DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 2, 2022

Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, MN 55419

RE: CCN: 245071
Cycle Start Date: May 25, 2022

Dear Administrator:

On July 27, 2022, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

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Electronically delivered
June 16, 2022

Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, MN 55419

RE: CCN: 245071
Cycle Start Date: May 25, 2022

Dear Administrator:

On May 25, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 25, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 25, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	245071	A. BUILDING _____ B. WING _____	C 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET CAREVIEW HOME	**5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/22/22-5/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/22/22 - 5/25/22 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: MN81467/H5071106C, MN81487/H5071108C, MN76142/H5071111C, MN83533/H50711783C, MN81686/H5071107C, MN80953/H5071110C, MN81287/H5071109C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2022

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 regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to	F 578		7/22/22

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F 578	Continued From page 2 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a valid Provider Orders for Life-Sustaining Treatment (POLST) was completed and signed for 1 of 1 residents reviewed for POLST completion. Findings include: R157's admission Minimum Data Set (MDS) dated 5/8/22, indicated R157 was moderately cognitively impaired, and required extensive assist of two staff for bed mobility, transfers, and dressing. The MDS indicated R157 had diagnoses including high blood pressure, diabetes, respiratory failure, and dementia. R157's Admission Record dated 5/24/22, indicated R157 was admitted on 5/2/22, and included family member (FM)-A was the responsible party and resident representative. Section A (CPR - cardiopulmonary resuscitation) of R157's original POLST (undated) was marked Do Not Attempt Resuscitation (Allow Natural Death) / Do Not Intubate (DNI). The form lacked documentation in sections C (documentation of discussion) and F (health care professional who prepared document). In addition, the POLST lacked a signature or verbal confirmation of code status by R157 or FM-A and lacked a provider signature.	F 578	Signed POLST was obtained for R157 on 5/24/22. POLST Policy updated 6/23/22. Audit of all resident advanced directives to ensure all have a signed POLST complete 6/24/22. Education will be provided to Admissions department to look for code status from hospital prior to admission by 7/1/22 Education will be provided to Health Unit Coordinators to ensure advanced directive orders are in place at admission by 7/1/22. Education will be provided to nurses on process to initiate POLST upon admission by 7/22/22. Education will be provided to nurse managers on reviewing POLST at care conferences by 7/1/22. Audits of new admission advances directives will be completed weekly x4 weeks and then monthly x3 months beginning 6/27/22 to ensure ongoing compliance. Results of audits will be reported to QAPI committee.	

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F 578	Continued From page 3	F 578		

A Care Conference Summary note dated 5/18/22, at 9:20 a.m. indicated R157 had a care conference on 5/18/2022, 10:15 a.m. The note identified the meeting was attended by (FM)-A and indicated "POLST/Code status was reviewed and current."

R157's Order Summary Report reviewed 5/23/22, at 5:04 p.m. lacked an order for code status.

R157's care plan reviewed 5/23/22, at 5:05 p.m. lacked indication of code status.

An interview on 5/23/22, at 5:01 p.m. RN-C stated a resident's code status was found in the electronic medical record or in the resident's paper chart. RN-C located the POLST in R157's paper chart and pointed out "DNR" was checked. RN-C had not noticed R157's POLST was not completed and was not signed by R157, FM-A's or the medical provider, but verified the form was incomplete.

An interview on 5/23/22, at 5:12 p.m. RN-D verified R157 had no code status order in the electronic record and the POLST was incomplete.

During interview on 5/23/22, at 5:39 p.m. registered nurse (RN)-B stated code status was found in the computer and the paper chart, and she would look in the paper chart for the document first if needed. She stated nurses asked the resident or representative to sign it on the first day of admission, and if the representative was not at the facility staff called them to obtain the information and informed the supervisor.

During interview on 5/23/22, at 6:07 p.m. FM-A

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F 578	Continued From page 4	F 578		

stated given R157's condition, he did not expect staff to perform CPR as she would not be able to handle the physical ramifications of cardiopulmonary resuscitation (CPR) and felt she would not survive being placed on a ventilator. He stated they had a care conference the previous week and they did not address code status at that time. He stated he was not sure if the facility had anything on record, and the time he addressed code status was with hospital staff before admission to the facility.

During interview on 5/23/22, at 7:40 p.m. RN-A stated the nurse filled out the POLST form right away with the family, made a copy for the paper chart for reference, and placed the original in a box for the provider to sign. Once signed, the original was uploaded into the electronic record and placed in the paper chart.

