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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XHA1

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 **03/19/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 03/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/08/2013 (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
03/22/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5071

At the time of the standard survey completed January 31, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On March 19, 2013, the Minnesota Department of Health and, on March 13, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 31, 2013, effective March 15, 2013. Therefore, the remedies outlined in our letter dated February 14, 2013, will not be imposed. See attached CMS-2567B forms for the results of the March 19, 2013 and March 13, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5071 April 8, 2013

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

Dear Mr. Hokanson:

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

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

Effective March 15, 2013 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2013

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

RE: Project Number S5071022

Dear Mr. Hokanson:

On February 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 31, 2013. 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 March 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 13, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 31, 2013, effective March 15, 2013 and therefore remedies outlined in our letter to you dated February 14, 2013, 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5071r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245071	A. Building B. Wing	3/19/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/15/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/15/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/15/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/15/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/15/2013**	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	Date:	Signature of Surveyor:	Date:
	SR/sd	03/26/13	16022	03/19/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/31/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245071	A. Building B. Wing 01 - MAIN BUILDING 01	3/13/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	02/11/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/sd	Date: 03/26/13	Signature of Surveyor: 16022	Date: 03/13/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/30/2013		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: XHA1

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 **01/31/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jamie Butterfass, HFE NE Ii 03/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/22/2013 CO. XHA1

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5071

At the time of the standard survey completed January 31, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6041

February 14, 2013

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

RE: Project Number S5071022

Dear Mr. Hokanson:

On January 31, 2013, 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:

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

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

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

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:

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 12, 2013, 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 March 12, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (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 May 1, 2013 (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 July 31, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

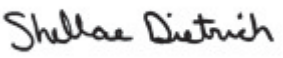
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5071s13.rtf

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 _____	01/31/2013

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 06 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	1. The NACS and care plan for R2 was updated to include the green beanies for positioning. 1/31/2013 2. Residents with physician ordered positioning devices will be reviewed for accuracy of care plan, NACS, and documentation by 3/22/13. 3/22/2013 3-15-13 3. Nursing staff will be educated on use of positioning devices by 3/22/13. 3/22/2013 3-15-13 4. Policy for shaving residents updated. 2/25/2013 5. The NACS and care plan for R56 was updated to include assist with shaving facial hair as needed per Resident request. 2/4/2013 6. Female residents with visible facial hair will be asked if they desire to be shaved, and NACS and care plans will be updated accordingly by 3/22/13. 3/22/2013 3-15-13 7. Nursing staff will be educated on policy for shaving female residents by 3/22/13. 3/22/2013 3-15-13 8. Random audits being completed to ensure compliance. On-going 9. DON and/or designee will monitor compliance. On-going	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3-28-13

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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by:
Based on observation, interview, and document review, the facility failed to revise the plan of care related to pressure ulcer interventions for 1 of 5 residents (R2) in the sample and for 1 of 1 resident (R56) who required assistance with facial hair removal.

Findings include:

Pressure ulcer:
R2 had diagnoses of Multiple Sclerosis, acute osteomyelitis, non-healing pressure ulcer Stage 4 (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures [e.g., tendon, joint capsule]. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) first identified on 10/27/10, and diabetes type II.

The quarterly Minimum Data Set (MDS) dated 12/6/12, identified R2 had one Stage 4 pressure ulcer, treatments included pressure reducing device for chair and bed, turning and repositioning program, nutrition or hydration intervention to manage skin problems, ulcer care, application of non-surgical dressings, and applications of ointments/medications. The MDS indicated R2 was totally dependent requiring physical assistance of two for bed mobility, transferring, and toileting. The MDS identified R2 had a functional limitation in range of motion with impairment on both sides.

Physician's Order instructed staff to use, "3 green positioning beannies (SIK) when in bed vs pillows," which was initiated on 12/18/09.

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The Nursing Assistant Care Sheet (NACS) (undated) noted R2 had a Stage 4 pressure ulcer on her coccyx, but did not identify that the green beanies were to be used for positioning.

R2's Treatment Administration Record for 1/13, indicated staff signed off that three green positioning beanies were used in bed versus pillows for that month.

R2's Plan of Care printed 1/30/13, did not address the use of the physician ordered green beanies for pressure ulcer preventions/interventions.

