Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 15, 2023

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

RE: CCN: 245271
Cycle Start Date: October 2, 2023

Dear Administrator:

On October 11, 2023, we notified you a remedy was imposed. On October 27, 2023, 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 October 25, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 26, 2023, did not go into effect. (42 CFR 488.417 (b))

In our letter of October 11, 2023, 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 October 26, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Electronically delivered
October 11, 2023

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

RE: CCN: 245271
Cycle Start Date: October 2, 2023

Dear Administrator:

On October 2, 2023, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 Region V Office for imposition. The CMS Region V Office 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 October 26, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 26, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 26, 2023.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 26, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Providence Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 26, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division 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 April 2, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 11, 2023

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

Re: Event ID: IGQD11

Dear Administrator:

The above facility survey was completed on October 2, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 10/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/29/23 and 10/2/23, a complaint survey was conducted at your facility by surveyor from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey. H52715951C (MN00097231, MN00097233) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 10/02/2023

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

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F 000	INITIAL COMMENTS On 9/29/23 and 10/2/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52715951C (MN00097231, MN00097233) with a deficiency issued at F695. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 695 SS=G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews, and records review, the	F 695	F695	10/25/23

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

Electronically Signed | 10/16/2023

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 695	Continued From page 1 facility failed to ensure provision of oxygen therapy according to orders for 1 of 1 resident (R1) reviewed for respiratory care. This resulted in harm for R1 whose saturation levels were 65% after not receiving continuous oxygen as ordered by physician and had to call Emergency Services herself because the facility failed to respond to her call light (2 hours and 15 minutes) when she became short of breath. Findings include: R1's order summary report (OSR) as of 9/29/23, listed R1's diagnoses including history of sudden cardiac arrest, dependence on supplemental oxygen, chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, and chronic obstructive pulmonary disease. The OSR directed staff to provide oxygen continuously at four liters per minute via nasal cannula, ensure tubing patency and proper flow rate, and ensure that portable tank is filled prior to use. The OSR also directed staff to obtain oxygen saturation and record results every shift. R1's quarterly Minimum Data Set (MDS) dated 7/27/23, showed that R1's cognition was not assessed, and R1 did not have any behavioral symptoms. The MDS identified R1's diagnoses including chronic obstructive pulmonary disease (COPD) and respiratory failure. MDS also indicated R1 was on oxygen therapy and independent with activities of daily living (ADLs) such as transfer, locomotion on unit, dressing, personal hygiene, and eating, but required limited physical assistance of one staff during toilet use. The corresponding care plan for the-above MDS, completed on 8/1/23, identified R1 with altered	F 695	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R1 has been discharged from the facility. 2. An internal audit was completed identifying all residents that currently receive Oxygen therapy. The Facilities Guideline on O2 delivery was reviewed. 3. All residents currently receiving Oxygen therapy had orders reviewed to ensure orders were accurate and o2 saturation monitoring was in place every shift. The Facilities Guideline on O2 delivery and monitoring was reviewed. 4. All facility Nursing Staff received re-education regarding the delivery and monitoring of residents on O2. Expectations regarding call light response times were also reviewed with Nursing Staff. The Nurse in question received a discipline for her documentation error.	

