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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245071 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/16/2024 |
| NAME OF PROVIDER OR SUPPLIER Mount Olivet Careview Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 5517 Lyndale Avenue South Minneapolis, MN 55419 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300</p> <p>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.</p> <p>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.</p> <p>Findings Include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness.</p> <p>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.</p> <p>R1's progress notes lacked information about both incidents with R2 on 7/6/24 and on 7/10/24.</p> <p>R2's significant change MDS dated [DATE] indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>On 7/15/24 at 10:48 a.m. RN-A stated she did not remember LPN-A telling her about the sexual abuse.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>The Mt [NAME] 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.</p> <p>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.</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300</p> <p>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.</p> <p>Finding include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE] indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness.</p> <p>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.</p> <p>R2's significant change MDS dated [DATE] indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss.</p> <p>R2's care plan lacked information about sexual abuse or inappropriate sexual behaviors.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>The facility policy Mt [NAME] 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 abuse, serious bodily injury or suspicion of a crime or within 24 hours for all other allegations.</p> |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300</p> <p>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.</p> <p>Finding include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE] indicated R1 was mildly cognitively impaired with diagnoses including seizures, depression, schizophrenia, and legal blindness.</p> <p>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.</p> <p>R2's significant change MDS dated [DATE] indicated R2 was severely cognitively impaired with diagnoses including traumatic brain bleed, paralysis of right side of body, and vision and hearing loss.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 investigation into the incident.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Mt [NAME] 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.</p> |