DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 91U5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00178

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245071**
2.STATE VENDOR OR MEDICAID NO.
(L2) **830242100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOUNT OLIVET CAREVIEW HOME**
(L4) **5517 LYNDALE AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55419**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **153** (L18)

13.Total Certified Beds **153** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	153			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Supervisor 05/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/14/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/29/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5071

May 14, 2015

Mr. Timothy Hokanson, Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, Minnesota 55419

Dear Mr. Hokanson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 16, 2015 the above facility is certified for:

153 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 153 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 12, 2015

Mr. Timothy Hokanson, Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, Minnesota 55419

RE: Project Number S5071024

Dear Mr. Hokanson:

On April 7, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 26, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 26, 2015, effective April 16, 2015 and therefore remedies outlined in our letter to you dated April 7, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245071	A. Building B. Wing	5/11/2015

Name of Facility	Street Address, City, State, Zip Code
MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **04/15/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **04/16/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/16/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/14/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/16/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/15/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	05/12/2015	15507	05/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/26/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245071	A. Building B. Wing **01 - MAIN BUILDING 01**	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**04/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0030	**04/01/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 05/12/2015	Signature of Surveyor: 28120	Date: 04/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/31/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 91U5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00178

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245071**
2.STATE VENDOR OR MEDICAID NO.
(L2) **830242100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOUNT OLIVET CAREVIEW HOME**
(L4) **5517 LYNDALE AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55419**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/26/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **153** (L18)

13.Total Certified Beds **153** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	153			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NE II 04/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/28/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1451
April 7, 2015

Mr. Timothy Hokanson, Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, Minnesota 55419

RE: Project Number S5071024

Dear Mr. Hokanson:

On March 26, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 5, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action

completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 26, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 September 26, 2015 (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.

INFORMAL DISPUTE RESOLUTION

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

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification Filecc: Licensing and Certification File

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 _____	03/26/2015

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 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED APR 17 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION All correction dates are 2015 GL	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure freedom from potential restraint use for 1 of 1 resident (R210) whose movement was restricted. Findings include: R210 was observed in her room on 3/25/15, at 7:14 a.m. The resident was seated in a wheelchair near the foot of the bed. A short time later at 7:21 a.m. the surveyor entered R210's room and noted she was in the same position and the wheelchair brakes were in the locked position. The call light was out of the resident's reach, tied to the grab bar at the head of the bed. R210 was	F 221	In all trap audits will be done 1-2x/wk from the monthly for 3 months then quarterly for 6 months → will review @ QAA meetings Rev P. Jain 4-17-15 @ 15:57 PM 4-17-15 per GL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-17-15

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 _____ B. WING _____	03/26/2015

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 221	Continued From page 1 moving her upper body forward and backward in the chair in a manner that showed she wished to move from the stationary position. When asked who locked the wheelchair brakes R210 replied, "the girl." A nursing assistant (NA)-A was then called to R210's room at 7:25 a.m. NA-A verified the call light was not within R210's reach, but denied leaving the resident in that position with the brakes locked. NA-A confirmed R210 did not have the ability to lock or unlock the wheelchair brakes. NA-A spoke briefly to the resident, and then left the room without unlocking the brakes and ensuring R210 could reach her call light. NA-A returned to the room at 7:34 a.m., unlocked R210's wheelchair brakes, and assisted the resident to the dining room. R210 was pushed up to a table where two other residents were sitting, and the wheelchair brakes were again locked. On 3/26/15, at 9:56 a.m. a licensed practical nurse (LPN)-A said R210 needed staff assistance to propel her wheelchair to the dining room for meals and activities due to the distance. The resident was, however, able to move "back and forth a little" in her wheelchair. On 3/26/15, at 10:53 a.m. NA-C was observed pushing R210's wheelchair to the dining room for Bible study. NA-C locked R210's wheelchair brakes then left her with other residents who were beginning to gather in a circle in the dining room. When NA-C was asked why the brakes had been locked, she responded that staff always had to lock R210's wheelchair brakes because "If not, she would move around and may hit other residents." NA-C further explained that when the NAs were busy, R210 "had to be moved close to	F 221	Involved NA/R's were re-educated on restraint procedure. Physical Device Policy/Procedure was revised. Call light procedure reviewed Staff were re-educated on physical device/ restraint policy and procedure and call light. Random audit are being done to ensure compliance The DON will monitor for compliance	4-10-15 4/13/15 4/10/15 4/10/15 4/13/15 4/14/15 4/15/15 On-going On-going

