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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LIQN

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 **06/15/2021** (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 **155** (L18)
13.Total Certified Beds **155** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	155			
(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 :
Karen Aldinger, Supervisor 07/15/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/15/2021 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 15, 2021

CMS Certification Number (CCN): 245071

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

Dear Administrator:

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 June 7, 2021 the above facility is certified for:

155 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 155 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 15, 2021

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

RE: CCN: 245071
Cycle Start Date: May 13, 2021

Dear Administrator:

On June 15, 2021, the Minnesota Department(s) 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LIQN

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 **05/13/2021** (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 **155** (L18)
13.Total Certified Beds **155** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	155			
(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 :
Renee McClellan, HFE NE II 06/18/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/23/2021 (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

Electronically delivered
June 1, 2021

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

RE: CCN: 245071
Cycle Start Date: May 13, 2021

Dear Administrator:

On May 13, 2021, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
Metro C 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: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 13, 2021 (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 13, 2021 (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
Program Assurance Unit
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 05/13/2021

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 5/10/21 through 5/13/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 025		5/13/21

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

Electronically Signed | 06/07/2021

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 _____	C 05/13/2021

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 025	Continued From page 1 *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to obtain a written agreement with a transportation company, to ensure residents could be transported to an alternate facility in an emergency. This had the potential to affect all 142 residents who currently resided in the facility. Findings include: The facility Emergency Preparedness Program (EPP), revised 02/12/21, included contact	E 025	On May 13, 2021 Mount Olivet Careview Home signed a transfer agreement with Mount Olivet Rolling Acres. This will allow MOCH to use additional busses provided by MORA to transfer residents to an alternate facility in the event of an emergency. This contract will allow us to transfer all current and future residents at MOCH. This contract will be reviewed and updated yearly by both parties involved.	

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 05/13/2021

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 025	Continued From page 2 information for transportation with two transportation companies. However, the EPP lacked any pre-arranged contract for this transportation. During interview on 5/13/21, at 8:15 a.m. the director of environmental services and safety (DESS)-A stated the facility does not have pre-arranged agreements for the transfer of patients during an emergency evacuation with local transportation providers. During interview on 5/13/21, at 10:00 a.m. the assistant director of nursing (ADON)-verified the facility EPP included contact information for transportation providers and the plan did not include pre-arranged written agreements with transportation providers. She stated,"I remember we use to have contract with the metro mobility, but I don't know where it is now."	E 025		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:	E 032		6/4/21

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 05/13/2021

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 032	Continued From page 3 (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure the communication plan included an alternative shared means for communicating with Federal, State, tribal, regional, and local emergency management agencies. This had the potential to affect all 142 residents currently residing in the facility. Findings include: The facility policy titled Emergency Preparedness Binder Emergency Preparedness Plan (EPP), revised 2/12/21 did not include an alternate communication plan as directed in the regulation. shared primary and alternative means of communication with other facilities, agencies and state and local officials it plans to communicate with during emergencies. On 5/14/21, at 8:15 a.m. the director of environmental services and safety (DESS)-A verified the EPP did not include shared alternative means of communication with Federal, State, tribal, regional, and local emergency management agencies. On 5/13/21, at 10:00 a.m. the assistant director of	E 032	On 6/4/2021 an Emergency Preparedness Communication Plan was developed. In this plan, a ham radio was identified as the alternate means for communication with Federal, State, Tribal, Regional, and Local emergency management agencies. The plan includes instructions on how to use the ham radio to contact these agencies. This plan will be reviewed annually.	