On 1/29/13, at 8:55 a.m. registered nurse (RN)-B indicated R2 has a Stage 4 pressure ulcer to the coccyx. RN-B reported the area was a non-healing coccyx ulcer.

On 1/30/13, at 9:00 a.m. R2 was observed in bed, lying facing the right with the left side rose off the bed with a pillow used for positioning.

On 1/30/13, at 9:13 a.m., two staff entered R2's room and closed the door. They came out at 9:25 a.m. R2 was then observed lying on the left side with the abductor pillow in place between the legs. The physician ordered green beanies were not in place.

On 1/30/13, at 10:07 a.m. R2 was up in her wheelchair to be taken to the beauty shop. R2 returned to the floor at 11:08 a.m. and refused lay in bed, requesting to be up in the chair until after lunch.

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On 1/30/13, at 12:15 p.m. R2 offered to be returned to bed, but initially declined requesting to stay up until her spouse arrived. After education was provided by RN-B and two nursing assistants (NAs), R2 agreed to lie in bed.

On 1/30/13, at 2:20 p.m. RN-B stated she needed to clarify with the nurse practitioner as to what the order for green beanies versus pillows meant. RN-B verified the green beanies were not available in the room, and added they may be in the laundry. RN-B added R2 had been here for such a long time that everyone knows what to do, as the NA sheet does not indicate to use the green beanies.

On 1/31/13, at 9:00 a.m. RN-B stated the order stating to use three green positioning beanies when in bed versus pillows meant that the beanies should be used for positioning and not the pillows. RN-B stated staff were not aware as the NA's yesterday and today were fairly new. RN-B stated she added the beanies to the NACS. RN-B reported the staff found the green beanies in a bag in the resident's closet in her room. RN-B confirmed the green beanies should have been added to the care plan.

Facial hair:
R56 was admitted with multiple diagnoses which included dementia and diabetes. The annual Minimum Data Set dated 1/1/12, identified R56 required extensive assistance of one person for personal hygiene, including shaving. R56's plan of care was not revised for the removal of facial hair.

On 1/28/13, at 4:43 p.m. R56 was observed to

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have a gray mustache and chin hair.

On 1/29/13, at 10:35 a.m. R56 was observed in her room sitting in her wheelchair with facial hair present on her upper lip and chin.

On 1/30/13, at 11:30 a.m. R56 was in her room sitting in her wheelchair moving towards the bathroom. R56 had obvious gray hair on her upper lip and chin.

On 1/31/2013, at 3:10 p.m., R56 had facial hair very evident on her upper lip and chin. R56 was asked how she would feel about having facial hair, and she replied, "I'd just get it off."

The Treatment Sheet dated January 2013, identified R56 required assistance for "Bath, hair, and nail care ... " The Treatment Sheet noted the bath, hair and nailcare was completed and signed off by the nurse on Wednesday (1/30/13). R56's facial hair was still present on Thursday (1/31/13).

The Nursing Assistant (NA) Care Card dated 1/29/13, indicated R56 was set up assist for grooming.

The care plan printed 1/31/13, indicated R56 had an alteration with activities of daily living, with no intervention noted related to facial hair removal.

On 1/31/2013 at 3:10 p.m. NA-H validated R56 had facial hair. NA-H stated if a resident was diabetic, the nurse would be responsible for removal of the facial hair. NA-H also stated if she noted a diabetic resident with facial hair, she would report that to the nurse.

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F 280	Continued From page 5 On 1/31/2013, at 3:25 p.m. licensed practical nurse (LPN)-B stated he was not certain what the policy instructed regarding the removal of facial hair. LPN-B stated he thought he would need to check to see if a consent form was signed. LPN-B confirmed the January 2013 Treatment Sheet order failed to identify whether "hair" care included facial hair. On 1/31/13, at 3:40 p.m. during an interview with registered nurse (RN)-A, she stated the January 2013 Treatment Sheet was not clear as to what would need to be done, or who would be responsible in reference to the notation on hair. RN-A verified it did need to be clarified so that everyone would be aware of the intent of the order. The facility Shaving policy received 1/31/13, at 5:00 p.m. (undated), noted that female residents with visible facial hair would be asked if they would like it shaved and if so facial hair would be removed with an individualized female razor. The plan of care was not revised for R56's facial hair removal nor did the plan of care denote if R56 would like to have the facial hair removed.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 282	1. Nursing staff will be educated on repositioning, following care plan, and minimizing layers between residents and air mattresses by 3/22/13. 2. Random audits being completed to ensure compliance. 3. DON and/or designee will monitor for compliance.	3/22/2013 On-going On-going

Pa TR 3-11-13 @1:49pm 245-13

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review, the facility failed to implement the plan of care to minimize the risk for development of pressure ulcers for 1 of 5 residents (R38).