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F 221	Continued From page 2 nurses' station so she could be watched." On 3/26/15, at 10:55 a.m. LPN-A was approached R210 and unlocked the wheelchair brakes. R210 moved in her wheelchair about two feet toward the middle of the circle. At 11:03 R210 was back in the original position in the circle and the wheelchair brakes were again locked. When LPN-A was then asked why the brakes were unlocked, she said it was to give way to other residents joining the circle, but she then re-locked them again for the Bible study. R210's admission Minimum Data Set (MDS) dated 10/31/14, indicated severe cognitive impairment; was at risk for falls; and needed one staff physical assist for activities of daily living (ADLs), transfers and mobility. Also, the resident had diagnoses including late effects of cerebrovascular disease and Alzheimer's disease, as well as a fall history. The care plan dated 11/10/14, described R210 as having the ability to make needs known, but would not always do so without staff prompting. R210 was described as "Impulsive at times and will attempt self transfer which may result in a fall." Staff were directed to anticipate R210's needs; observe and identify hazards in the environment to prevent avoidable accidents/falls; and keep call light within reach while the resident was in the room. During an interview on 3/26/15, at 12:11 p.m. the director of nursing (DON) stated that locking wheelchair brakes to restrict mobility would have been considered a restraint. The facility's policy on Physical Device Procedure	F 221		

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F 221	Continued From page 3 (PDP) revised on 11/19/10, indicated it was the facility's philosophy to provide residents with the highest possible quality of care and life by maintaining residents' dignity and independence by permitting residents to take the "[normal risks of everyday life.]" The PDP did not identify locking wheelchair brakes to prevent residents from moving was considered a potential restraint.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were within reach for 1 of 40 residents (R210) observed in the sample, and to ensure a television remote control was functional for 1 of 1 resident (R61) who reported television as a preferred activity. Findings include: R210 was observed in her room on 3/25/15, at 7:14 a.m. The resident was seated in a wheelchair near the foot of the bed. A short time later at 7:21 a.m. the surveyor entered R210's room and noted she was in the same position and the wheelchair brakes were in the locked position.	F 246		

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F 246	Continued From page 4 The call light was out of the resident's reach, tied to the grab bar at the head of the bed. R210 was moving her upper body forward and backward in the chair in a manner that showed she wished to move from the stationary position. When asked who locked the wheelchair brakes R210 replied, "the girl." A nursing assistant (NA)-A was then called to R210's room at 7:25 a.m. NA-A verified the call light was not within R210's reach, but denied leaving the resident in that position with the brakes locked. NA-A confirmed R210 did not have the ability to lock or unlock the wheelchair brakes. NA-A spoke briefly to the resident, and then left the room without unlocking the brakes and ensuring R210 could reach her call light. NA-A returned to the room at 7:34 a.m. to assist R210 to the dining room. R210's admission Minimum Data Set (MDS) dated 10/31/14, indicated severe cognitive impairment; was at risk for falls; and needed one staff physical assist for activities of daily living (ADLs), transfers and mobility. Also, the resident had diagnoses including late effects of cerebrovascular disease and Alzheimer's disease, as well as a fall history. The care plan dated 11/10/14, described R210 as having the ability to make needs known, but would not always do so without staff prompting. R210 was described as "Impulsive at times and will attempt self transfer which may result in a fall." Staff were directed to anticipate R210's needs; observe and identify hazards in the environment to prevent avoidable accidents/falls; and keep call light within reach while the resident was in the room.	F 246		

