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

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August 19, 2024

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

Re: Reinspection Results
Event ID: JJPF12

Dear Administrator:

On August 16, 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 July 16, 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
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August 2, 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 26, 2024, we informed you that we may impose enforcement remedies.

On July 16, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 16, 2024, the situation of immediate jeopardy to potential health and safety cited at **F600 - Free From Abuse and Neglect** was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 17, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 17, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 17, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mount Olivet Careview Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 16, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 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 December 4, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

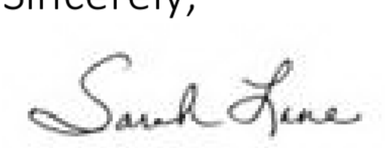
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
August 2, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: JJPF11

Dear Administrator:

The above facility was surveyed on July 11, 2024 through July 16, 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.

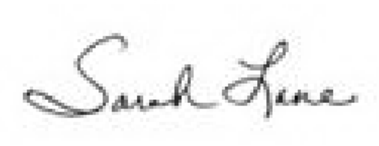
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 07/16/2024

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 7/11/24 through 7/12/24, and 7/15/24 through 7/16/24, 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: H50715600C (MN00104777) and H50714881C (MN00104238) with deficiencies cited at F600, F609, and F610. The survey resulted in an Immediate Jeopardy (IJ) at F600 when registered nurse (RN)-A failed to report an allegation R2 had touched R1 between her legs, and over her clothing on 7/6/24, and failed to implement preventative interventions to keep R1 safe. A second allegation of sexual abuse occurred on 7/10/24 when R2 put his hands down R1's pants. The IJ began on 7/6/24 and the immediacy was removed on 7/16/24. The above findings constituted substandard quality of care, and an extended survey was conducted on 7/16/24. 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 600	Free from Abuse and Neglect	F 600		8/7/24

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

Electronically Signed | 08/08/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600 SS=J	Continued From page 1 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report, investigate, and initiate interventions for sexual abuse resulting in subsequent sexual abuse for 1 of 3 residents (R1). R1 was sexually abused by R2 on 7/6/24, and again on 7/10/24. The immediate jeopardy began on 7/6/24 when RN-A failed to report an allegation R2 had touched R1 between her legs over her clothing and was identified on 7/15/24. The director of nursing, assistant director of nursing, associate administrator, and nurse manager were notified of the immediate jeopardy at 4:45 p.m. on 7/15/24. The immediate jeopardy was removed on 7/16/24, but noncompliance remained at the lower scope and severity level of D - isolated which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 600	F600 Free from Abuse and Neglect 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R2 was given a 1:1 on 7/15/24 by a staff member until 7/29/24. b. R2 will remain separated from R1 and not within arms distance of other residents on the unit. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. All female residents on the unit were interviewed on 7/15/2024 and stated that they felt safe. b. Any additional resident concerns would be identified through shift to shift report, morning report and weekly IDT meetings.	

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

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F 600	Continued From page 2 Findings Include: R1's annual Minimum Data Set (MDS) dated 6/13/24, indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness. R1's care plan dated 7/11/24, indicated R1 was at risk for abuse related to vision loss with instruction to staff to follow facility vulnerable adult policies and procedures. R1's progress notes lacked information about both incidents with R2 on 7/6/24 and on 7/10/24. R2's significant change MDS dated 6/13/24 indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss. R2's care plan printed 7/11/24, indicated R2 had an alteration in behavior. Focus added on 7/8/24 notifying R2 would grab at people within reach, attempt to grab people close, and grab hair. Interventions included providing items to engage in activity and remove R2 from immediate area if disruptive or if there is potential harm to self or others. Additional interventions added on 7/10/24 include 1 to 1 and keep R2 arm's length distance from other residents. R2's care plan lacked notification of sexually inappropriate behaviors. R2's fall follow up progress note dated 7/6/24 at 1:51 p.m. written by registered nurse (RN)-A indicated R2 had touched a female resident in the dining room. The note lacked any further information.	F 600	3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. All staff were educated on Vulnerable Adult reporting and Resident to Resident altercations starting on 7/15/2024. On-going education was done prior to staff working their next shift through 8/2/24. On 8/2/24, certified letters with education were sent to staff members that had not worked during this time frame. b. Facility will continue with annual vulnerable adult training and as needed training for staff. c. Random weekly audits will be conducted with staff on resident to resident altercations and the time frame for vulnerable adult reporting weekly x4 weeks and then monthly x 3 months. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. The results of these audits will be discussed at monthly quality assurance 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. 5. Date of completion: 8/7/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 3 R2's IDT note dated 7/8/24 at 9:42 a.m., indicated as R2 had declined, the instances of R2 touching and grabbing people and objects with his left hand have increased. The note lacked information about inappropriate sexual touching or interventions to prevent R2 from touching other residents. R2's nursing note dated 7/10/24 at 2:48 p.m., indicated R2 had been seen inappropriately touching a female resident who had been seated next to him. R2 had been removed to his room and placed on a 1 to 1. The note lacked indication of how long R2 would be on the 1 to 1. A facility report to the state agency on 7/10/24 indicated on 7/10/24, the health unit coordinator (HUC)-A stated she observed R2's left hand down R1's brief at approximately 9:45 a.m. The residents were immediately separated, R2 was placed on a 1:1 for 24 hours, and the unit staff were educated to provide activities for R2 and to keep him out of arms reach of other residents. On 7/11/24 at 1:46 p.m., R1 stated a male resident put his hands on her chest and legs. The touching made her "feel weird." She did not like the touching. On 7/11/2024 at 2:25 p.m., RN-A stated on 7/6/24 it was reported to her R2 had been witnessed touching R1 on her arm and leg in the dining room. The residents were separated, and RN-A wrote a progress note. RN-A stated she did not tell a supervisor, nurse manager or DON because she did not think the touching was intentional. On 7/11/2024 at 4:14 p.m., HUC stated on	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

