DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 15, 2023

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

RE: CCN: 245071
Cycle Start Date: May 1, 2023

Dear Administrator:

On June 9, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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May 4, 2023

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

RE: CCN: 245071
Cycle Start Date: May 1, 2023

Dear Administrator:

On May 1, 2023, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by August 1, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 1, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING _____ B. WING _____	C 05/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/1/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H50712005C (MN91987) H50711784C (MN93030, MN92957) with a deficiency issued at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		6/1/23

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

Electronically Signed | 05/12/2023

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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F 684	Continued From page 1 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R1) received an X-ray in a timely fashion after a fall that resulted in a fractured hip Findings include: R1's care plan dated 3/11/23, indicated R1 transferred with assist of two staff, walked only with physical therapists and redirect and reapproach when resistive/combative. The care plan dated 4/17/23, indicated R1 had a recent change in environment, and to approach later if resistive, observe for signs of anxiety, and offer reassurance and comfort. R1's admission Minimum Data Set (MDS) dated 3/17/23, indicated R1 was severely cognitively impaired, had verbal behaviors directed at others (threatening, screaming at others, cursing at others), but no other behaviors. R1's significant change MDS dated 4/14/23, indicated R1 had no behaviors in the lookback period. On 4/19/23, at 6:16 p.m. a progress note indicated R1 fell, a head strike was unknown, and range of motion (ROM) assessment and vital signs were not completed by registered nurse (RN)-A because R1 was combative. Family member (FM)-A was notified at 6:36 p.m. On 4/20/23 at 10:24 a.m. a provider note indicated R1 had pain in her left leg when donning and doffing her sock. On 4/20/23, at 2:41 p.m. a progress note indicated R1's ROM and pain were assessed with no pain or discomfort.	F 684	The Risk Management Program policy and the Assessing a Resident After a Fall policy were reviewed and updated. It is the policy of Mount Olivet to assess all residents after a fall. If a resident refuses assessment the nurse will attempt to re-approach and monitor the resident for any signs of pain or injury. The provider will be called and updated post-fall. If an X-Ray is ordered for a suspected injury and the X-Ray company is unable to give time parameters as to when they can make it to the facility, the nurse will call the provider and update them. All nurses will be educated on the policies and procedures by 6/1/2023. The Director of Nursing or her designee will audit risk management for completion of post-fall assessments and provider notification weekly x4 weeks and then monthly x3 months. Audit outcomes will be reported to the QAPI Committee.	

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F 684	Continued From page 2	F 684		

On 4/20/23, at 2:54 p.m. a progress note indicated nurse practitioner (NP)-A assessed R1, and ordered hydroxyzine (a medication used to relieve anxiety) for agitation.

On 4/20/23, at 8:23 p.m. a progress note indicated R1 complained of left thigh pain, the on-call provider gave an order for an X-ray, and the order was called to the X-ray provider. The technician informed the nurse the X-ray was scheduled for the morning of 4/21/23, as there was no technician available until then. FM-A was updated. There was no indication the provider was updated.

On 4/21/23, at 9:15 a.m. a progress note indicated, "On 4/20/23 resident allowed for vital signs and neuro checks to be obtained. Resident was noted with weakness in her left leg during neuro checks."

R1's radiology report dated 4/21/23, indicated R1 had an acute fracture of the left hip.

On 4/21/23, at 1:34 p.m. a progress note indicated R1 was transferred to the hospital for a left hip fracture.

On 5/1/23, at 12:06 p.m. licensed practical nurse (LPN)-A was interviewed and stated the process for assessment after a fall included examining the body parts, flexing the legs for signs of pain, and asking the resident if they hit their head. If the resident was unable to respond or didn't know if they hit their head, the nurse would initiate neuro checks (a neurology examination to assess reflexes to determine if the nervous system is impaired). LPN-A stated if the resident was not calm, staff would try to calm the resident for

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F 684	Continued From page 3 assessment, and if the resident was resistive, either try again or get other staff to assist with distraction or talking. "You try to calm them down so you can assess them." LPN-A stated if a fracture was suspected, the nurse would obtain an order for an X-ray, and, "Look for signs of pain in their face." LPN-A further stated if the X-ray technicians were not available, the nurse should call the provider to get an order to send the resident to the emergency room. "You don't wait until the next morning, you call to get the ok to send them in." On 5/1/23, at 12:15 p.m. registered nurse (RN)-A was interviewed and stated R1 was admitted to the unit on 4/19/23. RN-A stated no staff was familiar with her care or behaviors, so staff did not know if combative behavior was normal, and when R1 was found on the floor, she was combative. RN-A stated because R1 was combative, no neuro assessment or ROM assessment was completed before R1 was lifted from the floor with a Hoyer lift (an assistive device that allows residents to transfer between surfaces). RN-A stated the day after the fall, FM-A indicated R1 complained of left hip pain, so RN-A called NP-A for an X-ray order. RN-A stated when she called the X-ray provider, there were no technicians available for 4/20/23, but could come 4/21/23, in the morning. RN-A stated due to lack of ability to assess R1, there was no immediate concern to have the X-ray right away. RN-A stated FM-A was updated about the delay for X-ray, but did not remember if the provider was updated. On 5/1/23, at 12:01 p.m. the X-ray provider supervisor (S)-A was interviewed and stated the order to do the X-ray was received 4/20/23, at	F 684		

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F 684	Continued From page 4 8:20 p.m. S-A stated the X-ray was performed 4/21/23, at 10:00 a.m., and they did not have the staff to perform routine X-rays in the evenings or overnights. S-A stated technicians just fit the ordered X-rays into their day when it worked best for their schedule. S-A stated there was no ability to perform a stat (immediate, or prioritized first) X-ray. A policy was requested and not provided.	F 684		

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Electronically delivered

May 4, 2023

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

Re: Event ID: NNG711

Dear Administrator:

The above facility survey was completed on May 1, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 05/01/2023

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/1/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed: H50712005C (MN91987)	2 000		

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	00178	A. BUILDING: _____ B. WING _____	C 05/01/2023

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2 000	Continued From page 1 H50711784C (MN93030, MN92957) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		