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F 246	Continued From page 5 During an interview on 3/26/15, at 12:11 p.m. the director of nursing (DON) stated she expected staff to place call lights within residents' reach at all times and to address residents' concerns immediately. R61 was interviewed on 3/23/15, at 7:38 p.m. and reported participating in "some but not all" activities. R61 preferred instead, to stay in her room and watch sports shows on television (TV). R61 further stated, however, that it was sometimes frustrating if no one helped her turn on the TV or changed the channels. When asked why she did not use the TV remote control, she stated "that [remote] does not work." R61 stated she had reported the problem many times, but "no one listened." NA-E who was then helping R61's roommate attemped to use the remote and verified it was not working. NA-E informed the resident he would ensure maintenance staff was informed of the problem. On 3/26/15, at 9:30 a.m. R61 was watching TV in the day room. When R61 was asked if her TV remote control had been repaired she replied, "I don't think so. Nobody listens in here." R61 stated the TV remote control had not been working "for a long time" and claimed to have reported the problem to staff "many times." With R61's permission, NA-D and the surveyor checked the remote and found it was still not working. R61's annual Minimum Data Set (MDS) dated 3/5/15, indicated the resident had mild depression. The corresponding Care Area Assessment (CAA) of the MDS indicated R61 had minimal depressive symptoms and care plan goals were for improvement and avoiding	F 246	Re-Education of staff was done regarding need to position call light within reach and who to contact with resident concerns or if equipment not functioning. Therapeutic Recreation educated staff on need to check compliance of Interventions on care plan with the RAI process Random audits will be done to check for compliance. The DON will monitor for compliance	4/16/15 4/13/15 4/14/15 ~~4/15/14~~ ~~4/16/14~~ 4/13/15 On-going On-going

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F 246	Continued From page 6 complications. R61's care plan dated 3/7/15, indicated she was able to plan leisure activities and preferred to lie down in the afternoons making her unavailable for programs at those times. Interventions included monitor R61's leisure activities including "watching TV/sports." During an interview on 3/26/15, at 12:11 p.m. the director of nursing (DON) stated a TV remote control was considered a need for a resident who was assessed as able to use it and enjoyed watching TV as an activity. The facility's undated Care Plans Policy and Procedures (CPPP) indicated the facility's philosophy was to consider each resident's areas of weakness as well as areas of vulnerability and potential abuse. The CPPP directed staff to implement approaches appropriate to each resident, and to take actual steps to help residents achieve their goals and to help prevent abuse and neglect.	F 246		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to care plans were followed for incontinence care for 2 of 4 residents	F 282		

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F 282	Continued From page 7 (R210, R88) reviewed for urinary incontinence, for 2 of 3 residents (R210, R88) reviewed for pressure ulcers, and for 1 of 1 resident (R210) whose call light was observed out of reach. Findings include: R210's care plan dated 11/10/14, directed staff to toilet and reposition the resident every two hours while in the chair. The NA Assignment Sheet dated 3/24/15, described R210's cares and included R210's need for toileting and repositioning upon rising, before and after meals, and upon the resident's request. R210 was observed continuously on 3/14/15 as follows: From 7:14 to 7:33 a.m. the resident was seated in her room in her wheelchair. At 7:34 a.m. a nursing assistant (NA)-A assisted R210 to the dining room without repositioning or toileting. From 7:35 a.m. to 9:09 a.m. R210 remained in the dining room for breakfast. At 9:10 a.m. NA-G assisted R210 to the day room. She was then assisted from the day room to an activity at 9:21 a.m. R210 had not been repositioned during the observational period. On 3/25/15, at 9:27 a.m. NA-A stated R210 should have been assisted with toileting or repositioning "every two hours," but she had not been able to do so because she was busy attending to other residents' needs. At 9:49 the surveyor intervened regarding R210's lack of toileting and repositioning, at which time the NA brought R210 to use the toilet. R210's care plan dated 11/10/14, described R210 as having the ability to make needs known, but would not always do so without staff prompting.	F 282	Staff involved were re-educated on following individual care plan regarding repositioning and toileting The involved interdisciplinary staff were re-educated regarding the need to be repositioned/toileted per care plan/ care card to improve continence Nursing staff have been re-educated regarding repositioning/toileting per care plan/care card and placing call light with in reach Interdisciplinary plan set up regarding toileting before activities off the unit or per Individualized Care Plan Skin Integrity policy/ procedure revised Tissue Tolerance procedure revised Random audits are being done to ensure compliance The DON will monitor for compliance	3/28/15 4/13/15 4/14/15 4-13-15 4-14-15 4/13/15 4/14/15 4/15/15 ~~4/16/16~~ 04/16/15 4/13/15 4/10/15 4/10/15 On-going On-going

