019, included "Providence Place shall ensure that the resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents."	F 689		