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	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet Careview Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a dignified dining experience for 1 of 2 residents (R13) observed during dining.Findings include:R13's admission Minimum Data Set (MDS) dated [DATE], identified R13 had severe cognitive impairment, did not exhibit any disruptive verbal behaviors, was dependent with mobility using a wheelchair, preferred to have snacks between meals, and required substantial/maximal assistance with eating. R13's diagnoses included neurocognitive disorder with Lewy bodies (progressive dementia characterized by abnormal protein deposits in the brain), anxiety, unspecified severe protein-calorie malnutrition, and prediabetes.R13's care plan dated 12/31/26, indicated R13 sometimes understood, was usually understood, instructed staff to anticipate R13's needs and provide needed services. The care plan further indicated R13 was at risk for behaviors like yelling out due to her diagnoses, and instructed staff to offer distractions such as snack or beverage. The care plan further instructed staff to validate feelings and reassure R13's needs will be met.R13's provider order dated 12/30/25, indicated R13 required a pureed diet and thin liquid consistency.Continuous observation initiated on 2/23/26 at 5:21 p.m., R13 was in the dining room reclined in her wheelchair sitting at a table. No food or beverage was in front of her. R13 stated, Please help me, I'm hungry and I need food.- At 5:24 p.m., R13 called out, help me, I'm hungry. -At 5:44 p.m., R13 still called out for help and expressed her hunger. At times said, I need F-O-O-D! Various staff around assisted other residents into the dining room and set them up at their designated dining spots. No staff acknowledged R13's requests.-At 6:07 p.m., R13 continued to call out for help and state, I'm hungry. -At 6: 14 p.m., an unidentified staff placed a bowl of pretzels down in front of another resident (R118) who sat at a different table than R13 who still had no food or beverage in front of her.-At 6:18 p.m., R13 stated, I'm not doing ok this afternoon. I'm hungry. Registered nurse (RN)-D acknowledged R13's request and stated, We are just dishing up now [R13]; it won't be long.-At 6:24 p.m., R13 still called out, I'm hungry. I need food. Give me food. Help me. No food or beverage provided to R13.-At 6:35 p.m., several other residents at different tables had been served their dinner. Nothing provided to R13. RN-D stated again that the food was being dished up and her meal was coming in ten minutes. -At 6:38 p.m., R13 still expressing hunger, I need food.-At 6:40 p.m., R13's meal was placed on the table in front of her after waiting 1 hour and 19 minutes for dinner to be served. During observation on 2/24/26 at 8:17 a.m., R13 was in the dining room asleep in wheelchair before breakfast. Some other residents had a beverage in front of them, R13 had nothing.-At 8:43 a.m., nursing assistant (NA)-F stated breakfast was normally served at 8:15 a.m. and could not explain why it was so late this morning.-At 8:48 a.m., R13 had not received any food or beverage yet.-At 9:03 a.m., R13's breakfast was provided after 46 minutes of waiting. The breakfast consisted of a bowl of hot cereal and a formed rectangle of moistened and pureed croissant. R13 pulled off a chunk of the croissant with her hands and ate it. R13 stated she did not know what it was but that it tasted good.-At 9:06 a.m., NA-F stopped at R13's table and placed a lid over R13's plate and pushed the plate out of R13's reach. NA-F stated, I told you I will help you. -At 9:07 a.m., R13 called out, Can you get those for me? and pointed at her beverages, bring those here. An unidentified male staff uncovered (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's meal and repositioned her food and beverages so everything was within reach. R13 picked up the bowl of cereal in one hand and placed it on her lap. R13 picked up a spoon with the other hand and ate the cereal.-At 9:18 a.m., R13 finished breakfast and had completely cleared her plate, eating everything independently. During interview on 2/24/26 at 10:55 a.m., R13 stated she remembered waiting a long time for her dinner last evening and she was very hungry while she waited. R13 stated waiting that long while being that hungry was very frustrating.During interview on 2/24/26 at 2:03 p.m., NA-G stated breakfast was normally served about 8-8:15 a.m., lunch about noon, and dinner around 6 p.m. NA-G further stated residents should not wait more than about 15-30 minutes for their meals. If the meal was late, there were snacks that could be provided. NA-G stated staff could provide cheerios, pretzels, yogurt, or applesauce among other items, depending on the resident's diet.During interview on 2/24/26 at 2:16 p.m., NA-F stated R13 was able to eat independently at times and required assistance at times. NA-F stated she pushed R13's food away this morning since she was