Findings include:

R38 had diagnoses which included but were not limited to pemphigoid (autoimmune disease involving blistering of the skin) with a history of blistering on her buttock, Alzheimer's disease with communication problems, cachexia (muscle wasting), diarrhea, functional quadriplegia, and anemia.

R38's Quarterly Braden Scale assessment dated 1/10/13, indicate R38 was at high risk for pressure ulcer development. Risk factors included limited sensory perception, R38 could not communicate discomfort except by moaning or restlessness, R38's skin was often but not always moist, was chair fast, and completely immobile.

R38's plan of care revised 12/5/12, directed staff to reposition R38 every two hours and as needed, and utilized an alternating air mattress.

On 1/30/13, at 8:17 a.m. nursing assistant (NA)-E stated R38 was repositioned every 1.5 to two hours. NA-E reported R38 did lie down between meals. NA-E stated R38 had an air mattress and staff was to place a pillow between her legs and under her feet when in bed to prevent bed sores.

On 1/30/13, at 9:12 a.m. NA-E and NA-K used a Hoyer lift to transfer R38 from her wheelchair into her bed. There was a Pressure Guard APM mattress on the bed. NA-E and NA-K laid R38 on

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the mattress on top of a fitted sheet, a flat sheet, a blanket and a soaker pad. R38 was positioned to lay on her back with one pillow under each leg, one pillow between her legs, and one pillow under her right arm.

On 1/30/13, at 11:09 a.m. R38 was in the same position.

On 1/30/13, at 11:53 a.m. R38 was laying in her bed in the same position. At 11:55 a.m. NA-E entered R38's room with a Hoyer lift. R38 was incontinent of urine and stool, NA-E provided peri-cares. R38's bony prominences were observed over her coccyx and shoulder blades, no redness was noted. At 12:01 p.m. (approximately three hours since last she was last repositioned) NA-E and NA-K assisted R38 with a Hoyer lift into her wheelchair.

On 1/30/13, at 12:10 p.m. NA-E stated R38 required assistance of one to reposition from side to side in bed. NA-E reported she repositioned R38 around 11:00 a.m. NA-E explained she repositioned R38 by putting a pillow under her right arm but did not offload or move her off her back. NA-E verified the pillow under R38's right arm was placed there at 9:10 a.m. and had not been moved. NA-E stated she should have repositioned R38 on her side at 11:00 a.m. NA-K verified he did not reposition R38 during this time.

On 1/30/13, at 2:15 p.m. NA-E confirmed the staff lay R38 over a fitted sheet, a flat sheet, a blanket and a soaker pad.

On 1/30/13, at 2:17 p.m. NA-K stated R38 was to be repositioned every two hours but staff needed