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F 282	Continued From page 8 R210 was described as "Impulsive at times and will attempt self transfer which may result in a fall." Staff were directed to anticipate R210's needs; observe and identify hazards in the environment to prevent avoidable accidents/falls; and keep call light within reach while the resident was in the room. R210's admission Minimum Data Set (MDS) dated 10/31/14, indicated she was at risk for pressure ulcer development and was incontinent of urine. The Care Area Assessment (CAA) dated 11/6/14, indicated R210's pressure ulcer risk factors include requiring assistance to move; being confined to bed or chair most of the time; and requiring regular schedule for turning. The Analysis of Findings section of the CAA also indicated R210 had limited physical activity and bladder incontinence. During observations of R210 for toileting and repositioning on 3/25/15, at 7:14 a.m. the resident was seated in a wheelchair near the foot of the bed. A short time later at 7:21 a.m. the surveyor entered R210's room and noted she was in the same position and the wheelchair brakes were in the locked position. The call light was out of the resident's reach, tied to the grab bar at the head of the bed. R210 was moving her upper body forward and backward in the chair in a manner that showed she wished to move from the stationary position. When asked who locked the wheelchair brakes R210 replied, "the girl." A nursing assistant (NA)-A was then called to R210's room at 7:25 a.m. NA-A verified the call light was not within R210's reach, but left the room without ensuring the resident had her call light. NA-A returned to the room at 7:34 a.m. to	F 282		

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F 282	Continued From page 9 assist R210 to the dining room. R210's admission Minimum Data Set (MDS) dated 10/31/14, indicated severe cognitive impairment; was at risk for falls; and needed one staff physical assist for activities of daily living (ADLs), transfers and mobility. Also, the resident had diagnoses including late effects of cerebrovascular disease and Alzheimer's disease, as well as a fall history. During an interview on 3/26/15, at 12:11 p.m. the director of nursing (DON) stated she expected staff to follow the resident's care plans for both toileting and repositioning. In addition, she expected staff to place call lights within residents' reach at all times and to address residents' concerns immediately. R88's care plan dated 9/16/13, identified R88 as at risk for skin/pressure ulcers related to lower extremity edema, venous insufficiency and severe cognitive impairment. The goal indicated skin will remain intact. The interventions directed staff to follow the elimination care plan. The elimination section of the care plan identified R88 as being incontinent of bowel and bladder and directed staff to toilet upon arising, after meals, before bed and as needed. The goal indicated for skin to remain intact. The care plan directed staff to to toilet upon arising, after meals, before bed and as needed. R88's quarterly MDS dated 12/3/14, revealed diagnoses including Alzheimer's disease. R88 was identified as being always incontinent of urine required total assistance of two staff for transfers and extensive assistance of two staff for	F 282		

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F 282	Continued From page 10	F 282		

bed mobility and unable to ambulate. The resident had severely impaired cognitive skills and rarely or never understood others. The undated care sheet for R88 identified the resident as needing assist of two and mechanical lift for transfers and incontinent of bowel and bladder, check and change, before and after meals, hours of sleep and three times on night rounds.

R88 was continuously observed on on 3/25/15, from 7:05 until 9:20 a.m. At 7:05 a.m. R88 was in a wheelchair seated near the nursing station. At 8:30 a.m. R88 was assisted to eat breakfast. R88 remained in the dining room with no assistance with repositioning until he was wheeled to his room. At 9:20 a.m. R23 was in bed.