eating with her hands. NA-F stated R13 did appear pretty hungry this morning and therefore, probably should have let her try to eat without assistance. NA-F further stated some residents do not mind sitting in the dining room for quite a while before the meal was served. However, if they appeared or verbalized their hunger, snacks should be provided. NA-F stated they have cookies, crackers and coffee to offer residents if they waited too long. NA-F stated those on a pureed diet could be offered pudding or applesauce and that often food or beverage could act as a good distraction while they wait.During interview on 2/24/26 at 2:50 p.m., registered nurse (RN)-C stated the goal was residents did not wait longer than 30 minutes for a meal. RN-C stated an hour and 19 minutes was too long to wait, especially when R13 was verbalizing her hunger. RN-C stated R13 should have been offered a snack or a beverage while waiting for dinner. RN-C further stated R13 should not have had her food covered and pushed out of reach at breakfast.During interview on 2/25/26 at 12:36 p.m., director of nursing (DON) stated would not expect any resident to wait over an hour for their meal. If they were in that situation, staff were expected to offer a snack or beverage. DON stated R13's dinner and breakfast should have been handled differently to promote a more dignified dining experience.Facility policy Dignity, undated, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The policy further identified residents would be supported in exercising their rights and would be provided with a dignified dining experience.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure the manufacturer's recommended sling size was used for 1 of 1 resident (R132) reviewed for mechanical lift transfers. Findings include:R132's quarterly Minimum Data Set (MDS) dated [DATE], identified R132 had moderately impaired cognition and was dependent on staff assistance for bed mobility and transfers. Diagnoses included dysphagia (difficulty swallowing) following a stroke and non-Alzheimer's dementia. R132 had no falls since the last assessment.R132's significant change Care Area Assessment (CAA) dated 11/11/25, identified falls were triggered due to a history of falls. There was no documentation for self-transfers. Staff assisted with all transfers since R132 was unable to walk or stand independently.R132's mobility care plan intervention dated 1/13/26, identified dependence on two staff using a full body mechanical lift with medium size body sling. R132's Fall Risk assessment dated [DATE], identified non-weight bearing status and unpredictable level of comprehension and cooperation during transfers. R132's last weight was 125.4 pounds, and the full body mechanical lift sling size used was medium (appropriate for residents weighing 90 to 220 pounds).R132's height dated 2/10/26, was 66 inches (5 foot 5 inches tall).R132's Kardex (nursing assistant care sheet) dated 2/23/26, identified R132 was dependent on two staff for transfers using a full body mechanical lift with a sling size of medium.During an observation and interview on 2/23/26 at 1:10 p.m., nursing assistant (NA)-A took a EZ Way brand sling out of R132's closet without checking the size label, positioned the sling behind R132's back, brought the leg straps under R132's legs, crossed the straps, connected the sling to model L500 EZ Way Smart Lift (full body mechanical lift). NA-B raised R132 in the sling out of her wheelchair using the lift, pushed the lift over to the bed, lowered R132 to the bed and NA-A and NA-B removed the sling from under R132. NA-A put the sling in the closet, and the staff completed incontinence cares. When asked what sling size was used for R132's transfers, NA-A looked at the sling used for the transfer which was EZ Way brand, had burgundy straps and size L for large on the label. NA-A pointed to R132's Kardex in the closet which identified a size medium sling should have been used. NA-A stated staff should know what size sling to use because it was posted in R132's closet.During an observation on 2/24/26 at 8:50 a.m., R132 had a medium sized EZ Way brand sling with beige straps in her room, instead of the one used the previous day. During an observation and interview on 2/24/26 at 12:54 p.m., NA-C took a EZ Way brand sling out of R132's closet, checked the size label which was correctly identified as a medium, positioned the sling behind R132's back, brought the leg straps under R132's legs, crossed the straps, and connected the sling to model L500 EZ Way Smart Lift. NA-C raised R132 in the sling out of her wheelchair using the lift, NA-D helped maneuver the sling and R132 was assisted into bed for cares. When asked, NA-C and NA-D stated the Kardex should be checked prior to transfers to ensure its right size is used for safety reasons, annual and as needed training was provided on mechanical lift use.During an interview on 2/24/26 at 12:57 p.m., licensed practical nurse (LPN)-A stated the resident's sling size for transfers