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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RX3C

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 **6/6/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **153** (L18)
13.Total Certified Beds **153** (L17)

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

B.IIINotIinICmplianceIwithIProgram 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
	153			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Gayle Lantto, Unit Supervisor — 6/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Health Program Representative 06/20/16 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245071

June 20, 2016

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

Dear Mr. Hokanson:

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

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

Effective May 16, 2016 the above facility is certified for:

153 Skilled Nursing Facility/Nursing Facility Beds

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

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

June 20, 2016

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

RE: Project Number S5071025

Dear Mr. Hokanson:

On April 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 13, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 11, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2016, effective May 9, 2016 and therefore remedies outlined in our letter to you dated April 26, 2016, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245071 Y1	A. Building B. Wing Y2	6/6/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0242	Correction	ID Prefix F0246	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	05/09/2016	LSC	05/09/2016	LSC	05/09/2016
ID Prefix F0309	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/09/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GL/kfd	6/20/2016	15507	6/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/13/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245071	A. Building 01 - MAIN BUILDING 01 B. Wing	5/11/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 05/09/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/20/2016	37009	5/11/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RX3C

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 **04/13/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **153** (L18)
13.Total Certified Beds **153** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
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
	153			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sandra Tatro, HFE NEII — 05/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0366

April 26, 2016

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

RE: Project Number S5071025

Dear Mr. Hokanson:

On April 13, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
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: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 23, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 13, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

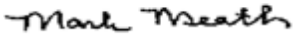
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING _____ B. WING _____	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	POC accepted 5/13/16 SDan HO RECEIVED MAY 06 2016 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5-6-16

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

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	245071	A. BUILDING _____ B. WING _____	04/13/2016

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a timely Medicare notice when services ended for 1 of 3 residents (R122) reviewed for liability notices and beneficiary appeal rights review. Findings include: On 4/13/16, at 1:21 p.m. a registered nurse-(RN)-B stated she gave residents Medicare denial notices to residents at least two days before Medicare coverage was going to end, as required. RN-B explained she had informed R122 coverage was ending on 2/16/16, however, the resident declined signing the notice stating she planned to leave regardless. However, RN-B verified the notice lacked documentation the conversation and date the resident had been informed coverage was ending. RN-B stated, "I should have dated and signed the appeal notice."	F 156	A Medicare Denial letter was presented to resident R122, who declined to sign the form, on 2/12/16 per the "Medicare Nurse's Notes Log" which was provided to the surveyors during survey. All residents discharging off Medicare A services have the potential to be affected. All residents who discharged off Medicare A services from 4/10/16 thru 4/29/16 were audited on 4/29/16 and no other residents were affected. Medicare Nurse was re-educated on 4/13/16 and again on 4/28/16 with all the MDS staff regarding the need to add the date presented, name of presenter, who the notice was given to and reason for declination to sign if they provided a reason, if they decline to sign the Denial letter. Notification of Non-coverage for Medicare/HMO Benefits policy was updated to reflect this change.	

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F 156	Continued From page 3 RN-B stated the facility had a policy that directed the staff to give residents two day's notice prior to services ending, but the policy did not direct staff to document the information. Although RN-B normally wrote a progress note when notices were given, she stated she had not documented notice was given to R122 two days prior to services ending. RN-B verified she wrote on the notice, "Going home not going to sign," but had not dated nor signed the notice. At 3:15 p.m. the director on nursing stated she was unable to determine when an who gave notice services were ending for R122 based on the documentation available. A 10/7/13, Notification of Non-coverage for Medicare/HMO Benefits policy indicated "When the Medicare Nurse/designee determines that the skilled care is no longer required, he/she will issue notice of Non-coverage. This notice must be issued at least two days prior to the last covered day."	F 156	All nursing staff was in-serviced on 4/18/16 and again on 5/5/16 and nurses again on 4/27/16 regarding the above requirements. Medicare A Denial Letter Audits will be done by Medicare Nurse/designee on all residents discharging off Medicare A services weekly x 4 weeks, then up to 5 residents weekly x 4 weeks and then up to 2 residents weekly x 4 weeks or until 100% compliance is achieved. Results will be monitored by the DON/ADON and reviewed in the quarterly QAPI meeting.	5/9/16
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 242		