NA-H, who consistently worked on R88's unit explained in an interview on 3/25/15, at 9:20 a.m. she had just assisted R88 to bed and changed his incontinent pad, which was wet. NA-H stated she was busy after breakfast and had been unable to provide care for R88. NA-H said she had assisted R88 out of bed at around 6:15 a.m. and had not provided any further cares until assisting resident back into bed just prior to 9:20 a.m. NA-H indicated R88 should have been repositioned every two hours and acknowledged this had not been provided for resident.

During an interview on 3/26/15, at 1:05 p.m. a registered nurse (RN)-A reported R88 was dependent on staff and should have been assisted to reposition and be checked and changed every two hours.

The undated Care Plans Policy and Procedures indicted the interventions were to include

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F 282	Continued From page 11 approaches to the resident as appropriate. The Skin Integrity: Data Collection and Management policy reviewed 6/25/14, directed staff regarding the prevention of prevention of skin breakdown to "Reposition per individualized care plan or at least every 2 hours." The Bladder Data Collection, Management, and Retraining Program policy reviewed on 1/29/07, directed staff to maximize the residents dignity, independence and continence with toileting....	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor skin conditions (bruises) for 1 of 3 residents (R144) reviewed for non-pressure related skin issues. Findings include: R144 was observed in her wheelchair on 3/24/15, at 11:51 a.m. Two purple bruises were noted on the tops of the resident's left hand and wrist. R144 was unable to state the cause of the bruises.	F 309		

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F 309	Continued From page 12 R144's quarterly Minimum Data Set (MDS) dated 12/17/14, revealed diagnoses including dementia and peripheral vascular disease. She required extensive assistance for bed mobility, transfers, walking, dressing, personal hygiene and toileting. The resident had severely impaired cognitive skills, unclear speech and sometimes understood others. Weekly skin audits included a body diagram and revealed the following: 1) 3/19/15 "Skin intact, no skin issues noted." 2) 3/12/15 "Shower done. Skin intact with old bruises on R [right] hand resolving. No redness noted at this time." 3) 3/5/15"Old bruised to RT [right] hand fading to yellow." The audits did not include the bruises noted on the hand and wrist. In addition, R144's interdisciplinary progress notes were reviewed from 2/27/15 to 3/25/15, and again no documentation was noted related to bruising on the left hand and wrist. R144's care plan revised on 12/16/14, indicated the resident was at risk for altered skin integrity related to dementia, peripheral vascular disease, incontinent of bowel and bladder, bruised easily due to aspirin use (known to contribute to bruising), wandering constantly increasing potential for bruises and skin tears and history of skin tears, and fragile skin. The interventions directed staff to check R144's skin weekly at the time of bathing. A registered nurse (RN)-A was interviewed on 3/26/15, at 12:57 p.m. and indicated resident has a history of skin discoloration/bruising. RN-A reviewed resident skin and record and indicated one of the two bruises on top of left hand may have been skin discoloration,but indicated he was	F 309		

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 _____	03/26/2015

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

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F 309	Continued From page 13 unable to find any documentation that the areas had been identified and were being monitored. RN-A further stated the areas should have been documented on the last skin assessment completed 3/19/15. The documentation should have included measurements and monitoring every shift. In addition, the physician and family should have been notified. The facility's 5/29/14, Skin Integrity: Data Collection and Management policy directed staff to complete a "Weekly Skin Inspection of residents is done on Bath day and documented on HER Weekly Skin Report form by LPN/RN at Careview."	F 309	Abuse Prohibition procedure revised Any resident with chronic skin issue will be addressed on the care plan. Re-education of staff on need to report bruises to supervisor completed Weekly skin data collection procedure reviewed with Nursing Auditing will be through quarterly data collection and weekly skin data collection	4/13/15 On-going 4/13/15 4/14/15 On-going
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions including timely repositioning for 2 of 3 residents (R210, R88) who identified at risk and who were reviewed for pressure ulcers. Findings include:	F 314	The DON will monitor for compliance	Ongoing