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F 695	Continued From page 2 respiratory status/difficulty of breathing related to COPD and chronic respiratory failure. The care plan directed staff to provide oxygen as ordered. The care plan indicated R1's specific behavior was related to refusal of showers/bathing and refusal for assistance with bathing. The care plan did not indicate behavior related to non-compliance with oxygen therapy, such as ability to get up from recliner and turn on/off oxygen tank/concentrator. The care plan also showed updates or revisions after the care plan completion date (8/1/23), as follows: -On 8/16/23, the care plan related to R1's respiratory problem directed staff to observe/document and report to nurse/medical practitioner any sign or symptom of respiratory distress including decreased pulse oximetry. The care plan pertaining to R1's limited physical mobility with fall risk, also indicated R1 required staff assistance for ambulation, transfer, and to propel wheelchair to and from all destinations. The care plan did not indicate that R1 had behavioral issues related to oxygen therapy as of this date. R1's discharge MDS dated 8/19/23 (most recent assessment data prior to the hospitalization on 9/25/23), indicated change in R1's ADL performance where R1 required staff supervision for bed mobility, transfer, locomotion on unit, dressing, and personal hygiene. This MDS noted R1 had rejection of care occurring one to three days in a seven-day period but did not identify any other behavioral symptoms that could impact a significant risk for illness or physical injury, or that could interfere with R1's care. The corresponding care plan to the assessment	F 695	The facility will complete weekly random audits x1 month on those receiving o2 to ensure flow rate is correct and resident continues to utilize o2 as ordered without issues/concerns. Care plans will be updated to include any changes or ongoing behavioral concerns surrounding call lights or removal of oxygen. Random call light audits will be completed ongoing x1 month to ensure timely response. Results of audits will be reviewed by QAPI committee monthly. 5. POC date of correction : October 25th, 2023	

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F 695	Continued From page 3 data identified on and after 8/19/23, showed the following updates/revisions: -On 8/21/23, the care plan related to ADL performance indicated further change, where R1 required set up with eating. The care plan revision did not indicate R1 had any behavior regarding oxygen therapy. -On 9/6/23, the care plan related to R1's limited physical mobility with fall risk, indicated that the intervention for fall was placement of "commode at bedside" and to "encourage [R1] to wear briefs for incontinence management." This care plan update did not show R1 had behaviors regarding oxygen therapy. -On 9/29/23 (survey entrance date), the interventions in the care plan related to R1's incontinence, indicated R1 prefers to wear "own underwear" and "uses commode independently." The care plan directed staff to keep commode at bedside and for staff to empty after each use. This recent care plan update showed conflict with R1's ADL performance that required limited assist of one-person physical help during toilet use that did not change since the MDS dated 7/29/23 and staff supervision required during transfers as identified since the care plan update on 8/16/23 and MDS dated 8/19/23. -On 9/29/23 (survey entrance date and while R1 was on discharged status and still at the hospital), the care plan related to R1's behavior was updated to include the following: refuses to allow staff to turn off call light; removes oxygen nasal cannula or will turn off tank; refuses to allow staff to replace or turn on oxygen tank; de-saturates and refuses assessments; calls 911	F 695		

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F 695	Continued From page 4	F 695		

independently of staff and removes oxygen before their arrival. The care plan did not indicate interventions or action plans specific to address these "behaviors" related to oxygen therapy.

R1's medication administration record (MAR) for the month of 9/23, indicated an order to obtain R1's oxygen saturation every shift and record result. The MAR also indicated that on 9/25/23, the evening medications, including R1's oxygen saturations "results" for the evening and night shifts were already entered as 93 and 92 respectively, even though R1 was discharged to the hospital at 1:20 p.m. in the afternoon.

The document titled, Nursing Home Visit-Progress Note dated 8/16/23, indicated provider evaluation following R1's hospitalization for hypercapnia (condition that occurs when a person has too much carbon dioxide (CO 2) in their bloodstream). The document indicated R1's COPD as severe disease with oxygen dependency. The document also indicated R1 was alert, talkative, pleasant, and reiterated to be on a full code status. The document dated 8/23/23, showed another provider "evaluation of respiratory status following hospitalization August 19 through 21 with altered mental status on chronic hypoxemic respiratory failure." The document noted provider discussion about hospice care related to R1's severe respiratory difficulty and likelihood of death due to the difficulty, however, R1 maintained to be on full code status. The document also noted the plan for R1 to remain on multiple breathing treatments and oxygen.