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F 242	Continued From page 4 review, the facility did not ensure the opportunity for bathing preferences for 3 of 3 residents (R2, R150, R205) reviewed for choices. Findings include: R2 stated during interview on 4/11/16, at 2:44 p.m. "They only give me one shower a week and I would like three showers a week. I do not think one shower a week is good hygiene." R2 reported she had informed staff she wanted additional baths, "...but staff told me they had too many residents to give me more than one a week." R2 reported he felt staffs' response to his request was "an excuse." R2's 3/22/16, Minimum Data Set (MDS) revealed the resident's cognition was intact, he required assistance from staff to bathe, and did not reject care. Bathing choices were noted as very important to the resident. On 4/11/16, at 6:51 p.m. a nursing assistant (NA)-A explained that residents could have had more than one bath or shower a week, and some residents bathed twice a week. NA-A verified on the bathing schedule that R2 presently was receiving one shower weekly. Later at 7:48 p.m. a registered nurse (RN)-A reported residents could get more than one shower a week, which was usually based upon resident request. RN-A said the second bath or shower would then be added onto the bathing schedule. RN-A stated all 34 residents presently residing on the 2W wing received only one bath or shower weekly. On 4/13/16, at 12:33 p.m. NA-B stated she	F 242	Resident R2 preference was noted and NAR care card was updated for him to receive/be offered 3 showers per week. Resident R150's NAR care card was updated to reflect her preference of a bath not a shower. Resident R205 did not ask the DON for a 2nd shower weekly as stated in the SOD. During 2 interviews with R205 and the DON on 2 consecutive days during the survey, R205 asked the DON "how often do I get a bath?" 3 times, to which the DON responded "weekly" and R205 replied, weekly, hmmm; I thought it was like every 3 weeks/2 weeks/2weeks. Each time the DON told R205 that he could have a bath/shower more frequently if he desired and he replied, "weekly is fine" then chuckled, smiled and said, "but I might ask for 2" and laughed again.	

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F 242	Continued From page 5 followed the bath schedule, and was unaware of R2's request for an additional bathing during the week. A licensed practical nurse (LPN)-A then explained at 12:38 p.m. that if a resident requested a second shower during the week, the request would be accommodated that shift. If more frequent bathing was requested, he gave the information to the supervisor and additional bathing was scheduled, care planned, and then was incorporated onto the NA care cards. LPN-A verified R2 was receiving a weekly shower on Sunday evenings. During a follow up interview with R2 at 12:42 p.m. the resident again stated he wanted a shower more than once a week, which he felt was not frequent enough. R2 stated he had previously clearly informed RN-A at his care conference he wanted additional bathing. On 4/13/16, at 12:46 p.m. RN-A stated bathing preferences were reviewed with residents and he was unaware R2 wanted additional bathing. RN-A stated he would put an additional shower on the bathing schedule for R2, and would try to space the shower day mid-way between his currently scheduled shower day. The NA care care for R2 indicated one weekly bath "Sun PM" (Sunday evening). R50 stated in an interview on 4/11/16, at 1:39 p.m. she preferred a bath, but always was given a shower. The resident stated, "I take whatever they give me," but was not given a choice because she believed staff preferred to give her a shower because she "'gets cleaner'".	F 242	He was in fact just changed from a PM shower to an AM shower, which he told the DON he was pleased about. This was communicated to the surveyor during the survey. NAR care card has been updated to offer showers to R205 2x/week. All residents have the potential to be affected by this deficiency. All residents were audited between 4/22/16 and 5/5/16 to determine if their preferences were being met. Any changes identified were made on the care plan/NAR care card. Nursing staff was re-educated on 4/18/16, 4/27/16 and again on 5/5/16 regarding following resident preferences, including asking residents if they would like a bath or shower when bathed. Resident preferences are identified during the admission process and reviewed with the MDS/Care Plan/Care Conference processes. Our policy regarding Care Conferences addressed resident	