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F 314	Continued From page 14 R210 was observed continuously on 3/14/15 as follows: From 7:14 to 7:33 a.m. the resident was seated in her room in her wheelchair. At 7:34 a.m. a nursing assistant (NA)-A assisted R210 to the dining room without repositioning. From 7:35 a.m. to 9:09 a.m. R210 remained in the dining room for breakfast. At 9:10 a.m. NA-G assisted R210 to the day room. She was then assisted from the day room to an activity at 9:21 a.m. R210 had not been repositioned during the observational period. On 3/25/15, at 9:27 a.m. NA-A stated R210 should have been repositioned "every two hours" but she had not been able to do so because she was busy attending to other residents' needs. At 9:49 the surveyor intervened regarding R210's lack of repositioning, at which time the NA brought R210 to use the toilet. R210's admission Minimum Data Set (MDS) dated 10/31/14, indicated she was at risk for pressure ulcer development. The corresponding Care Area Assessment (CAA) dated 11/6/14, indicated R210's pressure ulcer risk factors include requiring assistance to move; being confined to bed or chair most of the time; and requiring regular schedule for turning. The Analysis of Findings section of the CAA also indicated R210 had limited physical activity and bladder incontinence. R210's care plan dated 11/10/14, directed staff to reposition the resident every two hours while in the chair. The NA Assignment Sheet dated 3/24/15, described R210's cares and included R210's need for repositioning upon rising, before and after meals, and upon the resident's request.	F 314		

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F 314	Continued From page 15 During an interview on 3/26/15, at 12:11 p.m. the director of nursing (DON) stated she expected staff to follow the resident's repositioning schedule as directed by the care plan. R88 was assessed at risk for skin breakdown and was not repositioned every two hours during continuous observation on 3/25/15, from 7:05 until 9:20 a.m. At 7:05 a.m. R88 was in a wheelchair seated near the nursing station. At 8:30 a.m. R88 was assisted to eat breakfast. R88 remained in the dining room with no assistance with repositioning until he was wheeled to his room. At 9:20 a.m. R23 was in bed. NA-H, who consistently worked on R88's unit explained in an interview on 3/25/15, at 9:20 a.m. she had just assisted R88 to bed and changed his incontinent pad, which was wet. NA-H stated she was busy after breakfast and had been unable to provide care for R88. NA-H said she had assisted R88 out of bed at around 6:15 a.m. and had not provided any further cares until assisting resident back into bed just prior to 9:20 a.m. NA-H indicated R88 should have been repositioned every two hours and acknowledged this had not been provided for resident. R88's CAA summary/analysis for pressure ulcers dated 10/15/14, indicated "Resident is at risk for skin breakdown due to incontinence, inability to ambulate and off load, and dementia. His skin is checked with cares and on bath days. He has a pressure reducing mattress and cushion for his chair. skin barriers applied as indicated for protection. No ulcers on this review. Proceeding	F 314		

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F 314	Continued From page 16 to care plan with goal of intact skin." R88's quarterly MDS dated 12/3/14, revealed diagnoses including Alzheimer's disease. He required total assistance of two staff for transfers and extensive assistance of two staff for bed mobility and was unable to ambulate. The resident had severely impaired cognitive skills. R88's care plan dated 9/16/13, identified R88 as at risk for skin/pressure ulcers related to lower extremity edema, venous insufficiency (impaired flow of blood from veins back to the heart) and severe cognitive impairment. The goal was "skin will remain intact." Interventions directed staff to follow the elimination care plan, that directed staff to toilet upon arising, after meals, before bed and as needed. An undated care sheet R88 identified the resident as needing assist of two and mechanical lift for transfers. During an interview on 3/26/15, at 1:05 p.m. a registered nurse (RN)-A reported R88 was dependent on staff for repositioning and should have been assisted to reposition every two hours. The Skin Integrity: Data Collection and Management policy reviewed 6/25/14, directed staff regarding the prevention of prevention of skin breakdown to "Reposition per individualized care plan or at least every 2 hours."	F 314	Re-education of Nursing staff on prevention of pressure ulcers and following the care plan Skin integrity Procedure revised Tissue Tolerance procedure revised Re-education of nursing staff on the need to check to be sure the care plan and care card are consistent Random audits of compliance will be done to ensure compliance The DON will monitor for compliance	4/13/15 4/14/15 4/10/15 4/10/15 4/13/15 4/14/15 On-going On-gong

