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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YDVQ

Facility ID: 00236

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E102**
2.STATE VENDOR OR MEDICAID NO.
(L2) **411742500**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOUNT OLIVET 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 **09/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (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 **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:
X
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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		94		
(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): Health and Life Safety Code Post Certification Revisits verified correction of deficiencies issued pursuant to the August 13, 2105 standard survey. Effective September 25, 2015 the facility is certified for 94 nursing facility beds. Refer to the CMS 2567b for both health and life safety code.

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SWS 10/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/28/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24E102

October 21, 2015

Mr. Timothy Hokanson, Administrator
Mount Olivet 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective September 25, 2015 the above facility is certified for:

94 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 94 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.

Feel 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
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 21, 2015

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

RE: Project Number FE102024

Dear Mr. Hokanson:

On October 15, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 13, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 15, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 13, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on August 13, 2015, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our October 15, 2015 notice. The most serious LSC deficiencies in your facility at the time of the standard survey 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.

On October 12, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, as of September 25, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 15, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 13, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 13, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 13, 2015, is to be rescinded.

In our letter of October 15, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 13, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 25, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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 related to this letter.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3551

October 15, 2015

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

RE: Project Number SE102026

Dear Mr. Hokanson:

On August 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 23, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 13, 2015.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 13, 2015 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 13, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 13, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 13, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mount Olivet Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 13, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the September 23, 2015 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

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 February 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

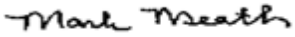
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

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(s)

cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E102	A. Building B. Wing	9/23/2015

Name of Facility	Street Address, City, State, Zip Code
MOUNT OLIVET 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 **F0314** Reg. # **483.25(c)** LSC	**09/23/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/23/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**09/23/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	10/15/2015	30923	09/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/13/2015	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E102	A. Building B. Wing **01 - MAIN BUILDING 01**	10/12/2015

Name of Facility	Street Address, City, State, Zip Code
MOUNT OLIVET 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	Correction Completed **09/25/2015**	ID Prefix	Correction Completed **09/25/2015**	ID Prefix	Correction Completed **09/25/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0017		Reg. # **NFPA 101** LSC K0018	
ID Prefix	Correction Completed **09/25/2015**	ID Prefix	Correction Completed **09/25/2015**	ID Prefix	Correction Completed **09/25/2015**
Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0038	
ID Prefix	Correction Completed **08/14/2015**	ID Prefix	Correction Completed **09/02/2015**	ID Prefix	Correction Completed **08/27/2015**
Reg. # **NFPA 101** LSC K0047		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **08/27/2015**	ID Prefix	Correction Completed **08/12/2015**	ID Prefix	Correction Completed **09/25/2015**
Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0072		Reg. # **NFPA 101** LSC K0103	
ID Prefix	Correction Completed **08/28/2015**	ID Prefix	Correction Completed **08/18/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0147		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/21/2015	28120	10/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/11/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YDVQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00236

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E102**
2. STATE VENDOR OR MEDICAID NO.
(L2) **411742500**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOUNT OLIVET 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 **08/13/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (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 **94** (L18)

13. Total Certified Beds **94** (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
		94		
(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 — 09/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 09/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
9-28-2015 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YDVQ

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8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/13/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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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 **94** (L18)

13.Total Certified Beds **94** (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
		94		
(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 — 09/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 09/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Certified Mail # 7013 2250 0001 6357 1195

August 26, 2015

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

RE: Project Number SE102026

Dear Mr. Hokanson:

On August 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 September 22, 2015, 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 September 22, 2015 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 November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement

of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 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:

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: gary.schroeder@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel 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
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

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
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET 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 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 complete a comprehensive assessment and wound documentation to determine if current skin interventions were effective in promoting healing and minimize the risk for further pressure ulcer development for 1 of 1 resident (R89) in the sample, reviewed for pressure ulcers. Findings include:	F 314	POC accepted in faith 9/1/15 9/11/15 Ok GL	

RECEIVED
SEP 04 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-4-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 1 R89's admission Minimum Data Set (MDS) dated 6/25/15, indicated R89 was cognitively intact and was independent with all activities of daily living (ADLs). The MDS also identified that R89 was admitted with a stage two pressure ulcer (presenting as a shallow open ulcer with a red pink wound bed) to right outer ankle. The corresponding Care Area Assessment (CAA) dated 7/2/15, triggered for a pressure ulcer assessment due to a stage two pressure ulcer on right lateral ankle which was present on admission. R89's care plan dated 7/1/15, identified pressure ulcer problem, "Alteration in her skin integrity with stage 2 pressure ulcer on her right lateral ankle which was present on admission". Interventions included, "Treatment as ordered, observe skin with cares for open areas, rashes, redness, skin tears and bruises and if observed it is reported to the nurse, and heal protectors to right ankle". R89's physician orders dated 7/1/15, included an order for wound documentation of open area to right outer ankle by nurse every Thursday morning. The resident's treatment record revealed the following order: "Allevyn Thin pad [gauze pads and dressing]: apply to right outer ankle topically every day shift every Monday and Thursday for open area unsupervised...Wound documentation of open area right outer ankle by nurse every Thursday morning". A review of the documentation revealed nursing staff made a checkmark every Thursday morning under the wound documentation section indicating that it had been completed. However, there was no evidence of documentation in the electronic medical records (EMR) or in the paper charting	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