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F 282	Continued From page 8 two people to assist her. NA-K added R38 was to lay down between meals. On 1/31/13, at 9:15 a.m. R38 was lying in bed, on her right side. The mattress had one fitted sheet, a flat sheet, a blanket and a soaker pad. On 1/31/13, at 10:50 a.m. licensed practical nurse (LPN)-A stated R38 should be repositioned every two hours, was at risk for skin break down and had a history of skin breakdown per R38's family. At 11:00 a.m. LPN-A confirmed R38 had one fitted sheet, a flat sheet, a blanket and a soaker pad under her while she was in bed. LPN-A was not sure what the manufactures recommendations indicated to have on the mattress. LPN-A reported it defeated the purpose of pressure reduction if there were a lot of materials between the air mattress and R38. On 1/31/13, at 11:01 a.m. registered nurse (RN) -A case manager reported staff should reposition R38 every two hours and as needed. R38's plan of care was not followed to maintain skin integrity. The Pressure Guard APM owner's manual dated 4/26/12, indicated multiple layering of linens or under pads beneath patient should be avoided for the prevention and treatment of pressure ulcers.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assist residents who were assessed to need assistance in grooming for 1 of 1 resident (R56) who required assistance with facial hair removal. Findings include: R56 was admitted with multiple diagnoses which included diabetes and dementia. The annual Minimum Data Set dated 1/1/12, identified R56 required extensive assistance of one person for personal hygiene, including shaving. R56 was observed on 1/28/13, at 4:43 p.m. to have a gray mustache and chin hair. On 1/29/13, at 10:35 a.m. R56 was observed in her room sitting in her wheelchair with facial hair present on her upper lip and chin. On 1/30/13, at 11:30 a.m. R56 was in her room sitting in her wheelchair moving towards the bathroom. R56 had obvious gray hair on her upper lip and chin. On 1/31/13, at 3:10 p.m. R56 had facial hair very evident on her upper lip and chin. R56 was asked how she would feel about having facial hair, and she replied, "I'd just get it off." The Treatment Sheet dated January 2013, identified R56 required assistance for "Bath, hair, and nail care ... " The Treatment Sheet noted the bath, hair and nailcare was completed and signed	F 312	1. Policy for shaving residents updated. 2/25/2013 2. The NACS and care plan for R56 was updated to include assist with shaving facial hair as needed per Resident request. 2/4/2013 3. Female residents with visible facial hair will be asked if they desire to be shaved, and NACS and care plans will be updated accordingly by 3/22/13. 3/22/2013 4. Nursing staff will be educated on policy for shaving female residents by 3/22/13. 3/22/2013 5. Random audits being completed to ensure compliance. On-going 6. DON and/or designee will monitor compliance. On-going 3-15-13 OK M TH 3-11-13 @ 1:49pm	

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off by the nurse on Wednesday (1/30/13). R56's facial hair was still present on Thursday (1/31/13).

The Nursing Assistant (NA) Care Card dated 1/29/13, indicated R56 was set up assist for grooming. The card also noted the resident was to receive a bath on Wednesday a.m. and Saturday p.m.

The care plan printed 1/31/13, indicated R56 had an alteration with activities of daily living, with no intervention noted related to facial hair removal.

On 1/31/13, at 3:10 p.m. NA-H validated R56 had facial hair. NA-H stated if a resident was diabetic, the nurse would be responsible for removal of the facial hair. NA-H also stated if she noted a diabetic resident with facial hair, she would report that to the nurse. R56 was admitted with diabetes.

On 1/31/13, at 3:25 p.m. licensed practical nurse (LPN)-B stated he was not certain what the policy instructed regarding the removal of facial hair. LPN-B stated he thought he would need to check to see if a consent form was signed. LPN-B confirmed the January 2013 Treatment Sheet order failed to identify whether "hair" care included facial hair.

On 1/31/13, at 3:40 p.m. during an interview with registered nurse (RN)-A, she stated the January 2013 Treatment Sheet was not clear as to what would need to be done, or who would be responsible in reference to the notation on hair. RN-A verified the removal of facial would need to be clarified so that everyone would be aware of the intent of the order.

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F 312	Continued From page 11 The facility Shaving policy received 1/31/13, at 5:00 p.m. (undated), noted that female residents with visible facial hair would be asked if they would like it shaved and if so facial hair would be removed with an individualized female razor. R56's plan of care did not denote if R56 would like to have the facial hair shaved off.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement treatment and services to minimize the risk for pressure ulcer development for 2 of 5 residents (R38, R2). Findings include: R38 was not provided with the appropriate care and services to minimize the risk of pressure ulcer development. R38 had diagnoses which included but were not limited to pemphigoid (autoimmune disease involving blistering of the skin) with a history of	F 314	1. Nursing staff will be educated on repositioning, following care plan, and minimizing layers between residents and air mattresses by 3/22/13. 2. The NACS and care plan for R2 was updated to include the green beanies for positioning. 3. Residents with physician ordered positioning devices will be reviewed for accuracy of care plan, NACS, and documentation by 3/22/13. 4. Nursing staff will be educated on use of positioning devices by 3/22/13. 5. Random audits being completed to ensure compliance. 6. DON and/or designee will monitor for compliance.	3-15-13 3/22/2013 1/31/2013 3-15-13 3/22/2013 3-15-13 3/22/2013 On-going On-going

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blistering on her buttock, Alzheimer's disease with communication problems, cachexia (muscle wasting), diarrhea, functional quadriplegia, and anemia.