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F 242	Continued From page 6 R150's 6/23/15, MDS indicated it was very important for her to choose whether she received a bath, shower, or bed bath. NA-C (NA)-C came into her room and reported R150 gets her shower on Wednesdays before breakfast. On 4/13/15, at 9:15 a.m. NA-C reported R150 received a shower on Wednesdays and had a shower before breakfast. When asked whether residents were given a choice between a bath and shower she said he told R150 it was time for her shower and since she did not disagree, he gave her a shower. NA-C explained residents' choices for bathing was noted on the NA care sheet, which directed each resident's care, and if it was not noted, the resident would be asked their preference. R150's bathing preference was not noted on the current NA care sheet. RN-C then stated in an interview at 9:28, staff was expected to ask a residents' bathing preference at the time of every bath, and explained, "That is how we make sure they are getting what they want." The Admission Data Sheet, dated 6/11/15, indicated R150 preferred a shower. At 10:31 a.m. RN-C explained that the information collected at the time of admission was reviewed at each care conference. A review of the Care Conference Summaries dated 12/10/15, 7/1/15, 9/17/15, and 3/9/16, however, lacked information showing personal preferences were reviewed and/or updated. RN-C shrugged his shoulders and stated, "I do not know why it wasn't reviewed." The Weekly Skin Check sheets dated from	F 242	preferences/choices. MDS Policy and Procedure which includes Care Plan Policy and Procedure was updated to reflect incorporating resident preferences and refers to the Care Conferences Procedure. Bathing Preference Audits will be done by Nurse Managers/Licensed Nurses on 18 residents weekly x 4 weeks, then 12 residents weekly x 4 weeks and then 6 residents weekly x 4 weeks or until 100% compliance is achieved. Results will be monitored by the DON/ADON and reviewed at the quarterly QAPI meeting. Care Conference Summary Preference Audits will be done by the DSS, DON, ADON or Administrative RN weekly on 18 residents x 4 weeks, then 12 residents per week x 4 weeks and then 6 residents per week x 4 weeks or until 100% compliance is achieved. Results will be monitored by the DON/ADON and reviewed at the quarterly QAPI meeting.	5/9/16

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F 242	Continued From page 7 1/13/16 through 4/13/16, noted R150 received a shower on bath day. An interview with the director of nursing on 4/13/16, at 2:07 p.m. stated she expected personal preference information to be reviewed at least quarterly in care conference meetings, but preferably the resident would be given a choice each week. R205 stated during an interview on 4/10/16, at 1:10 p.m. he received a shower monthly, and denied weekly showers. He said he had never requested more frequent showering. On 4/12/16 at 9:19 a.m NA-E wheeled R205 into the Spa Room, where he was bathed in a high-side tub. On 4/12/16, at 9:51 a.m. NA-E stated, "He gets a shower in that tub weekly, every Tuesday." R205's 10/16/15, MDS indicated the resident had moderately impaired cognition, and bathing choices were very important to the resident. The resident required assistance with activities of daily living, including bathing. Care conference summaries did not reflect a review of resident preferences, including whether R205 requested more frequent showering. During an interview on 4/13/16, at 11:18 a.m. the DON indicated R205 asked her yesterday if he could have a second shower per week, and added they set it up. The facility's 5/9/11, Bath/Shower Procedure lacked direction to staff to ensure choices were offered to residents prior to bathing.	F 242		

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F 246 F 246 SS=D	Continued From page 8 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed provide an environment which promoted sleep for 1 of 1 resident (R170) reviewed for accommodation of individual needs and preferences. Findings include: R170 reported during an interview on 4/10/16, at 1:41 p.m. he had a concern with his roommate stating, "He doesn't want to turn the lights out at night. He keeps the lights on all night." He further explained that he had informed the nurse "every night" but denied that anyone had ever gotten back to him regarding his concern. R170 reported he was of advanced age and needed more sleep, but stated, "I never get enough sleep. It is not good." On 4/12/16, at 11:38 a.m. the licensed social worker, (LSW)-A stated she was unaware of the situation as reported by R170. R170's family member (F)-A was interviewed on 4/12/16, at 2:47 p.m. and revealed she was	F 246 F 246	Staff was not made aware of resident R170's concern regarding the roommate's light on past the time preferred until he told the surveyor during survey. Staff immediately put measures in place to meet R170's needs. R170's roommate desires a light on at night to fall asleep and then staff turns it off once he is asleep. R170 goes to bed approximately 730pm and his roommate between 8-830pm and the light is out between 830-930p. Accommodations were made to furnish the roommate with a 2nd floor lamp next to his bed to use rather than his over the bed light, a 2nd over the bed table so he could work further away from R170's side of the room at night and solid room divider curtains that will block out more light between the 2 sides of the room were special ordered on 4/13/16 and are expected to arrive on 5/16/16. (OL-MF)	

