Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2024

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

RE: CCN: 245071
Cycle Start Date: June 4, 2024

Dear Administrator:

On August 2, 2024, we notified you a remedy was imposed. On August 16, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 7, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 17, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 2, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 16, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2024

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

Re: Reinspection Results
Event ID: G6RV12

Dear Administrator:

On July 25, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 4, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 26, 2024

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

RE: CCN: 245071
Cycle Start Date: June 4, 2024

Dear Administrator:

On June 4, 2024, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 September 4, 2024 (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 December 4, 2024 (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

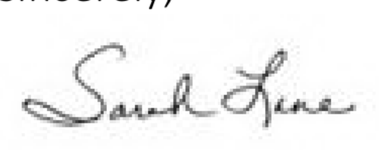
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 26, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: G6RV11

Dear Administrator:

The above facility was surveyed on June 3, 2024 through June 4, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

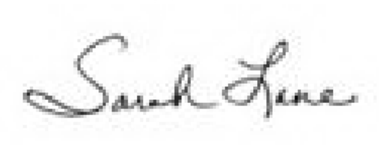
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 06/04/2024

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 6/3/24 and 6/4/24, 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: H50713445C (MN00102848 and MN00102844) with deficiencies issued at F677. 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 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 4 of 5 residents (R1, R3, R4, R5) who were dependent upon care of others to perform activities	F 677	F677-ADL Care Provided for Dependent Residents 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	7/22/24

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

Electronically Signed | 07/05/2024

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 677	Continued From page 1 of daily living (ADLs). In addition, the facility failed to develop and implement a comprehensive care plan to reflect the resident's current needs for 2 of 2 residents (R3, R4) reviewed for activities of daily living. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/13//24, indicated R1 had severe cognitive impairment, required moderate assistance with eating and was dependent upon staff for hygiene and transfers. R1's diagnoses list printed 6/4/24, indicated dementia and osteoarthritis. R1's care plan dated 5/6/24, indicated R1 was at risk for unintentional weight loss, required assistance of one staff for meal set-up, supervision, and cues as needed, assist of one for eating, and check/change incontinence brief upon rising, between meals, at bedtime and on night rounds. On 6/3/24 at 12:01 p.m., during an interview family member (FM)-A stated on 4/23/24, R1 was left in bed during a staffing shortage, and R1 was not given breakfast. FM-A stated she had a camera in the room that showed video of R1 still in bed around 10:00 a.m., when normally she is up and in the dining room at that time, and upon review of the video that morning, R1 had not gotten breakfast. FM-A stated she talked to RN-C around 10:00 a.m., and was told the unit was short-staffed and the facility tried to call staff to come in. FM-A stated she arrived at the facility around 11:45 a.m.,	F 677	practice? a. R1- expired in the facility b. R2- not affected by the deficient practice c. R3 and R4 □ These residents were reassessed for eating assistance, oral care, grooming, bathing and dressing. Kardex and care plan were updated with findings. d. R5- discharged from facility 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? a. All residents that reside in long-term care will be reviewed for their ADL needs, including: eating assistance, oral care, grooming, bathing and dressing, Any changes will be modified on the care plan and kardex. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? a. Nursing staff will be re-educated on ADL policy by July 22, 2024, including where to find information for eating assistance, oral care, grooming, bathing and dressing. Education will also include the procedure for who to notify in case there are changes in resident ADL status in the areas listed above. b. Nursing Administration or designee will audit 10% of residents on each unit weekly x4 weeks to ensure that care plans and kardexes are accurate and residents are receiving the ADL assistance that they	