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F 600	Continued From page 4 7/10/24 she witnessed R2 with his left hand in R1's pants between her legs. R2 had a smile on his face. R1's eyes were wide open. When HUC removed R2's hand from R1, R2 began grabbing at HUC's breast and private area. On 7/12/24 at 10:17 a.m., RN-B (nurse manager for the unit) stated she was not informed about R2 touching R1 inappropriately on 7/6/24. On 7/12/24 at 12:15 p.m., licensed practical nurse (LPN)-A stated on 7/6/24 she heard R1 yelling, "Stop it, stop it." LPN-A went to the dining room and found R2 with his left hand between R1's legs touching her private area over her clothing. LPN-A told R1's nurse (RN-A). LPN-A stated she told the assistant director of nursing (ADON) about the touching on 7/10/24, but no staff members had asked her any questions about it. On 7/15/2024 at 3:12 p.m., culinary server (CS) stated he was serving the lunch meal on 7/6/24 when he saw R2 rubbing R1 on her inner thigh. CS stated R2 had done that before. CS did not tell anyone because he thought nursing staff were already aware because they had moved R2 away from R1. On 7/15/24 at 10:48 a.m. RN-A stated she did not remember LPN-A telling her about the sexual abuse. On 7/15/24 at 1:57 p.m., the ADON stated on 7/10/24 she completed employee interviews regarding the sexual abuse which had occurred the same day. The ADON confirmed LPN-A told her R2 had touched R1 between her legs on her private area over her clothes on 7/6/24. There was no report submitted to the state agency and	F 600		

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	245071	A. BUILDING _____ B. WING _____	C 07/16/2024

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

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F 600	Continued From page 5 there was no investigation into the incident. On 7/15/24 at 2:28 p.m., the director of nursing (DON) stated she was aware R2 had touched a female resident prior to 7/10/24 but did not know the details. DON confirmed the statement from LPN-A about a resident touching another resident on their private area over clothing should have been reported to the in-house supervisor or nurse manager at the time of the incident, an investigation should have been completed and a report filed with the state agency. The Mt Olivet Careview Home Abuse Prohibition policy dated 7/2023 instructed staff to take immediate steps to make sure the resident is safe and immediately make an oral report of the incident to the staff nurse, nursing supervisor and director of nursing. An initial investigation should be completed to determine whether or not an incident meets criteria to report to the state agency. If so, the report to state agency should be completed within 2 hours if the allegation is abuse, serious bodily injury or suspicion of a crime or within 24 hours for all other allegations. Interviews should be completed with staff and all residents involved in an incident as soon as possible following the incident. The immediate jeopardy that began on 7/6/24, was removed on 7/16/24, when the facility placed R2 on ongoing 1:1 supervision, initiated care plan changes and interventions for R2, and initiated education to all staff members regarding vulnerable adult abuse reporting. This was verified through observation, interview and document review.	F 600		
F 609 SS=D	Reporting of Alleged Violations	F 609		8/7/24

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F 609	Continued From page 6 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, within 2 hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse. Finding include:	F 609	F609 Reporting of Alleged Violations 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R2 was given a 1:1 on 7/15/24 by a staff member until 7/29/24.	