A quarterly Minimum Data Set (MDS) dated 1/9/13, identified R38 was at risk for pressure ulcer development, did not currently have any pressure ulcers, and utilized a pressure relieving cushion/mattress and was on a repositioning program. The MDS identified R38 was non-communicative and had severe cognitive impairments.

R38's Quarterly Braden Scale assessment dated 1/10/13, indicate R38 was at high risk for pressure ulcer development. Risk factors included limited sensory perception, R38 could not communicate discomfort except by moaning or restlessness, R38's skin was often but not always moist, was chair fast, and completely immobile.

R38's plan of care revised 12/5/12, directed staff to reposition R38 every two hours and as needed, and utilized an alternating air mattress.

On 1/30/13, at 8:17 a.m. nursing assistant (NA)-E stated R38 was repositioned every 1.5 to two hours. NA-E reported R38 did lie down between meals. NA-E stated R38 had an air mattress and staff were to place a pillow between her legs and under R38's feet when in bed to prevent bed sores.

On 1/30/13, at 9:12 a.m. NA-E and NA-K used a Hoyer lift to transfer R38 from her wheelchair into her bed. There was a Pressure Guard APM

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mattress on the bed. NA-E and NA-K laid R38 on the mattress on top of a fitted sheet, a flat sheet, a blanket and a soaker pad. R38 was positioned to lay on her back with one pillow under each leg, one pillow between her legs, and one pillow under her right arm.

On 1/30/13, at 11:09 a.m. R38 was in the same position.

On 1/30/13, at 11:53 a.m. R38 was laying in her bed in the same position. At 11:55 a.m. NA-E entered R38's room with a Hoyer lift. R38 was incontinent of urine and stool, NA-E provided peri-cares. R38's bony prominence's were observed over her coccyx and shoulder blades, no redness was noted. At 12:01 p.m. (approximately three hours since last she was last repositioned) NA-E and NA-K assisted R38 with a Hoyer lift into her wheelchair.

On 1/30/13, at 12:10 p.m. NA-E stated R38 required assistance of one to reposition from side to side in bed. NA-E reported she repositioned R38 around 11:00 a.m. NA-E explained she repositioned R38 by putting a pillow under her right arm but did not offload or move her off her back. NA-E verified the pillow under R38's right arm was placed there at 9:10 a.m. and had not been moved. NA-E stated she should have repositioned R38 on her side at 11:00 a.m. NA-K verified he did not reposition R38 during that time.

On 1/30/13, at 2:15 p.m. NA-E confirmed the staff lay R38 over a fitted sheet, a flat sheet, a blanket and a soaker pad.

On 1/30/13, at 2:17 p.m. NA-K stated R38 was to

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be repositioned every two hours but staff needed two people to assist her. NA-K added R38 was to lie down between meals.

On 1/31/13, at 9:15 a.m. R38 was lying in bed, on her right side. The mattress had one fitted sheet, a flat sheet, a blanket and a soaker pad.

On 1/31/13, at 10:50 a.m. licensed practical nurse (LPN)-A stated R38 should be repositioned every two hours, was at risk for skin break down and had a history of skin breakdown per R38's family. At 11:00 a.m. LPN-A confirmed R38 had one fitted sheet, a flat sheet, a blanket and a soaker pad under her while she was in bed. LPN-A was not sure what the manufactures recommendations indicated to have on the mattress. LPN-A reported it defeated the purpose of pressure reduction if there were a lot of materials between the air mattress and R38.

On 1/31/13, at 11:01 a.m. registered nurse (RN) -A case manager reported staff should reposition R38 every two hours and as needed.

The Pressure Guard APM owner's manual dated 4/26/12, indicated multiple layering of linens or under pads beneath patient should be avoided for the prevention and treatment of pressure ulcers. R2's physician ordered positioning interventions (green beanies) were not implemented to aide with healing and to minimize the risk of further pressure ulcer development.