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MOUNT OLIVET HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

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F 314	Continued From page 2 indicating a nurse had assessed and measured the would to ensure it was healing. A monthly nursing summary note dated 8/3/15, identified the presence of a stage 2 wound on R89's right ankle from admission. It was described as "pin point size, scabbed with no redness or irritation around site. Allevyn dressing over site and will change weekly on bath day". During an interview on 8/11/15, at 7:05 p.m. R89 explained she had a "small scab" on her right ankle. R89 stated that she came to the facility with the wound and that she had been independently applying a dressing to her ankle. On 8/12/15, at 1:39 p.m. interview with a licensed practical nurse (LPN)-B on R89's unit, she reported she did not know anything about R89's wound. However, LPN-B stated that with any wound, "We are supposed to do weekly wound charting and measurement". On 8/12/15, at 1:46 p.m. in an interview with a registered nurse (RN)-A on R89's unit, she reported that there was a nurses' order in the treatment record for nurses to document the wound every week, and that she expected the nurses to do so. RN-A verified that there was no weekly wound documentation for R89. On 8/13/15, at 7:50 a.m., R89's wound dressing was observed with LPN-C. She washed her hands, donned on gloves and removed the wound dressing. LPN-C described the wound as a "pinpoint scab with a red pink wound bed". She changed gloves, cleansed wound with a dermal wound cleanser (a solution used to clean wounds), measured the wound and then covered	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

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

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F 314	Continued From page 3 it with Allevyn dressing. She reported the wound measurement of 0.2 x 0.1 centimeters (cm). The assistant director of nursing (ADON) stated on 8/13/15, at 9:55 a.m. that whenever a resident was admitted with a wound, it was supposed to be measured and documented, and then monitored weekly thereafter. ADON verified that there was no wound documentation for R89. ADON stated, "They were checking that they were looking at it but I guess there is no documentation". A "Skin Integrity: Data Collection and Management" policy dated 4/10/15, directed staff that, "Weekly skin inspection of residents done on bath day and documented on EHR [electronic health record] Weekly Skin Report Form by LPN/RN". It further directed that, "If an open area develops the Wound Documentation Form (EHR) is initiated. A member of the Skin Care Team will do weekly rounds on all stage 2, 3, &4 pressure wounds. They may view the stage 1 area(s) to determine if appropriate intervention measures are being done prn [as needed]".	F 314	Involved Nurses re-educated on the need to measure and document wounds per procedure. Policy/ procedure reviewed Nurses on unit re-educated on policy/procedure In-service by Wound MD on how to measure and document wounds Audits to be done for compliance with monthly charting and with the RAI process. DON to monitor for compliance	8/14/15 8/14/15 8/20/15 8/24/15 On-going On-going
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

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

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to label and date food that had been removed from its original packaging in the walk-in freezer. This had the potential to affect all the residents in the facility. Findings include: On 5/10/15, at 8:30 a.m. during the initial kitchen tour with the dietary director (DD), the following was noted: The walk-in freezer contained a square metal container with three bags of chicken pieces. The chicken was not labeled or dated. In addition there were two large bags of breadsticks and another bag containing a few slices of bread that was not labeled or dated. The DD verified the items had been removed from the original packaging and staff had not labeled nor dated the items. The DD stated the normal practice was to ensure all items are labeled and dated. The facility's Food Storage DATE policy directed staff to "assure food safety in the dietary department" which included "all food in opened containers are labeled, covered and dated."	F 371	All dietary staff re-educated on proper label and dating of foods All dietary staff review of policy and procedure for labeling and dating foods. Monthly audits will be completed Dietary Director to monitor for compliance	8/20/15 8/20/15 On going On going
F 431 SS=D	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 records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

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

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F 431	Continued From page 5 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 ensure narcotic medication was disposed of in a manner that minimized the possibility of drug diversion and according to facility policy. Findings include: On 8/10/15, at 8:58 a.m. a Fentanyl patch (a long-acting narcotic) change was observed for	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING _____ B. WING _____	08/13/2015