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 05/13/2021

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 032	Continued From page 4 nursing (ADON)-A verified the communication plan and procedure did not include a shared alternative means of communication with Federal, State, tribal, regional, and local emergency management agencies. ADON-A stated, "If we need alternate communication, the facility can goggle it".	E 032		
F 000	INITIAL COMMENTS On 5/10/21 through 5/13/21, a standard recertification survey was conducted at your facility. Complaint investigations were 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 SUBSTANTIATED H5071063C (MN00069530), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5071059C (MN00072365/MN00072291), H5071060C (MN00071417), H5071061C (MN00070929), H5071062C (MN00070311), H5071064C (MN00069327), H5071065C (MN00067683), and H5071067C (MN00067149). 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.	F 000		

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 05/13/2021

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	Continued From page 5 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and assess a new pressure ulcer for 1 of 7 (R105) residents reviewed for pressure ulcers. Findings include: R105's quarterly Minimum Data Set (MDS) dated 4/20/21, indicated R105 was cognitively intact and required extensive assist to total dependence with two assist for activities of daily living (ADLs). R105's pressure ulcer/injury Care Assessment Area (CAA) indicated R105 was at risk for developing pressure ulcers related to impaired mobility and incontinence. Staff were directed to	F 686	The affected resident received new treatment of monitoring and application of bacitracin to red area behind right ear every day and evening shift, effective 5/13/21 and resolved on 5/18/21. Padding was placed on the right side of the affected resident□s oxygen tubing on 5/13/21. Nursing order to check behind ears daily for skin integrity and to ensure padding intact due to use of oxygen tubing was added to the affected resident□s treatment record on 6/4/21. The affected resident was included in weekly skin check assessment audits and treatment record review, beginning 5/17/21 and	6/7/21

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 05/13/2021

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 686	Continued From page 6 observe skin daily with cares and complete weekly skin audits. R105's care plan dated 5/13/21, indicated R105 had potential for alteration in skin integrity due to bruises easily, chronic renal failure, decreased mobility, fragile skin, urinary and bowel incontinence. The care plan indicated R105 had a history of an open area. The goal indicated the skin will be intact. Interventions directed staff to complete daily skin observation with cares and report concerns to a nurse and complete weekly skin inspection by licensed nurse. R105's Comprehensive Skin Assessment dated 4/14/21, indicated R105 skin was intact but at risk for altered skin integrity. Further, indicated R105 use of oxygen with nasal cannula or mask was a skin risk factor. During observation and interview on 5/10/21, at 4:00 p.m. R105 pulled right ear forward and revealed a stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister). The area appeared as a ruptured blister, the wound bed was red with loose tissue around the edges. R105 stated it has been sore behind her right ear for a few days and she reported it to a nurse. R105 stated it was from the oxygen tubing as it was too tight. R105's weekly skin audit dated 5/11/21, indicated, "no skin concerns noted." It did not indicate a pressure ulcer behind R105's right ear. R105's March 2021, April 2021, and May 2021	F 686	ongoing. The policy on Skin Integrity: Data Collection and Management was reviewed and revised on 5/17/21 to effectively capture proper procedure for wound prevention, assessment, monitoring, and treatment. The Weekly Skin Check, Comprehensive Skin, and Admission Database Assessments were reviewed and revised on 5/17/21 and implemented on 5/28/21 following all staff education. Assessment changes include the addition of the five parameters of skin assessment: temperature, turgor, color, moisture, and integrity; along with system prompts to ensure a full head-to-toe assessment, assessing all areas of the skin such as back of head, behind the ears, under arms, under skin folds, peri-area, back of legs, between toes, etc. Education was delivered to nurses and nursing assistants on wound prevention measures and proper skin care techniques. Discussion on wound prevention included such things as lotioning dry skin, reducing shear and friction, applying barrier cream, reducing heel pressure, repositioning, care planning, etc. A case study example of a resident at risk for altered skin integrity was provided. Nurses were educated on the five parameters of skin assessment as well as trained on the changes made to the skin assessment forms with emphasis on completing a thorough head-to-toe body audit. Integrating skin assessment into daily workflow was also discussed.	

