STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet Home	5517 Lyndale Avenue South Minneapolis, MN 55419

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to accommodate resident preference and assist in maintaining and/or achieving independent functioning for 3 of 3 residents (R16, R60, R61) reviewed who expressed a desire to open the windows in their rooms as they wished. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated R16 was cognitively intact, had diagnoses of depression, macular degeneration (an age-related eye condition that affects vision,) heart failure, and kidney failure, and was independent with transfers and ambulation. R16's annual MDS 7/19/23, indicated R16's daily preferences were not assessed. R16's care plan dated 9/24/21, included R16 was legally blind and used a walker for mobility. During observation and interview on 6/24/24 at 12:54 p.m., R16 was seated in a chair in their room which had two crank-out style windows without cranks. R16 stated the facility took all the window cranks off because the state directed them to do so, and stated, I resent that! R16 further stated they would not be able to get over the ledge to fall or jump out because the window was too high. During interview on 6/25/24 at 10:56 a.m., nursing assistant (NA)-A stated some of the residents could have their windows open, including R16, but they had to ask staff to open them. NA-A walked to R16's room and confirmed there were no cranks on the windows. R16 was seated in their chair and stated the staff had to call maintenance to find a crank to open it, appeared to become frustrated, and stated it was crazy R16 couldn't open the windows themselves. During interview on 6/25/24 at 11:02 a.m., NA-B stated if a resident wanted their window(s) opened they asked staff, and the staff would crack them open. They indicated there was one crank handle on the floor for all the crank-style windows which was usually kept in a drawer at the nurse's desk. Trained medication aide (TMA)-B was seated at the desk, opened the drawers, and was unable to locate the window crank. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/25/24 at 11:06 trained medication aide (TMA)-A looked around the desk area and in the medication cart and stated someone must have used it and left it in a room, and they were unsure how many crank handles there were. They indicated residents could have their windows open a certain distance if they prefer, but the only person who asked to have their window open was a resident in a room with a sliding window. At 11:10 a.m., TMA-A called maintenance to try to get a crank to be able to open resident crank-style windows. During interview on 6/25/24 at 11:23 a.m., registered nurse (RN)-A stated sliding windows were recently altered to make sure they only opened four inches, and they removed the cranks from the crank-style windows to prevent residents from opening them farther than four inches and kept the cranks somewhere. RN-A stated the floor was stuffy and four inches was not very far and not even worth it, however they were instructed by leadership to limit the opening size to prevent anyone from jumping out. RN-A stated R16 was not at risk of jumping or falling out of the window and should be able to have it opened. During interview on 6/26/24 at 11:02 a.m., RN-A stated a resident asked them to open a window that morning because it was going to be a nice day. RN-A confirmed it could only be opened four inches, which did not allow any airflow. They stated the facility did not complete any individualized assessments to determine if each resident was cognitively and physically able to open and close the windows themselves. 44647 R60's annual Minimum Data Set (MDS) dated [DATE], indicated R60 as cognitively intact and had diagnoses of diabetes, anxiety, and depression. Furthermore, R60's MDS indicated it was very important for R60 to have fresh air or to be outside. R60's care conference summary dated 6/11/24, indicated R60 had complaint of inability to fully open windows in room. Staff explained to R60 windows can only be cracked open per regulations. During observation and interview on 6/24/24 at 1:07 p.m., R60 was sitting in their room in a wheelchair. R60 stated the facility just changes things when they want to and can no longer have the window open all the way due to a state code. R60's window was a slide open window and was open approximately 6 inches. On the slider track was a black stopper that was screwed in and prevented the window from being opened any further. R60 further stated it was frustrating and they really liked to have the window open for fresh air. R60 stated he understood the rule for some residents who were confused, but not for those who were independent. R61's quarterly MDS dated [DATE], indicated R61 was cognitively intact and had diagnoses of heart disease and depression. During observation and interview on 6/25/24 at 11:00 a.m., R61 was sitting in her wheelchair in her room. R61 was frustrated and stated could not open their window all the way R61's slider window had a black stopper on the track to prevent the window from opening further than approximately 6 inches. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/25/24 at 11:13 a.m., nursing assistant (NA)-C stated resident can have windows open if they wanted to. NA-C wasn't aware of any concerns with windows not being opened or not opening al the way. NA-C entered R61's room and verified the black stoppers in R61's windows. R61 stated to NA-C why can't they be open .it's not like I'm going to jump out! NA-C stated hadn't noticed the stoppers in place before. During interview with the assistant administrator (AA) and director of nursing (DON) on 6/2624 at 8:20 a.m., AA stated the facility hired a consultant to conduct a mock survey, identified the windows as a safety risk, and suggested they restrict any opening to four inches for the sliding windows, and remove the handles from the crank out windows to prevent residents from opening them and jumping or falling out of them. DON stated the facility wished to maintain resident autonomy and independence as much as possible and allow residents to make their own choices based upon diagnoses and cognition. The Resident Rights on Respect, Dignity, and Self-Determination Policy dated 8/31/21, indicated the facility respects and promotes the resident's right to self-determination thought support of resident choice, including, but not limited to, the right to choose activities, schedules, health care, and providers consistent with their interests, assessments, plan of care, and preferences and the right to make choices about aspects of their lives in the facility.