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F 431	Continued From page 6 R69. TMA-A removed the old patch, rolled it up in a glove and carried it to the medication cart at the nurse station down the hallway. Without another staff present, TMA-A immediately discarded the old patch in the sharps disposal box (used to prevent injury or needle re-use) on the medication cart. TMA-A then explained the staff "have another container we can use, but I use the sharps box," to dispose of the used Fentanyl patches. Because used patches could still contain medication, a registered nurse (RN)-B was apprised of the situation. She commented, on 8/13/15, at 10:41 a.m. "I think that's not the procedure. We flush them down the toilet...And if it's [TMA-A], she realized it was wrong and came to me. We went over the procedure." The facility's 5/1/15, Procedure: Destruction of Non-controlled Drugs addressed to Medication Administration Personnel, indicated "uncontrolled medications are to be disposed of in "the Hazardous Wastebox that is in CSR [unknown acronym] if unable to return to pharmacy," however, "used Narcotic (Fentanyl patches are not to be deposited in the hazardous waste box--but to be flushed down the resident's toilet after removal." The procedure additionally indicated, "Two staff (one must be a nurse) are to be present...." On 8/13/15, at 12:49 p.m. the assistant director of nursing stated, "It's supposed to be flushed, that's what's in the policy...I expect employees generally to follow facility policy."	F 431	Policy reviewed and revised Staff re-educated on proper disposal of used narcotic patches Used narcotic disposal procedure added to medication administration class for new employees Medication audit form revised Audits with med pass to ensure compliance every 6 months for TMA's, yearly for Nurses. DON to monitor for compliance	8/31/15 8/13/15 8/14/15 9/3/15 9/3/15 9/3/15 On going On going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Fire Safety 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 Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us	K 000	**APPROVED** *By Gary Schroeder at 3:02 pm, Sep 04, 2015*	

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MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9-4-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/11/2015**

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

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K 000	Continued From page 1 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 Home is a 4-story building with a no basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 2003, an addition was constructed to the South 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 94 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		

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K 011	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to separate the independent skilled nursing facilities in accordance with LCS (2000) Section 19.1.1.4.1. This deficient practice could affect all residents. Findings include: During facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that: 1. The kitchen doors separating Mt Olivet Home and Mt Olivet Care view are 60-minute and not the required 90-minute fire rating, 2. There are penetrations above the ceiling near the service hall room 114 that are not properly firestopped, 3. The corridor doors separating Mt Olivet Home and Mt Olivet Careview do not fully close and latch. These deficient practices were verified by the maintenance director at the time of the inspection.	K 011	The doors will be replaced with 90 minutes doors The penetrations have been sealed and fire caulked The corridor doors have been repaired. Dave Olson Dir. Of Engineering will monitor for compliance	Projected 9-25-15 9/3/15 8/21/15 On going
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 017		

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K 017	Continued From page 3 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has not maintained the corridors in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. This could affect the residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that: 1. There are penetrations above the ceiling in Room 303 leading into the corridor that are not properly firestopped, 2. Multiple rooms on the first floor that share a common wall with the corridor have their walls terminate above the suspended ceiling and do not prevent the passage of smoke into the	K 017	The penetrations have been fire caulked The common walls will be fixed so smoke will be prevented from entering the corridors. Dave Olson Dir. Of Engineering will monitor for compliance	8/31/15 projected 9/25/15 On going

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K 017	Continued From page 4 corridors. These deficient practices were verified by the maintenance director at the time of the inspection.	K 017		
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:	K 018		

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K 018	Continued From page 5 During facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that: 1. The kitchen double doors leading into the dining room do not latch closed, 2. The kitchen serving window shutter door does not automatically close in the event of a fire. These deficient practices were verified by the maintenance director at the time of the inspection.	K 018	The doors will be fixed so that they latch closed. The door will be replaced to automatically shut when there is a fire Dave Olson Dir. Of Engineering will monitor for compliance	Projected 9/25/15 Projected 9/25/15 On going
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that the old trash chute leading from the boiler room to the 4th floor is not protected by 90-minute fire doors. It could not be determined if the walls were 2-hour fire rated.	K 020	The doors will be replaced with 90 minutes fire doors Dave Olson Director of Engineering	Projected 9/25/15

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K 020	Continued From page 6 This deficient practice was verified by the maintenance director at the time of the inspection.	K 020		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect the residents. Findings include: During facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that: 1. The janitor closet Room(s) 201/203, 245/246, 345/346, 445/446 corridor walls terminate the suspended ceiling grid and do not extend to the roof deck, 2. The door leading into Room 462 does not have a fire rated label,	K 029	The walls will be fixed to extend to the roof deck The door will be replaced with the proper fire rated door	Projected 9/25/15 Projected 9/25/15