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F 677	Continued From page 2 and R1 had just gotten up and taken to the dining room for lunch. FM-A further stated she asked RN-C was cares R1 received that morning and, "[RN-C] had no idea what care my mom got that day, and just threw her hands up." FM-A further stated R1 was put to bed at 8:00 p.m., on 4/22/24, and was checked only once during the night and staff didn't check her brief, change her brief, or get R1 up until around 11:45 a.m., on 4/23/24. Video clips of care provided by FM-A indicated staff put R1 to bed on 4/22/24 at 8:00 p.m., on 4/23/24 at 3:47 a.m., two staff checked R1's brief and changed it, on 4/23/24 at 7:29 a.m., housekeeping staff cleaned R1's floor, on 4/23/24 at 8:48 a.m., laundry staff put clothing in R1's closet, and at 11:49 a.m., two staff entered the room to get R1 out of bed, dressed, and into her chair. R1 was not provided breakfast. On 6/3/24 at 3:29 p.m., during an interview nursing assistant (NA)-C stated morning shift has been getting more call-ins, cares don't get done, and residents don't get the attention they need. NA-C stated second shift has more staff than needed sometimes and can do cares on second shift when they are missed on first shift. On 6/4/24 at 9:07 a.m., during an interview registered nurse (RN)-B stated on 4/23/24, the unit was working short of one NA, and had to divide the residents into three care groups instead of four. RN-B stated many of the residents required assistance of two staff to get out of bed with a Hoyer Lift (mechanical lift used to move residents who cannot bear weight from one surface to another), and some residents required assistance of two staff for personal cares. RN-B stated when	F 677	need. If during the 4 weeks we find that we are in 90% or above compliance, audits will be transitioned to monthly x 4 months. Director of Nursing will be responsible for compliance. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? a. The results of these audits will be discussed at monthly Quality Assurance Taskforce meetings x 3 months, then at quarterly Quality Assurance meetings x 2 meetings, then as needed. The quality assurance committee will identify any trends or patterns and make recommendations to revise the plan of correction. Date of compliance: 7/22/2024.	

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F 677	Continued From page 3 the unit is short of NAs, the NAs first help residents who require only one staff for assistance to get up, dressed, and transported to the dining room, and then go help the residents who require two staff. RN-B further stated after residents were in the dining room, one staff must stay in the area to supervise the residents, so then one more NA is not available to help other staff get residents out of bed. RN-B stated RNs and trained medication aides (TMA)s assist to feed residents as needed. R3's quarterly MDS dated 3/27/24 indicated severe cognitive impairment and extensive assistance for eating. R3's diagnoses list printed 6/4/24, indicated dementia, malnutrition, and failure to thrive. R3's care plan indicated an inability to communicate discomfort, risk for unintentional weight loss dated 7/6/23, and assistance for eating with set-up, supervision, and cues dated 8/30/22. On 6/3/24 at 1:20 p.m., during an observation R3 was sitting in the dining room with a full plate of food in front of her, and clean silverware beside the plate. NA-A set R3's beverages closer to R3 but did not offer assistance or cues for R3 to eat. At 1:28, NA-A assisted R3 to drink juice from a glass and cleared R3's plate and took R3 away from the table. On 6/3/24 at 2:34 p.m., NA-A stated R3 used to be independent with eating, but now required staff to feed her. "I would say she is a total assist with	F 677		

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F 677	Continued From page 4 eating now. I feed her, and she eats." NA-A stated she reported to the nurse manager about a week prior R3's care plan should be adjusted for total assistance for eating but didn't know if the care plan was adjusted yet. On 6/4/24 at 9:31 a.m., during an observation and interview NA-A fed R3, and stated the unit was not easy to work, and stated the residents were total care, and by the end of a shift staff left totally exhausted. R4's admission MDS dated 8/9/23, indicated severe cognitive impairment and assistance of one for eating. R4's diagnoses list printed 6/4/24, indicated dementia and glaucoma. R4's care plan dated 8/4/23, indicated eating assistance of meal set-up, supervision, and cues for eating; encourage resident to participate as much as able. On 6/3/24 at 1:17 p.m., during an observation and interview R4 sat in the dining room with a clothing protector on and her meal and three glasses of beverage in front of her, in reach. At 1:35 p.m., a housekeeper removed R4's clothing protector. At 1:50 p.m., R4 sat with her head down and her plate of food still in front of her. R4 made no effort to feed herself. No staff offered to help, cued her, or interacted with R4. At 1:52 p.m., RN-A sat to feed R4. RN-A stated the meal was served at	F 677		