A review of the progress notes dated 9/1/23 through 9/26/23 showed no indications related to

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F 695	Continued From page 5	F 695		

R1 having behaviors related to noncompliance with oxygen therapy. The progress notes showed that on 9/5/23, R1 "fell on urine on the floor." Although, R1 was oxygen-dependent, the progress notes documented R1 "was not on supplemental oxygen and is not normally on oxygen." The progress notes dated 9/25/23, indicated R1 called 911 due to shortness of breath, and was taken to hospital at around 2:00 p.m.

The facility's call light log for four days (9/21/23 through 9/25/23) showed multiple times of prolonged call light response times (15 times of longer that 15 minutes, five times of longer than one hour, and two times of longer than two hours) as follows:

-On 9/21/23 at 8:41 a.m. (22 minutes)
-On 9/21/23 at 9:25 a.m. (21 minutes)
-On 9/21/23 at 6:30 p.m. (20 minutes)
-On 9/21/23 at 7:29 p.m. (21 minutes)
-On 9/21/23 at 8:12 p.m. (27 minutes)
-On 9/21/23 at 9:50 p.m. (1 hour and 9 minutes)
-On 9/22/23 at 9:31 a.m. (24 minutes)
-On 9/22/23 at 12:06 p.m. (1 hour and 22 minutes)
-On 9/22/23 at 6:59 p.m. (22 minutes)
-On 9/23/23 at 6:47 a.m. (53 minutes)
-On 9/23/23 at 11:26 a.m. (20 minutes)
-On 9/23/23 at 11:52 a.m. (21 minutes)
-On 9/23/23 at 12:39 p.m. (38 minutes)
-On 9/23/23 at 2:22 p.m. (2 hours and 38 minutes)
-On 9/24/23 at 1:05 p.m. (37 minutes)
-On 9/24/23 at 1:48 p.m. (28 minutes)
- On 9/24/23 at 3:30 p.m. (39 minutes)
- On 9/24/23 at 4:24 p.m. (27 minutes)
- On 9/24/23 at 7:41 p.m. (26 minutes)

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	245271	A. BUILDING _____ B. WING _____	C 10/02/2023

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PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

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F 695	Continued From page 6 -On 9/25/23 at 1:11 p.m. (2 hours and 15 minutes). This entry showed that R1 had call light on for more than 2 hours prior to EMS arrival at the facility and finding her in room with an oxygen saturation of 65%. During interview on 9/29/23 at 12:30 p.m., police officer (PO)-A indicated responding to R1's call at the facility on 9/25/23 at around 1:00 p.m. PO-A stated they found R1 sitting in recliner, alert, short of breath, and with oxygen nasal cannula in place, however, it was connected to an oxygen concentrator that was turned off. PO-A stated the oxygen concentrator was behind R1 at about three to four feet away from the recliner, which was not within R1's reach. PO-A also stated R1 reported to the emergency medical services (EMS) crew she started being short of breath and called for help via call light for "half an hour" but nobody was responding. PO-A indicated they checked R1's oxygen saturation and it was 65%, so they immediately connected R1 to their portable oxygen tank, after which R1 reported feeling better. PO-A stated he noticed an un-touched meal tray on R1's table but did not know what meal it was or what day or time it may have been brought in. PO-A also stated he observed that R1's call light was on and remained on while they worked with R1, but no staff came to the room. PO-A stated they only saw staff as they were leaving to take R1 to the hospital. PO-A further stated they stayed at the facility for about seven to 10 minutes. During interview on 9/29/23 at 12:02 p.m., family member (FM)-A indicated R1 had three recent hospitalizations, and with this last one, R1 was not able to breath. FM-A stated the facility told her that R1 was turning off oxygen and it was	F 695		