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 05/13/2021

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 686	Continued From page 7 treatment administration records (TARs) did not indicate a treatment for the stage II pressure ulcer. During observation on 5/11/21, at 2:24 p.m. R105 had a foam protector covering the oxygen tubing over her left ear. There was no protection over the tubing over her right ear and the open area remained behind her ear and under the tubing. R105 stated she told the nurse she had a sore behind her right ear, but the nurse only put the protector on the left ear and did not look at the other one, even though she mentioned it to her. When interviewed on 5/12/21, at 7:38 a.m. nursing assistant (NA)-A stated if an open area is noted during cares it is reported to the nurse immediately. NA-A further stated R105 had a history of a pressure ulcer to the buttocks however, did not have a pressure ulcer at this time. When interviewed on 5/12/21, at 7:39 a.m. registered nurse (RN)-A stated nurses completed weekly skin checks which consisted of checking a resident from head to toe for any bruises, redness, open areas, and any new skin changes. RN-A verified the open area on R105's right ear should have been noted on the weekly skin check. RN-A further stated when nurses notice a skin concern it would be charted, the doctor notified, a treatment order received, and report the open area to the nurse manager. Additionally, RN-A stated the oxygen tubing could be padded so it doesn't rub and cause a pressure ulcer or other skin concern. When interviewed on 5/12/21, at 8:11 a.m. the director of nursing (DON) stated a nurse should	F 686	Education was completed on 5/26/21 and 5/27/21 and will be incorporated into new hire orientation, annual training, and as needed, effective June 2021. House-wide audits were initiated and included skin assessment, repositioning, peri-care, and morning and bedtime cares. The skin assessment audit was conducted to ensure that the Weekly Skin Check assessment was successfully performed and that the documentation noted within the assessment matched the treatment record. The repositioning, peri-care, and morning and bedtime cares audits were conducted to reduce the risk of pressure ulcer development. All audits will continue weekly for four weeks, monthly for one quarter, and then will be re-evaluated through QAPI program and if found in compliance, will be completed as needed thereafter. Reports were produced from the EHR to identify residents at risk for pressure ulcers and included those currently on hospice, those with a 5% or 10% weight loss, those with a recent significant change per MDS, and those who currently use oxygen. For all residents identified as at risk, the care plan will be reviewed and updated by 6/21/21 to include pressure ulcer prevention strategies. The orders and care plan of those residents identified with an open area or pressure ulcer were reviewed and updated on 6/4/21 to ensure accuracy, consistency, and individualization within and across the treatment orders and care plan	

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 05/13/2021

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 686	Continued From page 8 do a full body audit when completing a skin assessment. The DON verified the stage II pressure ulcer to R105's right ear should have been noted on the skin assessment on 5/11/21. Further, the DON verified the nurse would call the doctor and report the open area to the nurse manager. During observation on 5/13/21, at 8:30 a.m. R105 had padding placed over the oxygen tubing that went over each ear. The pressure ulcer noted on 5/10/21, was healing, it was flat and pink in color. The loose tissue surrounding the wound had resolved. The Skin Integrity: Data Collection and Management policy dated 4/9/21, indicated weekly skin inspections would be completed on residents on bath days and documented on the electronic health record (EHR) "Weekly Skin Report Form" by a licensed practical nurse (LPN)/RN. Further indicated, if an open area develops the "Wound Documentation Form" on the EHR would be initiated, notify doctor for treatment order, and notify the dietitian.	F 686	interventions. Findings were communicated to the Registered Dietician for additional care plan follow-up. The weekly Interdisciplinary Team meeting format and Skin Integrity: Risk Management tool were reviewed and revised on 6/4/21 to identify residents at risk for altered skin integrity and to evaluate prevention measures for risk mitigation, as well as to review the treatment progress, care planning, and potential for new or additional intervention of residents with a new or current open area or pressure ulcer. The QAPI program will be utilized to review and evaluate progress and compliance on an ongoing basis for sustained practice change.	

Electronically delivered
June 1, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: LIQN11

Dear Administrator:

The above facility was surveyed on May 10, 2021 through May 13, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
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: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

Please 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.