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K 029	Continued From page 7 3. The 3rd floor dining room construction area is not properly separated from the corridor, 4. The north daycare storage room was converted from an activity room and does not meet the requirements of a hazardous area, 5. There are penetrations in the boiler room that are not properly firestopped. These deficient practices were verified by the maintenance director at the time of the inspection.	K 029	The third floor dining room construction area will be properly separated from the corridor. The storage room will be converted to meet the requirements of a hazardous area. Fire caulked penetrations in boiler room completed Dave Olson Director of Engineering will monitor for compliance	Projected 9/25/15 Projected 9/25/15 8/20/15 On going
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that the combination to the 3rd floor stairway doors and the central stair exterior exit door are not posted. None of these doors lead from a secured memory care unit. This deficient practice was verified by the	K 038	The combination to the stairwell doors will be posted Dave Olson Dir. Of Engineering	Projected 9/25/15

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K 038	Continued From page 8 maintenance director at the time of the inspection.	K 038		
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to provide proper exit signs in all means of egress. This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that the two exit signs near the 4th floor south stairway are not illuminated. This deficient practice was verified by the maintenance director at the time of the inspection.	K 047	The exits signs are fixed Dave Olson Dir. Of Engineering	8/14/15
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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K 052	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, record review revealed that there is no documentation that the resident rooms smoke alarms are tested monthly. This deficient practice was verified by the maintenance director at the time of the inspection.	K 052	Smoke detector alarms are tested monthly with documentation completed Dave Olson Dir. Of Engineering to monitor for compliance	9/2/15 On going
K 062 SS=E	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 record review and 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 the	K 062		

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K 062	Continued From page 10 residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that there isn't a pressure gauge on the south stairway standpipe. This deficient practice was verified by the maintenance director at the time of the inspection.	K 062	A pressure gauge has been added to the south stairway standpipe Dave Olson Dir. Of Engineering	8/27/15
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to maintain the fire/smoke dampers in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect the residents. Findings include: During the facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation and document review revealed that: 1. There are multiple cables running through the	K 067		

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K 067	Continued From page 11 fire damper at the Mt Olivet Home/Mt Olivet Careview corridor occupancy separation, 2. Documentation revealed that the last fire damper testing was on 03/18/2011. These deficient practices were verified by the maintenance director at the time of the inspection.	K 067	The fire damper has been removed, sealed and fire caulked. The fire dampers have now been tested and testing will be done every 4 years. Dave Olson Dir. Of Engineering will monitor for compliance	8/11/15 8/27/15 On going
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed there was an unattended blood pressure monitor in the corridor on the 4th floor. These deficient practices were verified by the maintenance director at the time of the inspection.	K 072	The blood pressure monitor was removed from the corridor and staff educated on proper storage. Dave Olson Dir. Of Engineering will monitor for compliance.	8/12/15 On going
K 103	NFPA 101 LIFE SAFETY CODE STANDARD	K 103		

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K 103 SS=E	Continued From page 12 Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has combustible construction materials in the interior walls and partitions not in accordance with Life Safety Code Section 19.1.6.3. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that there are wood stud walls in Room 329 and the 2nd floor mechanical room. This deficient practice was verified by the maintenance director at the time of the inspection.	K 103	These 2 walls will be removed and rebuilt with steel studs and 5/8 inch sheet rock to be in compliance. Dave Olson Dir. Of Engineering to monitor for compliance.	Projected 9/25/15 On going
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 13 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all residents. Findings include: During facility tour between 9:30 AM and 5:00 PM on 08/11/2015, record review revealed that: 1. The weekly generator test logs do not indicate all of the required weekly visual checks, 2. The monthly genset test records do not indicate the test load percentage of the diesel generator. These deficient practices were verified by the maintenance director at the time of the inspection.	K 144	The weekly generator test logs were revised to include all required weekly visual checks. Monthly test logs have been revised to include the test load percentage of the diesel generator. Dave Olson Dir. Of Engineering will monitor for compliance.	8/28/15 8/28/15 On going
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to comply with NFPA 70, The National Electric Code. This deficient practice could affect some residents. Findings include:	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 14 On facility tour between 9:30 AM and 5:00 PM on 08/11/2015, observation revealed that: 1. There are extension cords in use in Room(s) 411 and 423, 2. There is a multiplug adapter in use in Room 220, 3. There is a window air conditioner and a refrigerator plugged into a power strip in the cat room, 4. On Monday, 08/10/2015, MDH staff witnessed a cuckoo clock chain that had arched against the electrical outlet below. MDH staff brought this to the attention of maintenance and the clock was removed with the outlet was repaired. These deficient practices were verified by the maintenance director at the time of the inspection.	K 147	The extension cords have been removed. Staff to be re-educated 9/9, 9/10 & 9/11/15 The multiplug adapter was removed. The power strip was removed, new outlet added, the appliances are now plugged directly into the outlet. The cuckoo clock was removed and outlet repaired. Dave Olson Dir. Of Engineering will monitor for compliance.	8/18/15 To be done 8/11/15 8/11/15 8/10/15 On going