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F 677	Continued From page 5 approximately 12:30 p.m., and then took R4's plate to reheat it. RN-A sat with R4 to help her eat and stated staff should have checked on her, cued her to eat, or fed her. On 6/3/24 at 4:08 p.m., during an interview FM-B stated staff have told her sometimes R4 doesn't eat but is not at the point of needing to be fed, but staff should encouraged R4 to eat. On 6/4/24 at 8:58 a.m., during an observation and interview staff set up R4's tray, with silverware and beverages in reach. At 9:06 a.m., R4 was resting with her head down, looking at her tray and had not consumed any of her meal. At 9:20 a.m., R4 had not attempted to eat her meal independently. At 9:44 a.m., LPN-A warmed R4's meal, and sat to feed her and stated R4 ate when she was fed, and further stated R4 may need to be fed instead of cued now. On 6/4/24 at 12:48 p.m., during an observation and interview R4 sat at a table in the dining room with her meal in front of her, and made no effort to eat. At 1:14 p.m., RN-B sat with R4 to feed her. RN-B stated she tried first to encourage R4 to eat, but R4 made no effort to feed herself; RN-B fed her. On 6/4/24 at 1:17 p.m., during an observation and interview R4 sat in the dining room with a clothing protector on and her meal and three glasses of beverage in front of her, in reach. At 1:50 p.m., R4 sat with her head down and her plate of food still in front of her. R4 made no effort to feed herself. At 1:52 p.m., RN-A sat to feed R4, and stated staff should have checked on her, cued her to eat, or fed her.	F 677		

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	245071	A. BUILDING _____ B. WING _____	C 06/04/2024

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

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F 677	Continued From page 6 R5's end of PPS (prospective payment system/ Medicare) Stay MDS dated 5/22/24 indicated moderately impaired cognition, and set-up assistance for eating. R5's diagnoses list printed 6/4/24, indicated system sclerosis (hardening of tissue or body part) and dementia. R5's care conference notes dated 5/23/24, indicated R5's family observed R5 cannot cut her own food or open containers and family requested staff help R5 eat and sit with her when she eats. R5's care plan dated 5/10/24, indicated R5 was, "Very underweight," staff should encourage meals in the dining room, cue and encourage intake, and R5 may need assistance to open containers and cut meat. R5's care plan dated 5/24/24, indicated eating assistance: set-up, supervision/cues only related to forgetfulness. On 6/4/24 at 12:04 p.m., during an interview R5's friend (FR)-A stated R5 had a care conference on 5/23/24, during which family expressed concern R5 was not feeding herself and there were day staff was not helping R5. FR-A stated R5 doesn't eat what she does not like on her tray, does not remember to ask for an alternative, and without staff supervision, R5 will sometimes not eat anything for a meal. FR-A stated on 5/23/24, during a visit with R5, R5 didn't eat her meal, and her food was not cut for her.	F 677		

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F 677	Continued From page 7 On 6/4/24 at 1:01 p.m., during an interview NA-D entered R5's room, placed the meal tray on R5's bedside table, provided meal set-up, and left the room. On 6/4/24 at 1:09 p.m., during an interview R5 sat on her bed in her room with her meal tray on the bedside table in front of her and was eating alone, with no supervision, or cues. On 6/4/24 at 2:25 p.m., during an interview RN-C stated she expected staff to provide eating assistance to residents who required it. On 6/4/24 at 2:47 p.m., during an interview RN-D acknowledged R1 was not fed breakfast on 4/23/24, and further stated it was the expectation nurses would update a resident's follow residents' care plans and update care plans as needed. The Person-Centered Care Plan policy dated 6/26/19, indicated each resident was assessed for their individual risk factors and would be evaluated and revised as necessary.	F 677		

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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 6/3/24 and 6/4/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were	2 000		

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2 000	Continued From page 1 issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H50713445C (MN00102848 and MN00102844) with licensing orders issued at 0920. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 4 of 5 residents (R1, R3, R4, R5) who were dependent upon care of others to perform activities of daily living (ADLs). In addition, the facility failed to develop and implement a comprehensive care plan to reflect the resident's current needs for 2 of 2 residents (R3, R4) reviewed for activities of daily living. Findings include: R1's quarterly Minimum Data Set (MDS) dated	2 920	Corrected.	7/22/24