During interview on 5/24/22, at 8:45 a.m. director of nursing (DON) stated the POLST was addressed by the nurse immediately upon admission, and if there was not an order staff spoke with the resident about their wishes. She stated if the resident was not capable of making the decision, they contacted the responsible party or review hospital transfer paperwork to see if it included a POLST, and if not, initiated the completion of a POLST. She stated she did not know what happened regarding R157's POLST and was unsure of the signing process, but if there was not an order staff needed to obtain one.

The facility POLST policy dated 6/5/19, indicated upon admission a nurse will meet with the resident and/or responsible party to review, discuss, and complete the POLST. The policy

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F 578	Continued From page 5 indicated sections A, C, and F must be completed, and the goal is to have the MD/NP discuss and complete section B. When the sections are completed, the resident wished will be entered into the electronic medical record by nursing or health information. The policy also included the following underlined statement: "The Wishes of the resident are valid when the POLST is signed by the Resident/patient/ resident representative."	F 578		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure a safe temperature of less than 41 degrees Fahrenheit (F) was maintained in a food storage	F 812	Maintenance staff checked and fixed refrigerators that were not the appropriate temperatures on 3rd and 5th floor. All refrigerators are in working order and	7/1/22

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F 812	Continued From page 6 refrigerator. This practice could promote bacterial growth and food borne illness and had the potential to affect all 14 residents who resided on that unit. Findings include: During observation on 5/22/22, at 8:47 a.m. a temperature log was not found for two freezers and five refrigerators located on the second, third and fifth floor dining rooms. During observation on 5/22/22, at 11:30 a.m. a temperature log was not found for the refrigerator on the fourth floor dinning room refrigerator. During interview on 5/24/22, at 1:14 p.m. culinary director (CD)-A stated the nursing department's supervisor conducted daily temperature checks on the unit's dining room refrigerator. Culinary supervisor (CS)-B stated the nursing supervisor would note the temperature in the kitchen's logbook. During interview on 5/24/22, at 1:59 p.m. with CS-B and CD-A confirmed the nursing supervisor, not the dietary aids, were responsible to check and document the dining room's refrigerator temperature. CS-B stated on the days where a temperature was missing, that indicated staff forgot to check or document the temperature in the logbook. CS-B stated the 89 blank spaces on the temperature log was an ongoing problem with the staff. During interview on 5/25/22, at 8:18 a.m. nursing assistant (NA)-E stated the dietary aids check the dining room refrigerator's temperature.	F 812	within the appropriate temperature range. The Food Storage policy was reviewed and updated on 6/21/2022. Clarification was made that the culinary department is responsible for checking the temperature of food storing refrigerators. Education will be provided to culinary staff by 7/1/22 on the updated Food Storage policy, the process to take temperatures, temperature safe zones, and what to do if a Culinary Aid finds that a refrigerator is not at a safe temperature. To track refrigerator temperatures going forward a new temperature log was created and moved into the Culinary Aid binder on each unit. It is the responsibility of the Culinary Aid to check the temperature and document it each morning. Additionally, an audit tool was developed to check that the log is in each binder, temperatures are documented, and the temperatures are within the appropriate ranges. Culinary supervisors will complete this audit weekly x4 weeks. The Director of Compliance will then complete the audit monthly x3 months. Findings from these audits will be shared with the QAPI Committee.	

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F 812	Continued From page 7 During observation and interview on 5/25/22, at 8:19 a.m. dietary aid (DA)-C stated each morning the kitchen staff were responsible for checking the dining room refrigerator's temperature. DA-C was unable to explain why 13 out of 24 spaces on the log sheet for the second-floor west refrigerator were blank. During interview on 5/25/22, at 8:22 a.m. DA-C stated he "always checks" the second-floor east dining room refrigerator temperature. DA-C was unsure what the refrigerator temperature range should be. Review of the second-floor east's dining room log sheet indicated no temperature was documented for 24 out of 24 days. During interview on 5/25/22, at 8:28 a.m. DA-A stated the kitchen staff were required to check and document the dining room refrigerator's temperature. DA-A was not sure what the refrigerator temperature range should be. During an interview and observation on 5/25/22, at 8:32 a.m. the third-floor west dining room refrigerator temperature was 46 degrees. DA-E stated the refrigerator temperature should be above 35 degrees, but he did not know the maximum temperature range. The third-floor west refrigerator thermometer was a Sysco refrigerator/freezer thermometer. The gauged area from 26 to 32 degrees was highlighted in a light blue color and titled "deep chill." The gauge area from 35 to 41 degrees was highlighted in dark blue and titled "ref" for refrigerator. The gauged area from 50 degrees to 70 degrees was highlighted in red. DA-E was not aware of the highlighted areas on the thermometer gauge or what it indicated. DA-E stated if a temperature was not documented on the log sheet, the staff	F 812		