R2 had diagnoses of multiple sclerosis, acute osteomyelitis, non-healing pressure ulcer Stage 4 (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to

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muscle, bone, or supporting structures [e.g., tendon, joint capsule]. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) first identified on 10/27/10, and diabetes type II.

On 1/30/13, at 9:00 a.m. R2 was observed in bed, lying facing the right with the left side rose off the bed with a pillow used for positioning.

On 1/30/13, at 9:13 a.m. two staff entered R2's room and closed the door. They came out at 9:25 a.m. R2 was then observed lying on the left side with the abductor pillow in place between the legs. The physician ordered green beanies were not in place.

On 1/30/13, at 10:07 a.m. R2 was up in her wheelchair to be taken to the beauty shop. R2 returned to the floor at 11:08 a.m. and refused lay in bed, requesting to be up in the chair until after lunch.

On 1/30/13, at 12:15 p.m. R2 offered to be returned to bed, but initially declined requesting to stay up until her spouse arrived. After education was provided by RN-B and two nursing assistants (NAs), R2 agreed to lie in bed.

The quarterly MDS dated 12/6/12, identified R2 had one Stage 4 pressure ulcer, treatments included pressure reducing device for chair and bed, turning and repositioning program, nutrition or hydration intervention to manage skin problems, ulcer care, application of non-surgical dressings, and applications of ointments/medications. The MDS indicated R2 was totally dependent requiring physical

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assistance of two for bed mobility, transferring, and toileting. The MDS identified R2 had a functional limitation in range of motion with impairment on both sides.

Physician's Order instructed staff to use, "3 green positioning beannies (SIK) when in bed vs pillows," which was initiated on 12/18/09.

The Nursing Assistant Care Sheet (NACS) undated, noted R2 had a Stage 4 pressure ulcer on her coccyx, but did not identify that the green beanies were to be used for positioning.

R2's Treatment Administration Record for 1/13, indicated staff signed off that three green positioning beanies were used in bed versus pillows for that month.

R2's Plan of Care printed 1/30/13, did not address the use of the physician ordered green beanies for pressure ulcer preventions/interventions.

On 1/29/13, at 8:55 a.m. RN-B indicated R2 has a Stage 4 pressure ulcer to the coccyx. RN-B reported the area was a non-healing coccyx ulcer.

On 1/30/13, at 2:20 p.m. RN-B stated she needed to clarify with the nurse practitioner as to what the order for green beanies versus pillows meant. RN-B verified the green beanies were not available in the room, and added they may be in the laundry. RN-B added R2 had been here for such a long time that everyone knows what to do, as the NA sheet did not indicate to use the green beanies.

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F 314	Continued From page 17 On 1/31/13, at 9:00 a.m. RN-B stated the order stating to use three green positioning beanies when in bed versus pillows meant that the beanies should be used for positioning and not the pillows. RN-B stated staff were not aware as the NA's yesterday and today were fairly new. RN-B stated she added the beanies to the NACS. RN-B reported the staff found the green beanies in a bag in the resident's closet in her room. RN-B confirmed the green beanies should have been added to the care plan. On 1/31/13, at 9:22 a.m. NA-I stated he has worked with R2 in the past. NA-I reported R2 had the green beanies when on the second floor. NA-I stated he did float and relied on the NA sheets to be able to provide the most current care for the residents. On 1/31/13, at 1:20 p.m. R2 was viewed in bed and NA-I confirmed the green beanies were in a pillowcase and used between the resident's legs. Bed pillows were being used for positioning on either side of the resident. NA-J was on her first day off orientation, and stated she was not informed of the beanies versus pillows during her orientation. RN-B updated the NACS on 1/31/13, by long hand, but NA-I was unable to determine what was to be done.	F 314		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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F 431	Continued From page 18 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to lock medication/treatment carts which held medications, permit only authorized personnel to have access to keys, and had food items stored with medications having the potential to affect 94 of 146 residents residing on the affected units.	F 431	1. Pharmacy staff checked all medication and treatment carts for proper functioning. 2. Pharmacy staff repaired malfunctioning med carts. 3. On-going quarterly maintenance checks for medication and treatment carts to be done by pharmacy technicians. 4. Licensed staff/TMA's will be educated on policy for locking medication/treatment carts, proper handling of keys, ensuring proper/legible labeling of medications, and proper storage of supplements/alcoholic beverages by 3/22/13. 5. Pharmacy was informed of improper/illegible label for Ativan for replacement. 6. Facility policy for medication refrigerator written. 7. Random audits being completed to ensure compliance. 8. DON and/or designee will monitor compliance.	1/30/2013 2/7/2013 On-going 3/22/2013 2/28/2013 2/26/2013 On-going On-going