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F 315	Continued From page 17	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide timely assistance with incontinence for 2 of 4 residents (R210, R88) who were reviewed for incontinence care. Findings include: R210 was observed continuously on 3/14/15 as follows: From 7:14 to 7:33 a.m. the resident was seated in her room in her wheelchair. At 7:34 a.m. a nursing assistant (NA)-A assisted R210 to the dining room without toileting. From 7:35 a.m. to 9:09 a.m. R210 remained in the dining room for breakfast. At 9:10 a.m. NA-G assisted R210 to the day room. She was then assisted from the day room to an activity at 9:21 a.m. R210 had not been toileted during the observational period. On 3/25/15, at 9:27 a.m. NA-A stated R210 should have been toileted "every two hours" but she had not been able to do so because she was	F 315		

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F 315	Continued From page 18 busy attending to other residents' needs. At 9:49 the surveyor intervened regarding R210 not being toileted, at which time the NA brought the resident to the bathroom. R210's wheelchair and pants were wet, and the incontinent brief was soaked with strong smelling urine. NA-A stated, "[R210] is wet." R210's Minimum Data Set (MDS) dated 10/31/14, indicated the resident needed one staff physical assist for toileting, and was frequently incontinent of urine but also had some continent episodes. The corresponding Care Area Assessment (CAA) dated 11/6/14, indicated R210 was incontinent of bladder and bowel, despite frequent toileting. Staff was "continuing to develop the best toilet plan for [R210]." An Assignment Sheet dated 3/24/15, indicated R210 needed one staff assist for toilet use, and directed "staff to toilet up on rising, before and after meals and per res [resident] request." During an interview on 3/26/15, at 12:11 p.m. the director of nursing (DON) stated she expected staff to follow the resident's toileting plan as directed by the care plan. R88 was assessed as incontinent of bladder, however, was not toileted every two hours during continuous observation on 3/25/15, from 7:05 until 9:20 a.m. At 7:05 a.m. R88 was in a wheelchair seated near the nursing station. At 8:30 a.m. R88 was assisted to eat breakfast. R88 remained in the dining room with no assistance with changing his incontinence brief until just before 9:20 a.m. when R23 was observed in bed.	F 315		

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F 315	Continued From page 19 NA-H, who consistently worked on R88's unit explained in an interview on 3/25/15, at 9:20 a.m. she had just assisted R88 to bed and changed his incontinent pad, which was wet. NA-H stated she was busy after breakfast and had been unable to provide care for R88. NA-H said she had assisted R88 out of bed at around 6:15 a.m. and had not provided any further cares until assisting resident back into bed just prior to 9:20 a.m. NA-H indicated R88 should have had his incontinence brief checked and changed every two hours and acknowledged this had not been provided for the resident. R88's care plan dated 9/16/13, identified the resident was incontinent and staff was to follow toilet the resident upon arising, after meals, before bed and as needed. An undated care sheet for R88 identified the resident as incontinent of bowel and bladder, "check and change, before and after meals, hours of sleep and three times on night rounds." R88's Care Area Assessment (CAA) summary/analysis for urinary incontinence dated 10/8/14, indicated "Resident with advanced dementia is on hospice due to end stage dementia. He is dependent for toileting tasks and remains incontinence to of bladder and bowel. He is unable to anticipate needs for toilet an does not communicate needs. Staff toilet "according to scheduled plan and body language...can be resistive to toileting needs." He also was at risk for urinary tract infections. R88's quarterly MDS dated 12/3/14, revealed diagnoses including Alzheimer's disease. He was always incontinent of urine, required total assistance of two staff for transfers and extensive	F 315	Re-education of nursing staff on the need to have individualized care plans and to follow these The staff members involved have been re-education on the need to follow the care plan Random audits will be done to determine compliance The DON will monitor for compliance	4/13/15 4/14/15 4/15/15 4/16/15 4/10/15 On-going On-going