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F 609	Continued From page 7 R1's annual Minimum Data Set (MDS) dated 6/13/24 indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness. R1's care plan dated 2/20/18 indicated R1 was at risk for abuse related to vision loss with instruction to staff to follow facility vulnerable adult policies and procedures. R2's significant change MDS dated 6/13/24 indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss. R2's care plan lacked information about sexual abuse or inappropriate sexual behaviors. On 7/6/24 at 1:51 p.m. a progress note written by registered nurse (RN)-A indicated R2 had touched a female resident in the dining room. The note lacked any further information. On 7/11/24 at 1:46 p.m., R1 stated a male resident put his hands on her chest and legs. The touching made her "feel weird." She did not like the touching. On 7/12/24 at 12:15 p.m., licensed practical nurse (LPN)-A stated on 7/6/24 she heard R1 yelling, "Stop it, stop it." LPN-A went to the dining room and found R2 with his left hand between R1's legs touching her private area over her clothing. LPN-A told R1's nurse (RN-A). LPN-A stated she told the assistant director of nursing (ADON) about the touching on 7/10/24, but no staff members had asked her any questions about it.	F 609	b. R2 will remain separated from R1 and not within arms distance of other residents on the unit. c. Facility staff were re-educated on the policy for reporting vulnerable adult concerns immediately to a supervisor. d. RN that failed to report alleged violation to the supervisor was suspended pending the investigation and returned to work after she had re-education. e. ADON that failed to report the alleged violation to Administrator/DON was suspended pending the investigation and returned to work after she had re-education. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Facility staff were re-educated on the policy for reporting vulnerable adult concerns immediately to a supervisor. b. RN that failed to report alleged violation to the supervisor was suspended pending the investigation and returned to work after she had re-education. c. ADON that failed to report the alleged violation to Administrator/DON was suspended pending the investigation and returned to work after she had re-education. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. All staff were educated on Vulnerable Adult reporting and Resident to Resident altercations starting on 7/15/2024. On-going education was done prior to	

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F 609	Continued From page 8 On 7/15/2024 at 3:12 p.m., culinary server (CS) stated he was serving the lunch meal on 7/6/24 when he saw R2 rubbing R1 on her inner thigh. CS stated R2 had done that before. CS did not tell anyone because he thought nursing staff were already aware because they had moved R2 away from R1. On 7/12/24 at 10:17 a.m., RN-B (nurse manager for the unit) stated she was not informed about R2 touching R1 inappropriately on 7/6/24. On 7/15/24 at 1:57 p.m., the assistant director of nursing (ADON) stated there was no report submitted to the state agency and there was no investigation into the incident. On 7/15/24 at 2:28 p.m., the director of nursing (DON) stated she was aware R2 had touched a female resident prior to 7/10/24 but did not know the details. The DON confirmed the statement from LPN-A about a resident touching another resident on their private area over clothing should have been reported to the in-house supervisor or nurse manager at the time of the incident, an investigation should have been completed and a report filed with the state agency. The facility policy Mt Olivet Careview Home Abuse Prohibition dated 7/23 directed staff to take immediate steps to make sure the resident is safe and immediately make an oral report of the incident to the staff nurse, nursing supervisor and director of nursing. An initial investigation should be completed to determine whether or not an incident meets criteria to report to the state agency. If so, the report to state agency should be completed within 2 hours if the allegation is	F 609	staff working their next shift through 8/2/24. On 8/2/24, certified letters with education were sent to staff members that had not worked during this time frame. b. Facility will continue with annual vulnerable adult training and as needed training for staff. c. Random weekly audits will be conducted with staff on resident to resident altercations and the time frame for vulnerable adult reporting weekly x4 weeks and then monthly x 3 months. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. The results of these audits will be discussed at monthly quality assurance 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. 5. Date of completion: 8/7/2024	

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F 609	Continued From page 9 abuse, serious bodily injury or suspicion of a crime or within 24 hours for all other allegations.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were investigated for 1 of 3 residents (R1) reviewed for allegations of abuse. Finding include: R1's annual Minimum Data Set (MDS) dated 6/13/24 indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness. R1's care plan dated 2/20/18 indicated R1 was at	F 610	F610 Investigate/Prevent/Correct Alleged Violations 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. ADON that failed to investigate the alleged violation was suspended pending the investigation and returned to work after she had re-education. b. All staff that are assigned to investigate alleged violations were educated on 8/7/2024 in regards to	8/7/24