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F 812	Continued From page 8	F 812		

did not check it, or they forgot to document their findings. DA-E verified the refrigerator temperature was 46 degrees. DA-E stated the refrigerator had been open many times while serving breakfast causing a higher than recommended temperature. DA-E stated he would re-check the temperature later to ensure proper functioning. If the temperature remained high, he would notify his supervisor.

During interview on 5/25/22, at 8:41 a.m. NA-F stated the dietary aids check the dining room refrigerator temperatures.

During interview and observation on 5/25/22, 9:09 a.m. the fifth-floor dining room refrigerator temperature was within the red zone at 56 degrees. The fifth-floor dining room served 14 residents. DA-A verified the refrigerator temperature was 56 degrees. DA-A stated the temperature should be below 41 degrees. DA-A stated she would monitor the temperature and if it stayed high, she would notify her supervisor. DA-A stated the kitchen staff, not nursing staff are required to check and document the dining room refrigerator temperature. The current fifth floor temperature readings for the month of May included only six temperature readings and the rest of the dates were blank.

1. 5/1/22, 36 degrees.
2. 5/4/22, 36 degrees.
3. 5/13/22, 55 degrees.
4. 5/18/22, 32 degrees.
5. 5/19/22, 34 degrees.
6. 5/25/19. 32 degrees.

DA-A stated if the refrigerator temperatures are not logged, it indicated staff forgot to check it in the morning or document their findings in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING _____ B. WING _____	C 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9 logbook. During interview on 5/25/22, at 10:03 a.m. CD-A clarified nursing staff were responsible to review and document the dining room refrigerator's temperature daily. CD-A stated the refrigerator temperature must be below 40 degrees. If the refrigerator was above 41 degrees, he would contact the maintenance department. During observation on 5/25/22, at 10:32 a.m. the fifth-floor dining room refrigerator temperature was 54 degrees, The refrigerator's contents included: 1. One three-quart storage container half full of Delight French vanilla cream in a 0.5 fluid ounce container. 2. One two-quart container full of 1.5 teaspoons individual butter packets. 3. Two 64 fluid ounce containers of Dairystar lactose free milk. 4. 14 Snack Pack pudding in 13-ounce containers. 5. Four half pint Prairie Farms 1% low fat milk containers 6. Nine half pint Kemps Skim milk containers. 7. Six Yoplait four-ounce yogurt cups. 8. Eight Ensure Plus eight fluid ounce bottles. 9. Four Sysco Imperial thickened milk in eight fluid ounce bottles. 10. Two Hormel Thick and Easy honey consistency dairy beverage in an eight fluid ounce bottle. 11. One-liter pitcher full of orange juice 12. One-liter pitcher full of apple juice During interview on 5/25/22, at 10:44 notified CD-A about the fifth-floor dining room temperature was 54 degrees. CD-A stated on	F 812		

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	245071	A. BUILDING _____ B. WING _____	C 05/25/2022

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F 812	Continued From page 10 5/13/22, the same refrigerated temperature was 55 degrees. He notified the maintenance department. He was told the refrigerator had a buildup of frost that decreased the inside circulation causing the internal temperature to rise. CD-A agreed with the writers' observation the refrigerators contents had been exposed to temperatures in the 50's for at least 90 minutes. CD-A stated the contents stored at a temperature of 50 degrees would be fine for 2 hours before going bad. CD-A stated he would place another work order to the maintenance department. CA-A added he would bring a bin of ice to the fifth floor to store all of the dairy products. CD-A stated he conducted an audit this morning of all the dining room refrigerators. The fifth-floor dining room refrigerator was listed as 34 degrees. During an interview on 5/25/22, at 10:57 a.m. chief engineer (CE)-A stated on 5/13/22, he defrosted the fifth-floor refrigerator to resolve the above normal operating temperature. CE-A stated he was just notified this morning the temperature once more was above the required range. CE-A stated since this is the second time, he would replace the refrigerator. CE-A stated had he known the refrigerator temperatures were running high he would have monitored it more closely. During interview on 5/25/2, at 11:49 a.m. NA-D stated he used the milk from the fifth-floor dining room refrigerator to mix in five residents' breakfast oatmeal. During interview on 5/25/22, at 2:04 p.m. dietician (D)-C stated sustained temperatures above 41 degrees can cause bacterial growth and lead to resident illness. D-D was concerned no staff documented a refrigerator temperature on the	F 812		