Please feel free to call me with any 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
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/10/21, 5/11/21, 5/12/21, and 5/13/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and assess a new pressure ulcer for 1 of 7 (R105) residents reviewed for pressure ulcers. Findings include: R105's quarterly Minimum Data Set (MDS) dated 4/20/21, indicated R105 was cognitively intact and required extensive assist to total dependence with two assist for activities of daily living (ADLs).	2 900	Corrected.	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 900	Continued From page 3 R105's pressure ulcer/injury Care Assessment Area (CAA) indicated R105 was at risk for developing pressure ulcers related to impaired mobility and incontinence. Staff were directed to observe skin daily with cares and complete weekly skin audits. R105's care plan dated 5/13/21, indicated R105 had potential for alteration in skin integrity due to bruises easily, chronic renal failure, decreased mobility, fragile skin, urinary and bowel incontinence. The care plan indicated R105 had a history of an open area. The goal indicated the skin will be intact. Interventions directed staff to complete daily skin observation with cares and report concerns to a nurse and complete weekly skin inspection by licensed nurse. R105's Comprehensive Skin Assessment dated 4/14/21, indicated R105 skin was intact but at risk for altered skin integrity. Further, indicated R105 use of oxygen with nasal cannula or mask was a skin risk factor. During observation and interview on 5/10/21, at 4:00 p.m. R105 pulled right ear forward and revealed a stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister). The area appeared as a ruptured blister, the wound bed was red with loose tissue around the edges. R105 stated it has been sore behind her right ear for a few days and she reported it to a nurse. R105 stated it was from the oxygen tubing as it was too tight. R105's weekly skin audit dated 5/11/21, indicated, "no skin concerns noted." It did not indicate a	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 900	Continued From page 4 pressure ulcer behind R105's right ear. R105's March 2021, April 2021, and May 2021 treatment administration records (TARs) did not indicate a treatment for the stage II pressure ulcer. During observation on 5/11/21, at 2:24 p.m. R105 had a foam protector covering the oxygen tubing over her left ear. There was no protection over the tubing over her right ear and the open area remained behind her ear and under the tubing. R105 stated she told the nurse she had a sore behind her right ear, but the nurse only put the protector on the left ear and did not look at the other one, even though she mentioned it to her. When interviewed on 5/12/21, at 7:38 a.m. nursing assistant (NA)-A stated if an open area is noted during cares it is reported to the nurse immediately. NA-A further stated R105 had a history of a pressure ulcer to the buttocks however, did not have a pressure ulcer at this time. When interviewed on 5/12/21, at 7:39 a.m. registered nurse (RN)-A stated nurses completed weekly skin checks which consisted of checking a resident from head to toe for any bruises, redness, open areas, and any new skin changes. RN-A verified the open area on R105's right ear should have been noted on the weekly skin check. RN-A further stated when nurses notice a skin concern it would be charted, the doctor notified, a treatment order received, and report the open area to the nurse manager. Additionally, RN-A stated the oxygen tubing could be padded so it doesn't rub and cause a pressure ulcer or other skin concern.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 900	Continued From page 5 When interviewed on 5/12/21, at 8:11 a.m. the director of nursing (DON) stated a nurse should do a full body audit when completing a skin assessment. The DON verified the stage II pressure ulcer to R105's right ear should have been noted on the skin assessment on 5/11/21. Further, the DON verified the nurse would call the doctor and report the open area to the nurse manager. During observation on 5/13/21, at 8:30 a.m. R105 had padding placed over the oxygen tubing that went over each ear. The pressure ulcer noted on 5/10/21, was healing, it was flat and pink in color. The loose tissue surrounding the wound had resolved. The Skin Integrity: Data Collection and Management policy dated 4/9/21, indicated weekly skin inspections would be completed on residents on bath days and documented on the electronic health record (EHR) "Weekly Skin Report Form" by a licensed practical nurse (LPN)/RN. Further indicated, if an open area develops the "Wound Documentation Form" on the EHR would be initiated, notify doctor for treatment order, and notify the dietitian. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/13/2021

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) COMPLETE DATE
2 900	Continued From page 6 pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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 _____	**05/12/2021**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/12/2021. At the time of this survey, Mount Olivet Careview Home 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 | 06/07/2021

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 _____	**05/12/2021**

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
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 1 is a 3-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		