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F 246	Continued From page 9 aware of the problem and said, "I hear about it every day." She further explained staff was aware of the concern regarding the lights being left on at night by R170's roommate, as the resident's daughter (F)-B visited most evenings and had spoken to them "many times" regarding the problem. R170 added, "I only get two hours of sleep each night. The light bothers me. I can't sleep. I should not have to sleep during the day because then I can't sleep at night. " During a phone conversation on 4/12/16, at 3:01 p.m. F-B stated her father had brought his concerns regarding lack of sleep due to his roommate leaving the light on many times. She verified she had spoken to the evening and weekend nurses on at least two occasions. She further explained that her father had informed her that he had also told staff multiple times. "It is a big concern ever since the new roommate came. I have not heard any feedback or received anything in writing about the problem. " R170's current plan of care and progress notes were reviewed and lacked any information regarding R170's concerns about his roommate leaving the light on at night or his related lack of sleep. On 4/12/16, at 3:53 p.m. LSW-A stated she spoke with R170 and assisted him in filling out a concern form. She further explained that although he liked his room, she had put him on the list for a room change. She also stated new interventions were put in place that included close monitoring of the lights in the room, and a new room divider curtain was provided that would filter out more light. In addition, a sleep study was planned for R170.	F 246	All residents have the potential to be affected by this deficiency. All residents were audited between 4/22/16 and 5/4/16 to determine if their preferences were being met. Any changes identified were made on the care plan/NAR care card. All Staff were re-educated regarding Abuse Prevention and Concern Reporting expectations on 4/13/16. All Nursing Staff were re-educated on 5/5/16 regarding Concern Reporting expectations and Accommodation of Resident Needs. Resident preferences/needs are identified during the admission process and reviewed with the MDS/Care Plan/Care Conference processes. Our policy regarding Care Conferences addressed resident needs/preferences. MDS Policy and Procedure which includes Care Plan Policy and Procedure addressed develop, review and revise the	

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F 246	Continued From page 10 On 4/13/16, at 9:39 a.m. R170 was interviewed in his room. When asked how he slept he replied, "Pretty damn good until 6:00 when he [roommate] turned on his light and wouldn't turn it off. I really like my room and hate to give it up. But if I can't sleep, it is not good. I need sleep. I am glad you came. Thanks for sticking up for me. I don't lie. " On 4/13/15, at 1:45 p.m. the director of nursing stated she expected staff to carry forth concerns from residents and pass them on to the appropriate staff. "If we would have known about the problem we would have addressed it. It just never got to us." A policy regarding resident's accommodation of needs was requested but was not provided.	F 246	comprehensive plan of care to meet the resident's needs, was updated to reflect incorporating resident preferences and refers to the Care Conferences Procedure. Reasonable Accommodation of Needs Audits will be done by Nurse Managers/Licensed Nurses on 18 residents weekly x 4 weeks, then 12 residents weekly x 4 weeks and then 6 residents weekly x 4 weeks or until 100% compliance is achieved. Results will be monitored by the DON/ADON and reviewed at the quarterly QAPI meeting.	5/9/16
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services related to non-pressure skin conditions for 1 of 1 (R135) resident reviewed for skin problems.	F 309		

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(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 309	Continued From page 11 Findings include: R135 was observed on 4/10/16, at 2:10 p.m. with bruises on her left and right forearms and a skin tear to her right elbow. The uncovered skin tear was approximately 1.0 x 0.5 centimeters (cm) with a dark, dry scab. R135 explained she hit her elbow while going through the doorway to her room. She stated staff has not assessed or dressed it since it happened "quite a while ago." R135's medication administration record indicated she was currently receiving 81 milligrams of aspirin daily, known to contribute to bruising. R135's 9/10/15, care plan included the resident's risk for skin break down related to potential for mobility dependency with bed mobility and transfers, muscle weakness, fragile skin, "bruises easily due to aspirin use. Skin intact at this time." The care plan goal was to keep R135's skin intact. Staff was directed to complete skin checks weekly at bath time, and check pressure points with cares. The treatment administration record (TAR) for R135 for 4/16, lacked evidence of skin monitoring for any alteration in skin integrity. However the TAR indicated that a skin check was performed by staff on 4/9/16 and 4/2/16. A Summary of Weekly Skin Audit Note written 4/9/16 read, "Shower was done this morning. Old bruises remain to bilateral forearm[s]. No new skin issues reported." Additional Summary of Weekly Skin Audit Notes written 4/2/16, 3/26/16, 3/19/16, and 3/12/16 4/2/16 also noted, "Shower was done this morning. Old bruises remain to	F 309	R135's skin was inspected and concerns were documented in R135 progress notes and incident report completed on 4/13/16. Interventions were put into place to prevent reoccurrence. Resident's skin is observed daily with cares by the NAR and inspected weekly with bathing by the Licensed Nurse. No other residents were affected by this deficiency.	