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	245071	A. BUILDING _____ B. WING _____	C 05/25/2022

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F 812	Continued From page 11 fifth-floor dining room for 19 of 28 days. D-D stated she had elevated concern since an incident occurred on 5/13/22, when the refrigerator's temperature was 55 degrees. The facility policy Chapter 3: Food Production and Food Safety dated 2019, identified refrigerator's temperature was to be check two times a day. The policy stated the optimum temperature was 35 to 39 degrees.	F 812		

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	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2022**

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MOUNT OLIVET CAREVIEW HOME	**5517 LYNDALE AVENUE SOUTH** **MINNEAPOLIS, MN 55419**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/25/222. At the time of this survey, Mount Olivet Careview Home Bldg. 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/24/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Mount Olivet Careview Home Building 01 is a 5-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the Northside of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The	K 000		

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	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2022**

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K 000	Continued From page 2 new addition, Building 02, will be surveyed separately as new construction. The building is fully protected throughout by an automatic fire sprinkler system and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 155 beds and had a census of 150 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		7/1/22

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	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2022**

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MOUNT OLIVET CAREVIEW HOME	**5517 LYNDALE AVENUE SOUTH** **MINNEAPOLIS, MN 55419**

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, and 7.2.1.8.1. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 05/25/2022 between 09:00 AM and 14:00 PM, it was revealed by observation that the scrub/ uniform storage room did not have a self-closing device. An interview with the Director of (JK) verified these deficient findings at the time of discovery.	K 321	Hazardous Areas Enclosure policy has been created and reviewed. Maintenance staff have been educated to ensure compliance. The closer on the Scrub/ Uniform Storage Room was changed to an automatic closer on 5/30/2022. All other storage room doors will be reviewed to ensure they also have an automatic closer by 7/1/22. To ensure all hazardous areas have automatic closing doors going forward, there will be a room evaluation completed by Maintenance any time the purpose of a room is being converted. If it is being converted to a room that will contain hazardous materials maintenance will ensure there is an automatic closing door. A walkthrough audit of all hazardous areas will be conducted annually with findings reported to the QAPI committee.	
K 920 SS=B	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		7/1/22

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K 920	Continued From page 4 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6 and 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/25/2022 between 09:00 AM and 02:00 PM, it was revealed by observation that there was a space heater plugged into a power strip in the Volunteer Coordinator's office which was removed at the time of discovery.	K 920	All extension cords found to be plugged into power strips have been removed. A sweep of all office spaces will be completed to ensure compliance by 7/1/2022. Appliances, Power Cords, and Extension Cords policy updated 6/21/2022. Education will be provided by all staff that have an office by 7/1/2022. To ensure compliance, an audit of office spaces will be completed semi-annually and reported to the QAPI committee.	

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K 920	Continued From page 5 2. On 05/25/2022 between 09:00 AM and 02:00 PM, it was revealed by observation that there were two extension cords plugged into power strips in the T.R. first-floor office which were removed at the time of discovery. 3. On 05/25/2022 between 09:00 AM and 02:00 PM, it was revealed by observation that there was an extension cord being used in the nursing/ CSR office on the first floor that was removed at the time of discovery. 4. On 05/25/2022 between 09:00 AM and 02:00 PM, it was revealed by observation that there was a microwave and a coffee maker plugged into a power strip in the Social Workers' office that was removed at the time of discovery. An interview with the Director of (JK) verified these deficient findings at the time of discovery.	K 920		

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	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/25/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/25/2022. At the time of this survey, Mount Olivet Careview Home Bldg. 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Mount Olivet Careview Home Bldg. 02 addition is 5-stories with a full basement. Construction in 2017 and was determined to be of Type II(222) construction. There is an adjoining building which is separated from the skilled nursing facility by a 2 hr. fire separation. The 2nd through 4th Floors each have 4 smoke compartments, with the 5th Floor having 2 smoke compartments. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 155 beds and had a census of 150 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

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

Electronically Signed | 06/24/2022

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