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F 315	Continued From page 20 assistance of two staff for toileting was unable to ambulate. The resident had severely impaired cognitive skills. During an interview on 3/26/15, at 1:05 p.m. a registered nurse (RN)-A reported R88 was dependent on staff for changing his brief and should have been assisted with this every two hours. The facility's 1/29/07, Bladder Data Collection, Management and Retraining Program policy directed staff to maximize the residents dignity, independence and continence with toileting, to prevent skin breakdown and complication from elimination products. The policy directed staff to initiate an appropriate bladder program, and note the decision on the resident's care plan and make a summary note.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure kitchenette freezers were maintained in sanitary condition in	F 371		

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	245071	A. BUILDING _____ B. WING _____	03/26/2015

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F 371	Continued From page 21 1 of 6 kitchenettes observed. This had the potential to affect 21 residents residing on the 4th floor east unit. Findings include: During initial tour on 3/23/15, at 11:38 a.m. one white Ice-brix ice pack was stored with residents' ice cream in the freezer in the kitchenette on the fourth floor east unit. At the time of observation a nursing assistant (NA)-F stated she did not know why the ice pack was being used. A licensed practical nurse (LPN)-A then explained the ice pack was used to put on a resident's hands and was supposed to have been stored in the medication room freezer. LPN-A removed the ice pack from the food storage freezer and placed it in the medication storage freezer. On 3/26/15, at 11:30 a.m. the director of nursing (DON) stated, "We don't have reusable ice packs. Once used, it's thrown away. If anything, the ice pack should be put in the med [medication] refrigerator." On 3/25/15, at 2:53 p.m. the dietary services director (DSD) stated, "Ice packs do not belong there [freezer]." DSD stated that dietary staff were scheduled to clean dining room refrigerators and freezers daily, in the morning. DSD added, dietary staff were instructed to throw away any unwanted items from the freezers such as ice packs.	F 371	Staff have been re-educated regarding not to place ice packs in the food refrigerator freezer The home will purchase disposable ice packs or individualized reusable ones that have crushed ice in them with no need to place in freezer Sign placed on freezer to remind families to not place ice pack in freezer Dietary staff re-educated on what is allowed in the freezer when they do their daily checks Random audits to be done The DON will monitor for compliance	4/13/15 4/14/15 On-going 4/15/15 4/13/15 On-going On-going

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5071024

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

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	03/31/2015

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mount Olivet Careview Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok 4-21-15 RECEIVED APR 20 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-5-15
EXIT: 3-26-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4-17-15

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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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mount Olivet Careview Home is a 4-story building with a full 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 North side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 150 beds and had a census of 143 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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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
K 029 SS=F	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect the residents. Findings include: During facility tour between 9:45 AM and 11:30 AM on 03/31/2015, observation revealed that the staff have been filling the soiled linen room fire door strikes with gloves and other items preventing the doors from latching closed. This deficient practice was verified by the maintenance director at the time of the inspection.	K 029	Staff re-educated on locked door procedure MOCV door locking procedure revised Random audits completed to determine compliance The Engineering Department and Nursing Department will monitor compliance	4/1/15 4/2/15 4/15/15 On-going On-going
K 030 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Gift shops are protected as hazardous areas when used for storage or display of combustibles	K 030		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 030	Continued From page 3 in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinklered. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 19.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the gift shop was not properly separated in accordance with LSC (2000) section 19.3.2.5. This deficient practice could affect the residents. Findings include: During facility tour between 9:45 AM and 11:30 AM on 03/31/2015, observation revealed that the gift shop door, which opens into the corridor, is being propped open with a door chock. This deficient practice was verified by the maintenance director at the time of the inspection.	K 030	Door chock removed New magnetic door holder installed Dir. Of Engineering will monitor	3/31/15 4/1/15 On-going