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 _____	04/13/2016

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

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F 309	Continued From page 12 bilateral forearm[s]. No new skin issues reported. " A review of R135's incident reports involving skin issues indicated no report had been initiated since 11/2/15, when the resident sustained a bump on her head. During an interview on 4/13/16, at 12:55 p.m. a registered nurse (RN)-C verified an incident report had not been initiated for R135's bruising to bilateral forearms or the skin tear to her right elbow. RN-C further verified staff had not identified or monitored the skin issues until they were brought to the staffs' attention that day by the surveyor. During an interview on 4/13/16, at 1:07 p.m. a licensed practical nurse (LPN)-B revealed she was also unaware of R135's skin issues until it was brought to the staffs' attention by the surveyor. LPN-B stated she was in the process of initiating an incident report and updating the resident's care plan. A note written by LPN-C at 2:56 p.m. read, "Writer notify [sic] of old skin tear measuring 1.0 x 0.5 noted to right elbow and left forearm. Writer ask res [resident] how it happen resident stated 'I bumped my on the door it is fine,' but unable to state how it happened. Skin tear and bruise are healing and fading away. Will continue to monitor till resolved. Np [nurse practitioner]/family updated of skin tear and bruise." In an interview with the director of nursing (DON) on 4/13/16, at 1:56 p.m. it was verified documentation regarding R135's bruises and skin tear had not been documented in the nursing notes and/or on an incident report, nor had	F 309	Nursing staff was re-educated on 4/18/16, 4/27/16 and 5/5/16 regarding the expectation that daily skin observation and reporting must be done by the NAR and Weekly Skin inspections must be done by the Licensed Nurse and ALL abnormalities must be documented and investigated for cause and new intervention to prevent reoccurrence initiated. Skin Monitoring Audits will be done by Nurse Managers/Licensed Nurses on 18 residents weekly x 4 weeks, then 12 residents weekly x 4 weeks and then 6 residents weekly x 4 weeks or until 100% compliance is achieved. Results will be monitored by the DON/ADON and reviewed at the quarterly QAPI meeting.	5/9/16

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F 309	Continued From page 13 treatment been implemented to the skin tear and monitoring for healing of the both the skin tear and brusing. The DON explained nursing assistants are responsible to check residents" skin with daily cares and nurses inspected residents' skin weekly on bath day. Additionally the DON said any new skin issues should have been identified and reported, measured and documented and assessed regularly according to facility policy. The facility's 2/16/16, Skin Integrity: Data Collection and Management for Licensed Nursing Personnel policy directed staff to attempt to determine causative factors, complete accurate measurements of the wound, identify characteristics of the wound, consult guide for type of product to be used on the wound, Notify NP/MD (physician) when treatment is initiated or with a change, notify family during waking hours when open area has been identified, monitor dressing every shift and change as per protocol/order.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	04/12/2016

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 12, 2016. At the time of this survey, Mount Olivet Careview Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	**APPROVED** Tom Linhoff **By Tom Linhoff at 8:01 am, May 09, 2016** RECEIVED MAY - 9 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-4-16

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

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	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mount Olivet Careview Home is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the North side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 153 beds and had a census of 150 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect all 29 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on April 12, 2016, it was revealed that no documentation could be provided, that quarterly automatic sprinkler flow testing had been conducted. This deficient practice was verified by the Director of Maintenance at the time of the inspection.	K 062	The automatic Sprinkler flow testing will be conducted and documented quarterly. This procedure was implemented as of 4/12/16. The Director of Engineering will monitor this to prevent another occurrence.	5/9/16

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0366

April 26, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5071025

Dear Mr. Hokanson:

The above facility was surveyed on April 10, 2016 through April 13, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
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: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 Gayl Lantto at the phone number or email detailed above.