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2 920	Continued From page 3 3/13//24, indicated R1 had severe cognitive impairment, required moderate assistance with eating and was dependent upon staff for hygiene and transfers. R1's diagnoses list printed 6/4/24, indicated dementia and osteoarthritis. R1's care plan dated 5/6/24, indicated R1 was at risk for unintentional weight loss, required assistance of one staff for meal set-up, supervision, and cues as needed, assist of one for eating, and check/change incontinence brief upon rising, between meals, at bedtime and on night rounds. On 6/3/24 at 12:01 p.m., during an interview family member (FM)-A stated on 4/23/24, R1 was left in bed during a staffing shortage, and R1 was not given breakfast. FM-A stated she had a camera in the room that showed video of R1 still in bed around 10:00 a.m., when normally she is up and in the dining room at that time, and upon review of the video that morning, R1 had not gotten breakfast. FM-A stated she talked to RN-C around 10:00 a.m., and was told the unit was short-staffed and the facility tried to call staff to come in. FM-A stated she arrived at the facility around 11:45 a.m., and R1 had just gotten up and taken to the dining room for lunch. FM-A further stated she asked RN-C was cares R1 received that morning and, "[RN-C] had no idea what care my mom got that day, and just threw her hands up." FM-A further stated R1 was put to bed at 8:00 p.m., on 4/22/24, and was checked only once during the night and staff didn't check her brief, change her brief, or get R1 up until around 11:45 a.m., on 4/23/24. Video clips of care provided by FM-A indicated	2 920		

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2 920	Continued From page 4 staff put R1 to bed on 4/22/24 at 8:00 p.m., on 4/23/24 at 3:47 a.m., two staff checked R1's brief and changed it, on 4/23/24 at 7:29 a.m., housekeeping staff cleaned R1's floor, on 4/23/24 at 8:48 a.m., laundry staff put clothing in R1's closet, and at 11:49 a.m., two staff entered the room to get R1 out of bed, dressed, and into her chair. R1 was not provided breakfast. On 6/3/24 at 3:29 p.m., during an interview nursing assistant (NA)-C stated morning shift has been getting more call-ins, cares don't get done, and residents don't get the attention they need. NA-C stated second shift has more staff than needed sometimes and can do cares on second shift when they are missed on first shift. On 6/4/24 at 9:07 a.m., during an interview registered nurse (RN)-B stated on 4/23/24, the unit was working short of one NA, and had to divide the residents into three care groups instead of four. RN-B stated many of the residents required assistance of two staff to get out of bed with a Hoyer Lift (mechanical lift used to move residents who cannot bear weight from one surface to another), and some residents required assistance of two staff for personal cares. RN-B stated when the unit is short of NAs, the NAs first help residents who require only one staff for assistance to get up, dressed, and transported to the dining room, and then go help the residents who require two staff. RN-B further stated after residents were in the dining room, one staff must stay in the area to supervise the residents, so then one more NA is not available to help other staff get residents out of bed. RN-B stated RNs and trained medication aides (TMA)s assist to feed residents as needed.	2 920		

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2 920	Continued From page 5 R3's quarterly MDS dated 3/27/24 indicated severe cognitive impairment and extensive assistance for eating. R3's diagnoses list printed 6/4/24, indicated dementia, malnutrition, and failure to thrive. R3's care plan indicated an inability to communicate discomfort, risk for unintentional weight loss dated 7/6/23, and assistance for eating with set-up, supervision, and cues dated 8/30/22. On 6/3/24 at 1:20 p.m., during an observation R3 was sitting in the dining room with a full plate of food in front of her, and clean silverware beside the plate. NA-A set R3's beverages closer to R3 but did not offer assistance or cues for R3 to eat. At 1:28, NA-A assisted R3 to drink juice from a glass and cleared R3's plate and took R3 away from the table. On 6/3/24 at 2:34 p.m., NA-A stated R3 used to be independent with eating, but now required staff to feed her. "I would say she is a total assist with eating now. I feed her, and she eats." NA-A stated she reported to the nurse manager about a week prior R3's care plan should be adjusted for total assistance for eating but didn't know if the care plan was adjusted yet. On 6/4/24 at 9:31 a.m., during an observation and interview NA-A fed R3, and stated the unit was not easy to work, and stated the residents were total care, and by the end of a shift staff left totally exhausted.	2 920		