was in the care plan and should be correctly sized for stability. LPN-A stated the unit manager started training for the staff today and annual training was also provided on mechanical lift use.During an interview on 2/24/26 at 12:57 p.m., registered nurse (RN)-A stated the facility started re-education upon finding out from NA-A that the wrong sling size was used for a transfer the previous day. RN-A was not sure how long R132 had used a large sling size. RN-A stated sling size should follow the manufacturer's recommendations for safety and staff should always check the sling size to the Kardex prior to transfer. RN-A stated they followed the EZ Way Sling Size Chart (form #2-150), which was posted at the nurse's station.During an interview on 2/25/26 at 7:45 a.m., EZ Way representative (EZW)-A identified the sling fit size chart was in the manufacturer's user manual and using a size larger than the person's weight called for could potentially cause the resident to fall out of the sling (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during transfers. During an interview on 2/25/26 at 9:31 a.m., the director of nursing (DON) stated a minimum of annual training was completed on mechanical lift transfers with the facility staff and the EZ-Way vendors. Additional training was completed throughout the year as needed. The DON stated the Kardex was in the closet for staff to reference for appropriate sling size. The Kardex should have been checked before the resident transfer to ensure the correct size was used to ensure a safe transfer technique.During an interview on 2/25/26 at 9:50 a.m., the director of maintenance (DM) stated a safety program was established with the EZ Way representatives. Audits were completed on the function of the lift using a checklist from the manufacturer's guidelines. Nursing assessed the appropriate sling size using the manufacturer's guidelines. The expectation would be to follow the manufacturer's guidelines for use. The EZ Way Sling Size Chart (form #2-150) dated 9/13/24, identified a large sling (burgundy straps) should be used for resident weight of 190 to 330 pounds and maximum distance from tailbone to base of neck of 26 inches, and medium sling size (beige straps) should be used for resident weight of 90 to 220 pounds and maximum distance from tailbone to base of neck 24 inches.A policy on mechanical lift usage was requested and was not provided.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%). Two medication errors occurred out of 26 opportunities resulting in a 7.69% medication error rate for 1 of 6 residents (R150) observed during medication administration. Findings include:R150's admission Minimum Data Set (MDS) dated [DATE], identified R150 had moderate cognitive impairment, had occasional pain and received scheduled as well as PRN (as needed) pain medication. R150's diagnoses included type 2 diabetes with polyneuropathy (condition affecting nerves in multiple areas causing numbness and pain), dementia, and anxiety. R150's care plan dated 12/15/25, indicated pain and instructed staff to use both pharmacological and non-pharmacological interventions. R150's provider orders dated 12/11/25, indicated:-Lidocaine External Patch 4% (medicated adhesive patch to provide pain relief directly a specific area of the skin-releasing medication over a period of time). Apply to midback area topically one time a day for pain. Apply 1/2 patch to mid back area. On for 12 hours and off 12 hours and remove per schedule.-Lidocaine External Patch 4%. Apply to right leg topically one time a day for pain. Apply 1/2 patch to right leg. On for 12 hours and off 12 hours and remove per schedule. During observation on 2/25/26 at 8:18 a.m., licensed practical nurse (LPN)-B prepped R150's scheduled oral medications and then removed two full lidocaine 4% patches from the medication cart. LPN-B opened each of the lidocaine 4% packages and proceeded to date both patches. LPN-B grabbed the two patches along with R150's prepared oral medications and started to enter R150's room. Surveyor questioned the full lidocaine versus half patch order. LPN-B looked in R150's electronic medication record (eMAR) and stated the order was for just half a patch on each body site. LPN-B stated he did not work with R150 that often, but he should have checked the order and provided the medication as ordered. During interview on 2/25/26 at 12:19 p.m., registered nurse (RN)-B stated nurses were expected to administer medications as ordered by the provider. During interview on 2/25/26 at 12:41 p.m., director of nursing (DON) stated expectation for medications to be administered per provider order and would expect staff to check the eMAR order during medication administration. Facility policy Administration of Medications dated 12/2025, indicated appropriate medication administration procedure included, Verify the medication information as to the name of drug, strength, dose and hour of administration between the EMAR and the label on the punch card/bottle.