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.

l free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification FileP{

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 _____	04/13/2016

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

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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 April 10, 11, 12, and 13, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to: Minnesota Department of Health	2 000	RECEIVED MAY 06 2016 BY: _____ 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D A Pearce | TITLE: Administrator | (X6) DATE: 5-6-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Minnesota Department of Health Gayle Lantto Health Regulation Division Licensing and Certification P.O. Box 64900 St. Paul, Minnesota 55164-0900 gayle.lantto@state.mn.us	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		

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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services related to non-pressure skin conditions for 1 of 1 (R135) resident reviewed for skin problems. Findings include: R135 was observed on 4/10/16, at 2:10 p.m. with bruises on her left and right forearms and a skin tear to her right elbow. The uncovered skin tear was approximately 1.0 x 0.5 centimeters (cm) with a dark, dry scab. R135 explained she hit her elbow while going through the doorway to her room. She stated staff has not assessed or dressed it since it happened "quite a while ago." R135's medication administration record indicated she was currently receiving 81 milligrams of aspirin daily, known to contribute to bruising. R135's 9/10/15, care plan included the resident's risk for skin break down related to potential for mobility dependency with bed mobility and transfers, muscle weakness, fragile skin, "bruises easily due to aspirin use. Skin intact at this time." The care plan goal was to keep R135's skin intact. Staff was directed to complete skin checks weekly at bath time, and check pressure points with cares.	2 830		

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2 830	Continued From page 3 The treatment administration record (TAR) for R135 for 4/16, lacked evidence of skin monitoring for any alteration in skin integrity. However the TAR indicated that a skin check was performed by staff on 4/9/16 and 4/2/16. A Summary of Weekly Skin Audit Note written 4/9/16 read, "Shower was done this morning. Old bruises remain to bilateral forearm[s]. No new skin issues reported." Additional Summary of Weekly Skin Audit Notes written 4/2/16, 3/26/16, 3/19/16, and 3/12/16 4/2/16 also noted, "Shower was done this morning. Old bruises remain to bilateral forearm[s]. No new skin issues reported. " A review of R135's incident reports involving skin issues indicated no report had been initiated since 11/2/15, when the resident sustained a bump on her head. During an interview on 4/13/16, at 12:55 p.m. a registered nurse (RN)-C verified an incident report had not been initiated for R135's bruising to bilateral forearms or the skin tear to her right elbow. RN-C further verified staff had not identified or monitored the skin issues until they were brought to the staffs' attention that day by the surveyor. During an interview on 4/13/16, at 1:07 p.m. a licensed practical nurse (LPN)-B revealed she was also unaware of R135's skin issues until it was brought to the staffs' attention by the surveyor. LPN-B stated she was in the process of initiating an incident report and updating the resident's care plan. A note written by LPN-C at 2:56 p.m. read, "Writer notify [sic] of old skin tear measuring 1.0 x 0.5 noted to right elbow and left	2 830		

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2 830	Continued From page 4 forearm. Writer ask res [resident] how it happen resident stated 'I bumped my on the door it is fine,' but unable to state how it happened. Skin tear and bruise are healing and fading away. Will continue to monitor till resolved. Np [nurse practitioner]/family updated of skin tear and bruise." In an interview with the director of nursing (DON) on 4/13/16, at 1:56 p.m. it was verified documentation regarding R135's bruises and skin tear had not been documented in the nursing notes and/or on an incident report, nor had treatment been implemented to the skin tear and monitoring for healing of the both the skin tear and brusing. The DON explained nursing assistants are responsible to check residents" skin with daily cares and nurses inspected residents' skin weekly on bath day. Additionally the DON said any new skin issues should have been identified and reported, measured and documented and assessed regularly according to facility policy. The facility's 2/16/16, Skin Integrity: Data Collection and Management for Licensed Nursing Personnel policy directed staff to attempt to determine causative factors, complete accurate measurements of the wound, identify characteristics of the wound, consult guide for type of product to be used on the wound, Notify NP/MD (physician) when treatment is initiated or with a change, notify family during waking hours when open area has been identified, monitor dressing every shift and change as per protocol/order. SUGGESTED METHOD OF CORRECTION: The director of nursing and nurse managers could ensure residents' skin conditions were monitored.	2 830		

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2 830	Continued From page 5 Training could be provided as necessary, audits could be completed, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		

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	00178	A. BUILDING: _____ B. WING _____	04/13/2016

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

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21800	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a timely Medicare notice when services ended for 1 of 3 residents (R122) reviewed for liability notices and beneficiary appeal rights review. Findings include: On 4/13/16, at 1:21 p.m. a registered nurse-(RN)-B stated she gave residents Medicare denial notices to residents at least two days before Medicare coverage was going to end, as required. RN-B explained she had informed R122 coverage was ending on 2/16/16, however, the resident declined signing the notice stating she planned to leave regardless. However, RN-B verified the notice lacked documentation the conversation and date the resident had been informed coverage was ending. RN-B stated, "I should have dated and signed the appeal notice." RN-B stated the facility had a policy that directed the staff to give residents two day's notice prior to services ending, but the policy did not direct staff to document the information. Although RN-B normally wrote a progress note when notices were given, she stated she had not documented notice was given to R122 two days prior to services ending. RN-B verified she wrote on the notice, "Going home not going to sign," but had not dated nor signed the notice. At 3:15 p.m. the director on nursing stated she was unable to determine when an who gave notice services were ending for R122 based on the documentation available.	21800		