3-15-13 TH 3-11-13 1:49PM

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Findings include:

Medication keys were observed in nursing station drawers on 3 West (W), unlocked medication cart on 2W, unlocked treatment carts on 2W and 4 East (E), and faulty locking mechanism on a medication cart on 3W. In addition, non-medication items were stored in the 3W medication refrigerator.

On 128/13, at 6:04 p.m. the 2W treatment cart was unlocked. The cart was unattended. There were confused residents, nursing assistants (NA), and four family members in the area. The cart held a bottle of Lidocaine (a common local anesthetic), suppositories, insulin's, prescription creams, needles and sterile supplies stored in the cart. While determining what was stored in the cart, no facility staff intervened. The surveyor shut the drawers and completed continuous observation of the cart. Family (F)-A walked by the cart multiple times, and R49 wheeled herself by the cart and was very confused. At 6:23 p.m. licensed practical nurse (LPN)-D walked up to the treatment cart. Prior to her attempting to place the key in the lock, she was asked to open the drawers. LPN-D opened the door without inserting the key. LPN-D confirmed the above medications were stored in the cart. LPN-D verified the cart should have been locked.

On 1/28/13, at 6:27 p.m. a medication cart on 2W was observed unlocked. A Dynamex medication deliverer (DMD)-A was standing by the cart. All medications drawers were unlocked; several medications that were observed were hypertension medication, diuretics, and blood

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thinners. While determining some of the medications stored in the cart no staff intervened. At 6:35 p.m. LPN-D came by the cart to sign a sheet from DMD-A. At 6:40 p.m. LPN-D confirmed the cart was unlocked and unattended. LPN-D stated the medication cart should have been locked. When LPN-D attempted to lock the medication cart, it took several attempts to get the lock to push in so that none of the drawers were unlocked.

On 1/28/13, at 7:22 p.m. the treatment cart on 4E was unlocked. The cart had insulin, prescription creams, nasal spray, suppositories, sterile supplies and needles. No staff was in the area. At 7:23 p.m. NA-C walked by the cart with no nurses present. NA-B walked out with a Hoyer lift, stopped by the treatment cart and then kept walking. NA-D then walked past the treatment cart at 7:30 p.m. At 7:30 p.m. R56 and Family (F) -B came and sat within six feet of the treatment cart. At 7:33 p.m. registered nurse (RN)-B case manager walked by the cart. RN-B was asked to open the cart with a key. RN-B opened a drawer without unlocking the cart. RN-B confirmed there were medications stored in the cart and it should be locked when unattended.

On 1/29/13, At 10:40 a.m. the treatment cart on 2W was observed to be unlocked. There was a bottle of Lidocaine, suppositories, insulin's, prescription creams, needles and sterile supplies stored in the cart. While determining what was stored in the cart, no facility staff intervened. There were confused resident in the area. At 10:46 p.m. LPN-B came from the hall from the 2 east unit closed off by two doors. LPN-B went up to the treatment cart. LPN-B verified the cart was