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F 695	Continued From page 7 because of that her saturation went down to 60%. FM-A stated that during a care conference on 8/28/23, the facility indicated R1 was declining with cares and had limited mobility. FM-A indicated behaviors related to R1 turning off oxygen tank/concentrator was not identified during the care conference. FM-A said, "I have never seen her touch her oxygen concentrator or tank at all, never." FM-A also stated during one of her visited she had witnessed R1 wait an hour for a light to be answered. FM-A further stated that oxygen management and the long un-answered call lights are among the reasons why she requested that R1 not return to the facility when she gets discharged from the hospital. During interview on 9/29/23 at 12:53 p.m., the hospital staff (HS)-A identified HS-B as the one who encountered R1, who presented for shortness of breath at the emergency department. On 10/02/23 at 4:30 p.m., HS-B verified having seen R1 at the emergency department on 9/25/23. HS-B stated that R1 remains a patient at the hospital with an admitting diagnosis of acute on chronic hypercapnic hypoxic respiratory failure. During interviews with multiple staff members who provided direct care with R1, indicated consistent staff knowledge and observations about R1's lack of ability to transfer independently and that R1 did not exhibit behaviors pertaining to turning her oxygen concentrator off and not letting staff members turn off call light when answered, as follows: -On 9/29/23 at 4:31 p.m., nursing assistant (NA)-A R1 used to go to the bathroom herself but within the last month, she could no longer do that	F 695		

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F 695	Continued From page 8 because of difficulty breathing and shortness of breath. NA-A stated R1 cannot transfer herself without staff. NA-A also stated R1 was compliant with oxygen use and had not observed R1 take her oxygen off. NA-A further stated that R1 "will let you turn the call light off when you are there but once you turn back, she would put her light on again." -On 9/29/23 at 4:45 p.m., licensed practical nurse (LPN)-A stated R1 cannot turn oxygen on or off and staff members had to do that for her. LPN-A stated that although R1 can put or remove the nasal cannula from nostrils, she is alert and was compliant with oxygen use. LPN-A also stated she never saw R1 remove her oxygen cannula or turn off oxygen tank. LPN-A further stated R1 will let staff turn off the call light when answered. -On 9/29/23 at 4:50 p.m., NA-B stated R1 could not get up from recliner and walk by herself, R1 needed staff assistance for transfers. NA-B also stated R1 could not turn on or off the oxygen concentrator or tank. NA-B also stated "once [R1] puts the light on, it's automatic, you have to be there." NA-B further stated he always turned the call light off when responding to R1's call, and R1 did not say anything. -On 9/29/23 at 4:53 p.m., NA-C stated that she worked with R1 almost every day. NA-C described R1 as someone who cannot get up from recliner without staff supervision and could not go to the bathroom by herself. NA-C stated R1 was alert and cooperative with oxygen therapy. NA-C further stated she never saw R1 take off her oxygen or turn off the oxygen concentrator or tank.	F 695		

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F 695	Continued From page 9 -On 10 to 23 at 12:39 p.m., NA-F stated R1 was always in recliner chair and would not get up without staff helping. NA-F stated R1 always had her oxygen on. NA-F also stated to have never seen R1 without oxygen. -On 10/2/23 at 6:00 a.m., NA-G stated she had worked with R1, who needed one assist to get her up from recliner NA-G stated she never saw R1 remove or take oxygen off. NA-G also stated R1 would let staff turn call light off when she answered. -On 10/2/23 at 3:42 p.m., NA-H stated R1 always had her oxygen on, and he never saw R1 remove oxygen cannula or turn off oxygen tank. NA-H also stated R1 had always let him turn off call light when answered. -On 10/2/23 at 4:11 p.m., LPN-B described R1 as "a complicated case" because she gets very anxious when not connected to her oxygen. LPN-B stated, "If she's in her recliner, then she could not turn off or on her oxygen." LPN-B further stated R1 "is declining" and needed staff assistance to stand up. During interview on 10/02/23 at 12:23 p.m., LPN-A indicated she was the nurse for R1 on 9/25/23. LPN-A stated R1 was difficult during medication pass at about 9:00 a.m. LPN-A stated one of the aides helped R1 to the bathroom while a podiatry staff was waiting to take her to another floor for podiatry services. LPN-A stated she left R1 in her room with an aide at about 9:45 a.m. and had no idea when R1 returned from podiatry services. LPN-A also stated she did not know that R1 was short of breath and had low oxygen saturation. LPN-A stated she did not know that	F 695		