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21800	Continued From page 7 A 10/7/13, Notification of Non-coverage for Medicare/HMO Benefits policy indicated "When the Medicare Nurse/designee determines that the skilled care is no longer required, he/she will issue notice of Non-coverage. This notice must be issued at least two days prior to the last covered day." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure residents are provided notices for Medicare coverage as required. Training could be provided as necessary, audits could be completed, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed provide an environment which promoted sleep for 1 of 1 resident (R170)	21810		

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21810	Continued From page 8 reviewed for accommodation of individual needs and preferences. Findings include: R170 reported during an interview on 4/10/16, at 1:41 p.m. he had a concern with his roommate stating, "He doesn't want to turn the lights out at night. He keeps the lights on all night." He further explained that he had informed the nurse "every night" but denied that anyone had ever gotten back to him regarding his concern. R170 reported he was of advanced age and needed more sleep, but stated, "I never get enough sleep. It is not good." On 4/12/16, at 11:38 a.m. the licensed social worker, (LSW)-A stated she was unaware of the situation as reported by R170. R170's family member (F)-A was interviewed on 4/12/16, at 2:47 p.m. and revealed she was aware of the problem and said, "I hear about it every day." She further explained staff was aware of the concern regarding the lights being left on at night by R170's roommate, as the resident's daughter (F)-B visited most evenings and had spoken to them "many times" regarding the problem. R170 added, "I only get two hours of sleep each night. The light bothers me. I can't sleep. I should not have to sleep during the day because then I can't sleep at night. " During a phone conversation on 4/12/16, at 3:01 p.m. F-B stated her father had brought his concerns regarding lack of sleep due to his roommate leaving the light on many times. She verified she had spoken to the evening and weekend nurses on at least two occasions. She further explained that her father had informed her	21810		

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21810	Continued From page 9	21810		

that he had also told staff multiple times. "It is a big concern ever since the new roommate came. I have not heard any feedback or received anything in writing about the problem. "

R170's current plan of care and progress notes were reviewed and lacked any information regarding R170's concerns about his roommate leaving the light on at night or his related lack of sleep.

On 4/12/16, at 3:53 p.m. LSW-A stated she spoke with R170 and assisted him in filling out a concern form. She further explained that although he liked his room, she had put him on the list for a room change. She also stated new interventions were put in place that included close monitoring of the lights in the room, and a new room divider curtain was provided that would filter out more light. In addition, a sleep study was planned for R170.

On 4/13/16, at 9:39 a.m. R170 was interviewed in his room. When asked how he slept he replied, "Pretty damn good until 6:00 when he [roommate] turned on his light and wouldn't turn it off. I really like my room and hate to give it up. But if I can't sleep, it is not good. I need sleep. I am glad you came. Thanks for sticking up for me. I don't lie. "

On 4/13/15, at 1:45 p.m. the director of nursing stated she expected staff to carry forth concerns from residents and pass them on to the appropriate staff. "If we would have known about the problem we would have addressed it. It just never got to us."

A policy regarding resident's accommodation of needs was requested but was not provided.

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21810	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nursing and licensed social workers could ensure the individual needs of residents are honored. Training could be provided as necessary, audits could be completed, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has	21830		

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specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable

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21830	Continued From page 12 to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the opportunity for bathing preferences for 3 of 3 residents (R2, R150, R205) reviewed for choices. Findings include: R2 stated during interview on 4/11/16, at 2:44 p.m. "They only give me one shower a week and I would like three showers a week. I do not think one shower a week is good hygiene." R2 reported she had informed staff she wanted additional baths, "...but staff told me they had too many residents to give me more than one a week." R2 reported he felt staffs' response to his request was "an excuse."	21830		