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 _____	**05/12/2021**

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
K 000	Continued From page 2 new addition, Building 2, 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 144 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of the maintenance, inspection, and testing of fire-rated door assemblies in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.7.3.1,	K 761	Maintenance team will create a new points of inspection form for each fire-rated door and ensure documentation of pass/fail, date of inspection, and specific name and location of those doors	6/7/21

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 _____	**05/12/2021**

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
K 761	Continued From page 3 19.7.6, 4.6.12, and the Standard for Fire Doors and Other Opening Protectives NFPA 80-2010, section 5.2.1 This deficient practice could affect all 155 residents. Findings include: On a facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a review of the records provided for review, the documentation did not detail the individual doors inspected, dates on which the inspections occurred, and the points of inspection that were assessed for each door. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 761	inspected by 6/21/21. Each individual fire-rated door will be inspected annually and documented on the points of inspection form by the Maintenance Team. Director of Engineering will report findings to the QAPI committee on an annual basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 12, 2021. At the time of this survey, Mount Olivet Careview Home 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 18 New 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 | 06/07/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
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 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 000	Continued From page 2 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 144 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in accordance with the Life Safety Code NFPA 101, 2012 edition sections 18.2.1, 18.7.3.1, 7.1.10.1. This deficient practice could affect all residents within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, it was observed that the Floor 1 Business Office corridor had storage boxes obstructing the path of egress and access to the exit door.	K 211	Storage boxes were removed from the path of egress and exit door access by the Business Office Director on 5/17/21. An Exit Door audit will be conducted monthly by the Maintenance team to monitor the paths of egress and exit door access and ensure they are free and clear of obstruction. Director of Engineering will supervise and report to QAPI monthly to review and evaluate need for further follow-up. Staff education on emergency egress pathways will be conducted annually and as needed.	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 211	Continued From page 3 This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 211		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1 hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain the fire-resistance rating of an enclosed stairway according to the Life Safety Code NFPA 101, 2012 edition, sections 18.3.1.1 through 18.3.1.6, and 8.6.2. This deficient practice could affect all 155 residents. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, the following observations were made: 1) The 4th Floor, B4 Stairway, had a large hole, approximately 1 foot by 1 foot, in the concrete block wall. 2) The 3rd Floor, B3 Stairway, had a large hole, approximately 1 foot by 1 foot, in the concrete block wall.	K 311	The 4th floor B4 stairway and 3rd floor B3 stairway holes were patched and sealed to meet the correct fire-rating requirements on 5/14/21 by an outside service provider. Following future construction or service needs, holes will be patched and sealed accordingly. Maintenance team will monitor quarterly and report to Director of Engineering to ensure completion of hole repair.	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 311	Continued From page 4 This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 311		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility manual initiation devices of the fire alarm system in accordance with the Life Safety Code NFPA 101-2012 edition section 18.3.4.2.2 (1), and National Fire Alarm and Signal Code NFPA 72-2010, section 17.14.5. This deficient practice could affect all 155 residents. Findings Include: On facility tour between 10:00 AM and 02:00 PM on 04/27/2021, during the walk-through of the facility, access to fire alarm pull-stations was obstructed in the following areas: 1) Floor 4 Nurses Station. 2) Basement corridor adjacent to Room 66. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	Fire alarm pull-station obstructions on floor 4 nurses station and basement corridor adjacent to room 66, were removed on 5/13/21 by the Maintenance Team. A Fire Alarm Pull-Station audit will be performed monthly to ensure the pull-stations remain free and clear of obstructions. Director of Engineering will supervise and report to QAPI monthly to review and evaluate need for further follow-up. Staff education on fire alarm pull-station accessibility will be conducted annually and as needed.	6/7/21