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F 695	Continued From page 10 R1 called 911. LPN-A indicated the next time she saw R1 was when she was leaving with the EMS crew, where R1 identified her to them as the nurse. Regarding pre-signing medications and pre-entering data R1's oxygen saturation for the evening of 9/25/23, despite R2 being in the hospital, LPN-A could not explain how it happened but acknowledged that was an error. During interview on 10/02/23 at 10:15 a.m., NA-D identified herself taking care of R1 on 9/25/23. NA-D stated she remembered R1 was rocking in her chair and described R1 as one who did not have the capability to get up from the recliner without a staff member to help. NA-D stated, "In my opinion, she's a sit to stand" indicating R1's need for an assistive device to help with transfers. NA-D stated that she assisted R1 into her recliner when she returned to the room from podiatry service, and that she switched R1's oxygen tubing from the portable tank to the longer tubing going to the concentrator. NA-D stated she did not touch the oxygen concentrator to turn it on, but NA-D said she knew the concentrator was already on because of the noise coming from the machine, and that she asked R1 if it was on, which R1 replied it was working. NA-D denied manually checking the oxygen concentrator to ensure it was on. NA-D further stated the last time she was in R1's room that day was about 12:30 p.m. and then she went to the 1st floor to relieve another staff member. NA-D indicated not knowing R1 called 911 related to shortness of breath. NA-D stated she did not see the EMS people arrive at or leave the facility. During interview on 10/02/23 at 3:46 p.m., the nurse practitioner (NP) stated that R1 "recently had a decline overall," and NP indicated talking to	F 695		

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F 695	Continued From page 11 R1 about going into hospice care but R1 declined. The NP stated R1 had severe COPD and it is very important to have the oxygen on all the time, and R1 understood that need. The NP stated that an oxygen saturation of 65% "is not compatible with life." The NP added oxygen deprivation produces confusion to the person, and if not getting enough oxygen, a person may say something or does something because of the confusion, and could change a person, or make a difficult personality. The NP further stated, "I'm grateful she called herself in." During interview on 10/2/23 at 4:55 p.m., the director of nursing (DON) stated that she won't argue that R1 de-saturated on 9/25/23 but added R1, "did this to herself." The DON stated R1 got up from recliner and walked towards oxygen concentrator to turned it off. The DON stated she knew this because R1, "did it before and she fell because she was trying to get up to go turn off her oxygen." The DON contradicted the information derived from pre-existing records dated prior to the incident (such as the behavior care plan dated 8/1/23 without the revisions made on 9/29/23 and the MDS data dated 8/19/23), and from all the other interviews, including staff members, regarding R1's decline in condition, and R1 having no behaviors related to oxygen use. The DON also did not consider the most recent revisions in R1's care plan related to ADLs (care plan revisions dated 8/16/23 and MDS dated 8/19/23), instead, the DON marked the old interventions in the care plan and said R1 can walk short distances in her room independently. The DON also stated that R1's behaviors also included not allowing staff to turn the call light off after being answered, which was not corroborated by any of the direct care staff	F 695		

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F 695	Continued From page 12 members interviewed. The DON stated surveyor "should ask the management staff because they know" this as R1's behavior. Regarding staff giving/signing off evening medications, including pre-entering assessment data for the evening and night shifts related to R1's oxygen saturation despite R1 having left the building at 1:20 p.m. on 9/25/23, the DON stated having no expectations pertaining to that practice "as long as it gets done and on record." The facility's assessment and care plan policy were requested but the DON stated the facility follows the RAI (Resident Assessment Instrument) manual. The facility's respiratory care policy/procedure was also requested, and the facility provided a document titled, Documentation Guide: Community Life, undated, which did not specify guidelines for staff to follow to ensure provision of respiratory care, specifically, oxygen therapy according to the orders.	F 695		