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21830	Continued From page 13 R2's 3/22/16, Minimum Data Set (MDS) revealed the resident's cognition was intact, he required assistance from staff to bathe, and did not reject care. Bathing choices were noted as very important to the resident. On 4/11/16, at 6:51 p.m. a nursing assistant (NA)-A explained that residents could have had more than one bath or shower a week, and some residents bathed twice a week. NA-A verified on the bathing schedule that R2 presently was receiving one shower weekly. Later at 7:48 p.m. a registered nurse (RN)-A reported residents could get more than one shower a week, which was usually based upon resident request. RN-A said the second bath or shower would then be added onto the bathing schedule. RN-A stated all 34 residents presently residing on the 2W wing received only one bath or shower weekly. On 4/13/16, at 12:33 p.m. NA-B stated she followed the bath schedule, and was unaware of R2's request for an additional bathing during the week. A licensed practical nurse (LPN)-A then explained at 12:38 p.m. that if a resident requested a second shower during the week, the request would be accommodated that shift. If more frequent bathing was requested, he gave the information to the supervisor and additional bathing was scheduled, care planned, and then was incorporated onto the NA care cards. LPN-A verified R2 was receiving a weekly shower on Sunday evenings. During a follow up interview with R2 at 12:42 p.m. the resident again stated he wanted a shower	21830		

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21830	Continued From page 14 more than once a week, which he felt was not frequent enough. R2 stated he had previously clearly informed RN-A at his care conference he wanted additional bathing. On 4/13/16, at 12:46 p.m. RN-A stated bathing preferences were reviewed with residents and he was unaware R2 wanted additional bathing. RN-A stated he would put an additional shower on the bathing schedule for R2, and would try to space the shower day mid-way between his currently scheduled shower day. The NA care care for R2 indicated one weekly bath "Sun PM" (Sunday evening). R50 stated in an interview on 4/11/16, at 1:39 p.m. she preferred a bath, but always was given a shower. The resident stated, "I take whatever they give me," but was not given a choice because she believed staff preferred to give her a shower because she "'gets cleaner'". R150's 6/23/15, MDS indicated it was very important for her to choose whether she received a bath, shower, or bed bath. NA-C (NA)-C came into her room and reported R150 gets her shower on Wednesdays before breakfast. On 4/13/15, at 9:15 a.m. NA-C reported R150 received a shower on Wednesdays and had a shower before breakfast. When asked whether residents were given a choice between a bath and shower she said he told R150 it was time for her shower and since she did not disagree, he gave her a shower. NA-C explained residents' choices for bathing was noted on the NA care sheet, which directed each resident's care, and if	21830		

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21830	Continued From page 15 it was not noted, the resident would be asked their preference. R150's bathing preference was not noted on the current NA care sheet. RN-C then stated in an interview at 9:28, staff was expected to ask a residents' bathing preference at the time of every bath, and explained, "That is how we make sure they are getting what they want." The Admission Data Sheet, dated 6/11/15, indicated R150 preferred a shower. At 10:31 a.m. RN-C explained that the information collected at the time of admission was reviewed at each care conference. A review of the Care Conference Summaries dated 12/10/15, 7/1/15, 9/17/15, and 3/9/16, however, lacked information showing personal preferences were reviewed and/or updated. RN-C shrugged his shoulders and stated, "I do not know why it wasn't reviewed." The Weekly Skin Check sheets dated from 1/13/16 through 4/13/16, noted R150 received a shower on bath day. An interview with the director of nursing on 4/13/16, at 2:07 p.m. stated she expected personal preference information to be reviewed at least quarterly in care conference meetings, but preferably the resident would be given a choice each week. R205 stated during an interview on 4/10/16, at 1:10 p.m. he received a shower monthly, and denied weekly showers. He said he had never requested more frequent showering. On 4/12/16 at 9:19 a.m NA-E wheeled R205 into the Spa Room, where he was bathed in a high-side tub. On 4/12/16, at 9:51 a.m. NA-E stated, "He gets a shower in that tub weekly,	21830		

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21830	Continued From page 16 every Tuesday." R205's 10/16/15, MDS indicated the resident had moderately impaired cognition, and bathing choices were very important to the resident. The resident required assistance with activities of daily living, including bathing. Care conference summaries did not reflect a review of resident preferences, including whether R205 requested more frequent showering. During an interview on 4/13/16, at 11:18 a.m. the DON indicated R205 asked her yesterday if he could have a second shower per week, and added they set it up. The facility's 5/9/11, Bath/Shower Procedure lacked direction to staff to ensure choices were offered to residents prior to bathing. SUGGESTED METHOD OF CORRECTION: The director of nursing and licensed social workers could ensure residents' right to make personal choices are promoted. Training could be provided as necessary, audits could be completed, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		