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F 610	Continued From page 10 risk for abuse related to vision loss with instruction to staff to follow facility vulnerable adult policies and procedures. R2's significant change MDS dated 6/13/24 indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss. On 7/6/24 at 1:51 p.m. a progress note written by registered nurse (RN)-A indicated R2 had touched a female resident in the dining room. The note lacked any further information. On 7/11/24 at 1:46 p.m., R1 stated a male resident put his hands on her chest and legs. The touching made her "feel weird." She did not like the touching. On 7/12/24 at 12:15 p.m., licensed practical nurse (LPN)-A stated on 7/6/24 she heard R1 yelling, "Stop it, stop it." LPN-A went to the dining room and found R2 with his left hand between R1's legs touching her private area over her clothing. LPN-A told R1's nurse (RN-A). LPN-A stated she told the assistant director of nursing (ADON) about the touching on 7/10/24, but no staff members had asked her any questions about it. On 7/12/24 at 10:17 a.m., RN-B (nurse manager for the unit) stated she was not informed about R2 touching R1 inappropriately on 7/6/24. On 7/15/24 at 1:57 p.m., the ADON stated on 7/10/24 she completed employee interviews regarding the sexual abuse which had occurred the same day. The ADON confirmed LPN-A told her R2 had touched R1 between her legs on her	F 610	completing a thorough investigation. Any staff that were not here on 8/7/2024 will be educated prior to their next day of work. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. ADON that failed to investigate the alleged violation was suspended pending the investigation and returned to work after she had re-education. b. All staff that are assigned to investigate alleged violations were educated on 8/7/2024 in regards to completing a thorough investigation. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. All staff that are assigned to investigate alleged violations will update DON or designee as investigation is ongoing. b. If during the investigation new alleged violations are reported, then they will be reported to Administrator/DON or designee immediately. c. DON or designee will review OHFC files periodically during the investigation process. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. The results of these reviews will be discussed at monthly quality assurance meetings x 3 months, then at quarterly	

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F 610	Continued From page 11 private area over her clothes on 7/6/24. There was no investigation into the incident. On 7/15/24 at 2:28 p.m., the director of nursing (DON) stated she was aware R2 had touched a female resident prior to 7/10/24 but did not know the details. The DON confirmed the statement from LPN-A about a resident touching another resident on their private area over clothing should have been investigated. The Mt Olivet Careview Home Abuse Prohibition policy dated 7/23 directed an initial investigation should be completed to determine whether or not an incident meets criteria to report to the state agency. An investigation should include interviewing the residents and staff involved as soon as possible, notifying the police of physical or sexual abuse, care planning any immediate interventions, completing pertinent resident assessments, and completing ongoing evaluation of interventions. The Interdisciplinary committee should review all cases.	F 610	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. 5. Date of completion: 8/7/2024	

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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 7/11/24 through 7/12/24, and 7/15/24 through 7/16/24, 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 order was issued. Please indicate in your electronic plan of	2 000		

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H50715600C (MN00104777) and H50714881C (MN00104238) with a licensing order issued at 144.651 Subd. 14 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 Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report, investigate, and initiate interventions for sexual abuse resulting in subsequent sexual abuse for 1 of 3 residents (R1). R1 was sexually abused by R2 on 7/6/24, and again on 7/10/24.	21850	Corrected.	8/7/24

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21850	Continued From page 3 The immediate jeopardy began on 7/6/24 when RN-A failed to report allegation R2 had touched R1 between her legs over her clothing and was identified on 7/15/24. The director of nursing, assistant director of nursing, associate administrator, and nurse manager were notified of the immediate jeopardy at 4:45 p.m. on 7/15/24. The immediate jeopardy was removed on 7/16/24, but noncompliance remained at the lower scope and severity level of D - isolated which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding include: R1's annual Minimum Data Set (MDS) dated 6/13/24 indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness. R1's care plan dated 7/11/24 indicated R1 was at risk for abuse related to vision loss with instruction to staff to follow facility vulnerable adult policies and procedures. R1's progress notes lacked information about both incidents with R2. R2's significant change MDS dated 6/13/24 indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss. R2's care plan printed 7/11/24 indicated a R2 had an alteration in behavior focus added on 7/8/24 notifying R2 would grab at people within reach, attempt to grab people close, and grab hair.	21850		