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2 920	Continued From page 6 R4's admission MDS dated 8/9/23, indicated severe cognitive impairment and assistance of one for eating. R4's diagnoses list printed 6/4/24, indicated dementia and glaucoma. R4's care plan dated 8/4/23, indicated eating assistance of meal set-up, supervision, and cues for eating; encourage resident to participate as much as able. On 6/3/24 at 1:17 p.m., during an observation and interview R4 sat in the dining room with a clothing protector on and her meal and three glasses of beverage in front of her, in reach. At 1:35 p.m., a housekeeper removed R4's clothing protector. At 1:50 p.m., R4 sat with her head down and her plate of food still in front of her. R4 made no effort to feed herself. No staff offered to help, cued her, or interacted with R4. At 1:52 p.m., RN-A sat to feed R4. RN-A stated the meal was served at approximately 12:30 p.m., and then took R4's plate to reheat it. RN-A sat with R4 to help her eat and stated staff should have checked on her, cued her to eat, or fed her. On 6/3/24 at 4:08 p.m., during an interview FM-B stated staff have told her sometimes R4 doesn't eat but is not at the point of needing to be fed, but staff should encouraged R4 to eat. On 6/4/24 at 8:58 a.m., during an observation and interview staff set up R4's tray, with silverware and beverages in reach. At 9:06 a.m., R4 was resting	2 920		

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2 920	Continued From page 7 with her head down, looking at her tray and had not consumed any of her meal. At 9:20 a.m., R4 had not attempted to eat her meal independently. At 9:44 a.m., LPN-A warmed R4's meal, and sat to feed her and stated R4 ate when she was fed, and further stated R4 may need to be fed instead of cued now. On 6/4/24 at 12:48 p.m., during an observation and interview R4 sat at a table in the dining room with her meal in front of her, and made no effort to eat. At 1:14 p.m., RN-B sat with R4 to feed her. RN-B stated she tried first to encourage R4 to eat, but R4 made no effort to feed herself; RN-B fed her. On 6/4/24 at 1:17 p.m., during an observation and interview R4 sat in the dining room with a clothing protector on and her meal and three glasses of beverage in front of her, in reach. At 1:50 p.m., R4 sat with her head down and her plate of food still in front of her. R4 made no effort to feed herself. At 1:52 p.m., RN-A sat to feed R4, and stated staff should have checked on her, cued her to eat, or fed her. R5's end of PPS (prospective payment system/ Medicare) Stay MDS dated 5/22/24 indicated moderately impaired cognition, and set-up assistance for eating. R5's diagnoses list printed 6/4/24, indicated system sclerosis (hardening of tissue or body part) and dementia. R5's care conference notes dated 5/23/24, indicated R5's family observed R5 cannot cut her own food or open containers and family requested	2 920		

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2 920	Continued From page 8 staff help R5 eat and sit with her when she eats. R5's care plan dated 5/10/24, indicated R5 was, "Very underweight," staff should encourage meals in the dining room, cue and encourage intake, and R5 may need assistance to open containers and cut meat. R5's care plan dated 5/24/24, indicated eating assistance: set-up, supervision/cues only related to forgetfulness. On 6/4/24 at 12:04 p.m., during an interview R5's friend (FR)-A stated R5 had a care conference on 5/23/24, during which family expressed concern R5 was not feeding herself and there were day staff was not helping R5. FR-A stated R5 doesn't eat what she does not like on her tray, does not remember to ask for an alternative, and without staff supervision, R5 will sometimes not eat anything for a meal. FR-A stated on 5/23/24, during a visit with R5, R5 didn't eat her meal, and her food was not cut for her. On 6/4/24 at 1:01 p.m., during an interview NA-D entered R5's room, placed the meal tray on R5's bedside table, provided meal set-up, and left the room. On 6/4/24 at 1:09 p.m., during an interview R5 sat on her bed in her room with her meal tray on the bedside table in front of her and was eating alone, with no supervision, or cues. On 6/4/24 at 2:25 p.m., during an interview RN-C stated she expected staff to provide eating assistance to residents who required it. On 6/4/24 at 2:47 p.m., during an interview RN-D	2 920		

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2 920	Continued From page 9 acknowledged R1 was not fed breakfast on 4/23/24, and further stated it was the expectation nurses would update a resident's follow residents' care plans and update care plans as needed. The Person-Centered Care Plan policy dated 6/26/19, indicated each resident was assessed for their individual risk factors and would be evaluated and revised as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependent on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their care needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		