STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	03/19/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the physician was notified of significant weight changes for 1 of 3 residents (R3) reviewed for change of condition. In addition failed to notify the family of a change in condition and start of a new medication for 1 of 3 residents (R1). Findings include: R3's admission Minimum Data Set ((MDS) dated [DATE], identified R3 had intact cognition. R3 required extensive assistance with bed mobility, transfers, dressing, toileting and hygiene. R3 required supervision with walking in room, locomotion on unit and was independent with eating. R3's hospital discharge orders dated 2/21/20, included an order to call physician if weight increased by 2 pounds (lbs.) in 24 hours or 5 lbs. in 7 days from admission weight. Further, R3 had been in the hospital due to a fall, foot and blood stream infection and heart failure exacerbation. R3's facility orders dated 2/21/20, directed the staff to perform daily weight (+/- 2 lbs. in one day or +/-5 lbs. in one week). Record amount of weight difference. R3's record review of weights and vitals section revealed the following: 2/21/20 -2/23/20 lacked evidence of weight being obtained. [DATE]-2/28/20 showed 6.9 lbs. weight loss (389.3 lbs. to 382.4) in one day. The documentation lacked notification of the physician. [DATE]-3/11/20 showed a 13.1 lbs. weight increase (377.5 lbs. to 390.6 lbs.) in one day. The documentation lacked notification of the physician. 3/11/20-3/12/20 showed a 5.4 lbs. weight loss (390.6 lbs. - 385.2 lbs.) in one day. The documentation lacked notification of the physician. 3/12/20-3/13/20 showed a 2.1 lb. weight loss (385.2 lbs. - 387.3 lbs.) in one day. The documentation lacked notification of the physician. When interviewed on 3/19/20, at 12:20 p.m. licensed practical nurse (LPN)-A stated if a resident had a change in condition nursing were to notify the doctor or nurse practitioner right away. Additionally nursing would call family or emergency contact if there was a change in the plan of care. LPN-A stated those calls and updates would be documented in the nurse's notes. When interviewed on 3/19/20, at 12:25 p.m. clinical manager registered nurse (RN)-A stated typically the nurse would call and update the provider of weight differences if a resident had an order to notify of changes. Expectation would be to always notify the doctor with change even if resident was stable and to document the notification. On 3/19/20, at 12:57 p.m. the director of nursing (DON) stated there were some gaps and lack of documentation in the progress notes about weight changes. DON stated with a change in condition the expectation would be to chart and use situation, background, assessment and recommendation (SBAR) in the nurses progress notes that doctor and family were notified. The DON stated some of the discrepancies in R3's weight were from a new wheelchair cushion and differences between weights from the wheelchair versus the lift. DON stated they obtained a clarified order from the nurse practitioner on 3/19/20, about weights. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1 was moderately impaired for daily decision-making ability, totally dependent for transfers between surfaces, required extensive assist of 2 staff for dressing, personal hygiene and toilet use. The MDS further indicated R1 had left-sided weakness. R1's care plan, last revised 3/2/20, indicated family member (FM)-B was R1's guardian, and was to be updated, along with physician with any change in condition and before R1 was sent to the hospital. A progress note (PN) dated [DATE], at 5:53 a.m., indicated R1 was sent to the hospital per orders from the on-call provider. The PN further indicated the Nurse Practitioner was updated via voice message, but there was no indication FM-B was notified that R1 was sent to the hospital. A PN dated [DATE], at 3:39 p.m., indicated FM-B was notified when R1 returned from the hospital. A PN dated 3/6/20, at 2:37 p.m. indicated R1 was started on [MEDICATION NAME] (an antibiotic) for Urinary Tract Infection [MEDICAL CONDITION], and there was no indication FM-B was notified. On 3/19/20, at 12:42 p.m., FM-B was interviewed by phone and stated R1 was tested for a UTI, but had not heard anything more from the facility. FM-B further stated she would expect to be notified if R1 started on any new medication, and that would include an antibiotic. On 3/19/20, at 2:20 p.m., registered nurse (RN)-B was interviewed and stated family would be notified of any change in condition and that inlcude hospitalization and medication changes. RN-B further stated this notification would be documented in the progress notes. On 3/19/20, at 2:27 p.m. clinical manager RN-C was interviewed and stated family would be notified if a resident was started on an antibiotic for a UTI. RN-C further stated family notification should be documented in progress notes. On 3/19/20, at 2:46 p.m. the director of nursing (DON) was interviewed and stated a residents' primary contact should be notified for hospitalization s and any change in medications and that would include the start of antibiotics. The DON further stated the progress notes should reflect notification of these changes to family. The facility policy Change in Condition dated 12/2019, identified staff are to initiate the change in condition (SBAR) tool when a resident has a change in condition. Non-immediate and routine notifications to be made same day during normal business hours. The SBAR tool is to be used for all changes that require physician/nurse practitioner notification unless there are other specific physician/nurse practitioner directed orders. The policy directed staff to notify the family/primary contact using the SBAR format.

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

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.