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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) COMPLETE DATE
21850	Continued From page 4 Interventions included providing items to engage in activity and remove R2 from immediate area if disruptive or if there is potential harm to self or others. Additional interventions added on 7/10/24 include 1 to 1 and keep R2 arm's length distance from other residents. R2's care plan lacked notification of sexually inappropriate behaviors. R2's fall follow up progress note dated 7/6/24 at 1:51 p.m. written by registered nurse (RN)-A indicated R2 had touched a female resident in the dining room. The note lacked any further information. R2's IDT note dated 7/8/24 at 9:42 a.m., indicated as R2 had declined the instances of R2 touching and grabbing people and objects with his left hand have increased. The note lacks information about inappropriate sexual touching or interventions to prevent R2 from touching other residents. R2's nursing note dated 7/10/24 at 2:48 p.m., indicated R2 had been seen inappropriately touching a female resident who had been seated next to him. R2 had been removed to his room and placed on a 1 to 1. The note lacked indication of how long R2 would be on the 1 to 1. A facility report to the state agency on 7/10/24 indicated on 7/10/24, the health unit coordinator (HUC)-A stated she observed R2's left hand down R1's brief at approximately 9:45 a.m. The residents were immediately separated, R2 was placed on a 1:1 for 24 hours, and the unit staff were educated to provide activities for R2 and to keep him out of arms reach of other residents. On 7/11/24 at 1:46 p.m., R1 stated a male resident put his hands on her chest and legs. The	21850		

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 07/16/2024

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21850	Continued From page 5 touching made her "feel weird." She did not like the touching. On 7/11/2024 at 2:25 p.m., RN-A stated on 7/6/24 it was reported to her R2 had been witnessed touching R1 on her arm and leg in the dining room. The residents were separated, and RN-A wrote a progress note. RN-A stated she did not tell a supervisor, nurse manager or DON because she did not think the touching was intentional. On 7/11/2024 at 4:14 p.m., HUC stated on 7/10/24 she witnessed R2 with his left hand in R1's pants between her legs. R2 had a smile on his face. R1's eyes were wide open. When HUC removed R2's hand from R1, R2 began grabbing at HUC's breast and private area. On 7/12/24 at 10:17 a.m., RN-B (nurse manager for the unit) stated she was not informed about R2 touching R1 inappropriately on 7/6/24. On 7/12/24 at 12:15 p.m., licensed practical nurse (LPN)-A stated on 7/6/24 she heard R1 yelling, "Stop it, stop it." LPN-A went to the dining room and found R2 with his left hand between R1's legs touching her private area over her clothing. LPN-A told R1's nurse (RN-A). LPN-A stated she told the assistant director of nursing (ADON) about the touching on 7/10/24, but no staff members had asked her any questions about it. On 7/15/2024 at 3:12 p.m., culinary server (CS) stated he was serving the lunch meal on 7/6/24 when he saw R2 rubbing R1 on her inner thigh. CS stated R2 had done that before. CS did not tell anyone because he thought nursing staff were already aware because they had moved R2 away from R1.	21850		

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21850	Continued From page 6 On 7/15/24 at 10:48 a.m. RN-A stated she did not remember LPN-A telling her about the sexual abuse. On 7/15/24 at 1:57 p.m., the ADON stated on 7/10/24 she completed employee interviews regarding the sexual abuse which had occurred the same day. The ADON confirmed LPN-A told her R2 had touched R1 between her legs on her private area over her clothes on 7/6/24. There was no report submitted to the state agency and there was no investigation into the incident. On 7/15/24 at 2:28 p.m., the director of nursing (DON) stated she was aware R2 had touched a female resident prior to 7/10/24 but did not know the details. DON confirmed the statement from LPN-A about a resident touching another resident on their private area over clothing should have been reported to the in-house supervisor or nurse manager at the time of the incident, an investigation should have been completed and a report filed with the state agency. The Mt Olivet Careview Home Abuse Prohibition policy dated 7/2023 instructed staff to take immediate steps to make sure the resident is safe and immediately make an oral report of the incident to the staff nurse, nursing supervisor and director of nursing. An initial investigation should be completed to determine whether or not an incident meets criteria to report to the state agency. If so, the report to state agency should be completed within 2 hours if the allegation is abuse, serious bodily injury or suspicion of a crime or within 24 hours for all other allegations. Interviews should be completed with staff and all residents involved in an incident as soon as possible following the incident.	21850		

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21850	Continued From page 7 The immediate jeopardy that began on 7/6/24, was removed on 7/16/24, when the facility placed R2 on ongoing 1:1 supervision, initiated care plan changes and interventions for R2, and initiated education to all staff members regarding vulnerable adult abuse reporting. This was verified through observation, interview and document review. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the policy and procedures for identifying and reporting of abuse. The DON or designee could educate all staff on these policies and procedures. The DON or designee could perform audits to ensure the policies are being followed. The results of those audits could be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21850		