K 353	Sprinkler System - Maintenance and Testing	K 353		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 353 SS=F	Continued From page 5 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and test the automatic fire sprinkler system in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient practice could affect all 155 residents. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during the walk-through of the facility, the following observations were made:	K 353	The ceiling tiles in the 3rd Floor, Room 3-2 Data Closet, 2nd Floor, SJ 2-1 Janitor Closet, and 1st Floor, Business Office Data Closet, will be installed by 6/21/21. The sprinkler escutcheon in the 2nd Floor, Housekeeping Room across from Room 232 will be installed by 6/21/21. The Maintenance team will monitor quarterly for missing ceiling tiles and sprinkler escutcheons and install as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 353	Continued From page 6 1. A ceiling tile was missing in the 3rd Floor, Room 3-2 Data Closet. 2. A sprinkler escutcheon was missing in the 2nd Floor, Housekeeping Room across from Room 232. 3. A ceiling tile was missing in the 2nd Floor, SJ 2-1 Janitor Closet. 4. A ceiling tile was missing in the 1st Floor, Business Office Data Closet. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to fire extinguishers and mount them in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.5.12, 9.7.4.1, and NFPA 10 Standard for Portable Fire Extinguishers, 2010 edition, section 6.1.3.8 and 7.2.2(2). This deficient practice could affect all 155 residents. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, the following observations were made: 1) Access to the portable fire extinguisher on the	K 355	The portable fire extinguisher in the basement Laundry Room and portable fire extinguisher in the basement adjacent to Men's Locker Room were remounted to the correct height by the Maintenance team on 5/26/21. The obstructions to the portable fire extinguisher on the 5th Floor at the Nurses Station, the portable fire extinguisher adjacent to Room 417, the portable fire extinguisher adjacent to Room 233, and the portable fire extinguisher in the basement, adjacent to Room 66, were removed by the Maintenance team on 5/14/21. A portable fire extinguisher audit will be conducted	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 355	Continued From page 7 5th Floor at the Nurses Station was obstructed. 2) Access to the portable fire extinguisher adjacent to Room 417 was obstructed. 3) Access to the portable fire extinguisher adjacent to Room 233 was obstructed 4) Access to the portable fire extinguisher in the basement, adjacent to Room 66, was obstructed. 5) The portable fire extinguisher in the basement Laundry Room was mounted higher than 5 feet. 6) The portable fire extinguisher in the basement adjacent to Men's Locker Room was mounted higher than 5 feet. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 355	monthly by the Maintenance team to ensure each fire extinguisher is free and clear of obstruction and mounted at the correct height. Director of Engineering will supervise and report to QAPI monthly to review and evaluate need for further follow-up. Staff education on portable fire extinguisher accessibility will be conducted annually and as needed.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by:	K 374		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 374	Continued From page 8 Based on observation and staff interview, the facility failed to inspect and maintain smoke barrier doors in accordance with the Life Safety Code NFPA 101-2012 edition, sections 18.3.7.3 and 8.5.4, and Standard for Fire Doors and Other Opening Protectives NFPA 80-2010, section 6.3.1.7. This deficient practice could affect all 155 residents. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, it was observed that the smoke barrier doors in the following locations exhibited door-to-door vertical gaps greater than a one-eighth inch: 1) The 3rd Floor Therapy Room smoke barrier doors. 2) The 1st Floor smoke barrier doors adjacent to the Lyndal Lounge. 3) The 1st Floor smoke barrier doors adjacent to Room 110. 4) The 1st Floor smoke barrier doors adjacent to the time clock. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 374	The door-to-door vertical gap of the 3rd Floor Therapy Room smoke barrier doors, the 1st Floor smoke barrier doors adjacent to the Lyndale Lounge, the 1st Floor smoke barrier doors adjacent to Room 110, and the 1st Floor smoke barrier doors adjacent to the time clock, were repaired with smoke seal to ensure proper seal and to meet fire door rating standards. The new points of inspection form will be utilized annually to monitor for potential door-to-door vertical gaps and any gaps identified will be repaired with smoke seal. Inspection and documentation will be completed by the Maintenance team with supervision by the Director of Engineering and reported to the QAPI committee on an annual basis.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 511	Continued From page 9 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain security and accessibility of electrical breaker panels in resident corridors in accordance with the Life Safety Code NFPA 101-2012 edition, sections 18.5.1.1 and 9.1.2, the National Electrical Code NFPA 70-2011, section 110.26, and the Health Care Facilities Code NFPA 99, section 6.3.2.2.1.3. This deficient practice could affect all 155 residents. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, the following observations were made: 1) There was an obstructed electrical breaker panel on the 4th Floor in Room SO 4-2. 2) There was an obstructed electrical breaker panel on the 1st Floor. 3) There was an obstructed electrical breaker panel in the basement Laundry Room. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 511	The obstructions identified for the electrical breaker panel on the 4th Floor in Room SO 4-2, the electrical breaker panel on the 1st Floor, and the electrical breaker panel in the basement Laundry Room, were removed on 5/26/21 by the Maintenance team. An Electrical Breaker Panel audit will be performed monthly by the Maintenance Team to ensure the panels remain free and clear of obstructions. Director of Engineering will supervise and report to QAPI monthly to review and evaluate need for further follow-up. Staff education on electrical breaker panel accessibility will be conducted annually and as needed.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes	K 541		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 541	Continued From page 10 2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. *The fire resistance rating of chute charging room shall not be required to exceed one hour. *Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. *Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure proper operability of linen chute doors in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 18.5.4.1 and 9.5.2 and Fire Doors and Other Opening Protectives NFPA 80 -2010 edition, sections 4.3.7, 5.1.3.1, 5.1.3.2 This deficient practice could affect all residents on the 2nd floor. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, it was observed that the Room 2-E linen chute door did not close and self-latch when tested. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 541	The Room 2-E linen chute door was repaired on 5/26/21 by the Maintenance team to ensure proper operation of closing and self-latching. The Maintenance team will perform a facility walk-through to test all linen chutes on a quarterly basis and repair as needed.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 761	Continued From page 11 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of the maintenance, inspection, and testing of fire-rated door assemblies in accordance with the Life Safety Code NFPA 101 - 2012, sections 18.7.3.1, 18.7.6, 4.6.12, and the Standard for Fire Doors and Other Opening Protectives NFPA 80-2010, section 5.2.1. This deficient practice could affect all 155 residents. Findings include: On a facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a review of the records provided for review, the documentation did not detail the individual doors inspected, dates on which the inspections occurred, and the points of inspection that were assessed for each door. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 761	Maintenance team will create a new points of inspection form for each fire-rated door and ensure documentation of pass/fail, date of inspection, and specific name and location of those doors inspected by 6/21/21. Each individual fire-rated door will be inspected annually and documented on the points of inspection form by the Maintenance Team. Director of Engineering will report findings to the QAPI committee on an annual basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 914	Continued From page 12	K 914		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing at resident bed locations in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 6.3.3.2, 6.3.4.1, and 6.3.4.2. This deficient practice could affect all 155 residents. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a review of the available	K 914	Resident Room Outlet Inspection form will be updated to identify the location of the outlets under inspection in resident sleeping rooms by the Maintenance team by 6/21/21. Each resident room outlet will be inspected annually and documented on The Resident Room Outlet Inspection form. Inspection and documentation will be completed by the Maintenance team with supervision by the Director of Engineering and reported to the QAPI committee on an annual basis.	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 914	Continued From page 13 documentation, the inspection records did not identify the location of the inspected outlets in resident sleeping rooms. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 914		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **02 - NEW ADDITION** B. WING _____	**05/12/2021**

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
K 923	Continued From page 14 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store medical gas cylinders in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 11.3.3.3, 11.6.2.3 (11), 11.6.5. This deficient practice could affect all residents within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 03:00 PM on 05/12/2021, during a walk-through of the facility, it was observed that the alcove across from Room 3-3 had an oxygen cylinder that was not secured against tampering or tipping. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 923	The oxygen cylinder identified was secured in a cart to prevent tampering or tipping on 5/12/21 by the Maintenance team. The Maintenance team will monitor securement of oxygen cylinders and report to Director of Engineering quarterly. Staff education on oxygen cylinder storage and securement will be conducted annually and as needed.	