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F 431	Continued From page 21 unlocked and unattended. LPN-B stated it should have been and promised he would lock it from now on. On 1/31/13, at 2:19 p.m. director of nursing (DON) stated the nursing staff did not stop the surveyor from entering the cart because they were a surveyor. DON reported she was aware that it was the facility nurses responsibility to ensure medications were stored safely from visitors that were not employed by the facility. The Medication Administration Protocol revised on 11/30/11, identified medication carts were to be locked when out of sight or unattended. On 1/28/13, at 4:50 p.m. LPN-F was noted to access a drawer in the 3W nursing station to obtain the keys to the medication cart/medication room, and proceed to the medication cart to dispense medications. On 1/29/13, at 6:15 p.m. during a 3W medication room tour LPN-H verified that R76 had a full and unopened bottle of Ativan (a controlled substance used to decrease anxiety and or agitation) with a partially readable patient name and an unreadable dosage gauge (covered by another label). In addition, non-medications were stored in the medication refrigerator which included: a can of soda, a can of Michelob Golden Light, a can of Labatt's Blue, a can of Miller Highlife; LPN-H stated these items had been "provided by families, and they didn't want them left in the other refrigerator in case someone got at them." Six juice boxes of resource boost breeze and five cans of ensure were also stored in the medication refrigerator, but were not labeled for specific	F 431		

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residents. LPN-H stated that nutritional supplements had been stored in the medication refrigerator since the big refrigerator in the kitchenette had been replaced with a smaller refrigerator.

On 1/30/13, at 7:30 a.m. LPN-E was observed for medication administration task, and was noted to have difficulty getting the medication cart to lock and capture the drawers. After dispensing medication, LPN-E locked the medication cart, and then checked the drawers; both the 2nd and 3rd drawers continued to open after the medication cart was locked. LPN-E then put the medications down on top of the medication cart, used the keys to unlock the lock, shut the 2nd and 3rd drawers and locked the medication cart again. LPN-E then attempted to open the drawers again, and again the 2nd and 3rd drawers continued to open after the medication cart was locked. LPN-E then used the key to unlock the medication cart for the third time, opened and closed all the drawers, then relocked the medication cart. All of the drawers were secured after the third attempt to lock the medication cart.

On 1/31/13 at 08:20 a.m. the DON stated the medication carts were reviewed by the company (Omnicare) on 1/30/13. The DON revealed she would receive a report on issues. The DON stated she was surprised the medication carts were not checked on an annual basis and the facility would now have the cart function and locking reviewed on a yearly basis and replaced if needed.

On 1/31/13, at 10:20 a.m. LPN-I was noted to put the medication keys in a drawer in the 3W

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F 431	Continued From page 23	F 431		

nursing station desk and exit the stairway door to leave the floor. At 10:35 a.m. LPN-I was noted to return to the floor, access the drawer in the nursing station desk and obtain the keys to the medication cart.

On 1/31/13, at 4:00 p.m. LPN-G was noted to open the 3W nursing station drawers and place the medication keys in the drawer, next to RN-D (without comment) and exit the unit by the stairway. After 15 minutes LPN-G returned to the floor and accessed the medication keys from the drawer next to RN-D. When asked why the keys were put into the drawer instead of being handed off to a nurse, LPN-G stated that if there was someone sitting at the desk they could put them in the drawer, but if there was no-one at the desk they have to hand off the keys to a nurse or another TMA. When reminded the facility policy and regulations state that the keys must be carried by a person, RN-D and LPN-G both stated yes.

The Omnicare Inc.®. Policy for Long Term Care (LTC) Facility's Pharmacy Services and Procedures Manual dated 5/10/10, indicated:
" 1. Facility should ensure that only authorized facility staff, as defined by facility, should have possession of the keys.... Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law.
3.2 Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals
3.3 Facility should ensure that all medications

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 _____	01/31/2013

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 431	Continued From page 24 and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 3.6 Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biological's are stored. 6. Facility should destroy and reorder medications and biological's with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels. 9. Facility should ensure that resident medication and biological storage areas are locked and do not contain non-medication/biological items."	F 431		

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	245071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/30/2013

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K 000	INITIAL COMMENTS	K 000		

DC: 03.12.2013

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mount Olivet Careview Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

EXIT: 01.31.2013

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

POC ok
3-8-13

RECEIVED
MAR - 5 2013
DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-28-13

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

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mount Olivet Careview Home is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the North side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 150 beds and had a census of 146 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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K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 09:30 and 12:00 on 01/30/2013, observation revealed that the breakroom door is being propped open with a water jug.	K 018	1. Allstate Communication was hired to install an electronic door hold that releases for fire alarms. 2. Director of Engineering/designee will conduct monthly audits of the doors.	2/11/2013 On-going

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K 018	Continued From page 3 This deficient practice was verified by the Director of Engineering at the time of the inspection.	K 018		