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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** 44647 Based on observation, interview and record review the facility failed to ensure an electric lift chair was assessed for safe use for 1 of 1 residents (R11) reviewed for positioning. R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 had cognitive impairment and diagnoses of osteoporosis (disease causing weak bones), spinal stenosis (narrowing of the spinal column) and dementia. Furthermore, R11's MDS indicated R11 required partial to moderate assist from sit to stand and used a walker for mobility. R11's physical device data assessment dated [DATE], indicated R11 was not assessed for safe use of an electric lift chair. R11's care plan dated 5/7/24, indicated R11 required staff assistance as needed for transfers. R11's care plan lacked indication R11 used an electric lift chair or required assistance with use. R11's Kardex dated 6/25/24, lacked indication R11 used an electric lift chair or required assistance with use. R11's provider and nursing orders reviewed 6/24/24, lacked indication R11 used an electric lift chair. R11's physical therapy (PT) note dated 3/14/24, indicated R11 stood from raised recliner with stand by assist (standing near resident to maintain safety during task being performed). R11's assessment for safe use of electric lift recliner was requested however was not received. R11's medical record lacked indication R11 had been assessed for safe use of an electric lift chair. An observation on 6/24/24 at 12:35 p.m., R11 was seated in the lift recliner and was eating lunch. R11's tray table was in front of her with lunch on it. On the right arm of the chair was the remote for the lift chair. The lift recliner was lifted and R11 was tilted forward while seated in the chair. R11 stated why do I need to sit up like this .why can't I go back? Furthermore, R11 wasn't sure how to get the chair back down. When interviewed on 6/26/24 at 9:32 a.m., trained medication assistant (TMA)-C stated electric lift chairs were recommended by PT. If the chair was needed, the manager would be notified to obtain a lift chair. TMA-C stated R11 had worked with therapy and used a electric lift chair independently. TMA-C further stated R11 had some confusion at times but did not require help with the electric chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/26/24 at 9:35 a.m., licensed practical nurse (LPN)-A stated PT assessed residents for safe use of an electric lift chair. LPN-A stated there were no assessments completed by nursing for safe use of electric lift chairs on a routine basis and if there was an issue PT would be notified. LPN-A stated R11 did not have an electric lift chair and verified there was no provider order for one. LPN-A further stated R11 would need staff to help with a lift chair because R11 was confused sometimes. LPN-A verified the electric lift chair in R11's room and stated the chair was one brought by family. LPN-A stated R11 should have an assessment to make sure the chair was used safely. LPN-A was not sure how long R11 had the chair. When interviewed on 6/24/24 at 9:46 p.m., registered nurse (RN)-B stated physical device data assessments were not normally completed for electric lift chairs. RN-B further stated device assessments were for grab bars and code alerts. When interviewed on 6/26/24 at 1:16 p.m., the Director of Nursing (DON) stated electric lift chairs were not always PT driven and sometimes residents come from home with them and have already been using them. DON verified electric lift chairs were included on the physical device data assessments and if the electric chair was in use by a resident an assessment was needed. The DON further stated residents with cognitive impairments should be assessed to ensure continued safe use of the chair. A facility policy titled Physical Device Procedure dated 3/16/16, directed staff to assess the use of a physical device upon admission, annually, and with a significant change and will be reviewed quarterly for continued use. Furthermore, the policy directed staff to ensure a provider order was in place and documentation of the device was included on the care plan.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to implement resident-specific non-pharmacological interventions to address pain according to the resident's goals and preferences for 1 of 1 residents (R15) reviewed for pain. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], included they were moderately cognitively impaired, had diagnoses of rheumatoid arthritis, osteoarthritis, depression, and psychotic disorder, and was independent with ambulation. R15 received scheduled pain medications, did not receive PRN (as needed) medications, and did not receive non-pharmacological interventions for pain. R15 indicated they had frequent pain in the previous five days and rated it at a level four on a 1-10 scale. R15's pain Care Area Assessment (CAA) dated 2/13/24, included R15 has frequent/chronic bilateral knee pain with the pain intensity of 4 with contributory factors including a diagnosis of arthritis and low back pain. They received acetaminophen (a drug used to treat mild or moderate pain) three times per day, methotrexate (for pain related to rheumatoid arthritis) weekly, prednisone (to decrease inflammation) every other day, and Voltaren (a gel applied to skin to relieve arthritis pain) daily and PRN. The assessment indicated no PRN medications were used. R15 had severe cognitive impairment and had a goal to be as comfortable as possible. R15's care plan revised 3/7/24, included R15 had an alteration in comfort related to diagnoses of osteoarthritis, osteoporosis, autonomic neuropathy, history of right femur fracture, rheumatoid arthritis, and low back pain, received scheduled pain medication orally and topically, and had PRN topical medication available. The care plan included the following interventions: *Alter environment for comfort. *Provide comfortable room temperature or remove/add blanket or sweater as needed. *Meds (medications) as ordered *Monitor effectiveness of new or changed interventions using EHR (electronic health record) documentation *Observe for verbal and non-verbal signs of pain and update provider as needed. *Pain assessment quarterly and as needed. The care plan lacked resident-centric, non-pharmacological approaches to address R16's pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Pain assessment dated [DATE], included R15 frequently had moderate pain in the previous five days in both knees and right hip, received scheduled pain medications, did not receive PRN medications, and had no non-pharmacological interventions. The assessment indicated R15 reported bilateral knee pain related to longstanding diagnosis of arthritis as well as right hip pain, and received acetaminophen, Voltaren, methotrexate, and prednisone. The assessment included R15 was frequently noted walking in hallways and frequently reports pain with doing so. Advised to stop walking if experiencing pain. States she does not want to be on any more meds for pain. Care plan reviewed. R15's Order Summary Report dated 6/26/24, included: *Acetaminophen 1000 mg (milligrams) three times per day for pain *Methotrexate Sodium 2.5 mg, give 5 tablets once every Monday related to rheumatoid arthritis *Prednisone 2.5 mg once every other day, and 5 mg once on opposite days related to rheumatoid arthritis *Voltaren Gel, 1%, apply 4 grams topically to bilateral knees daily, and as needed for pain The report lacked orders for non-pharmacological pain interventions. During interview on 6/24/24 at 1:38 p.m., R15 was seated on the side of their bed, appeared to be in distress as evidenced by facial grimacing, and stated, I ache, my knees are bad. My knees are so sore. They lifted their pant legs to expose their knees, which appeared slightly swollen. R15 indicated staff did not offer ice packs or other interventions to help with pain. During interview on 6/25/24 at 9:19 a.m., trained medication aide (TMA)-B stated if a resident asked for pain medication, they asked the resident about their pain level and gave medications. They indicated R15 had acetaminophen PRN but no other interventions for pain. During interview on 6/25/24 at 10:56 a.m., nursing assistant (NA)-A stated R15 often asked for pain pills and NA-A would inform the nurse. They indicated they did not use any non-pharmacological interventions for R15's pain. During interview on 6/25/24 at 11:23 a.m., registered nurse (RN)-A stated R15 had chronic pain and had a pain assessment completed quarterly which indicated they had knee and hand pain, but not every day. They reviewed R15's medical record and confirmed R15 had pain medications and was advised by staff to stop walking if they had pain, however no non-pharmacological interventions were in place or identified on the care plan to address R15's pain. They indicated it was important to try alternatives to limit the medications needed, and it allowed anyone to assist the resident, not just licensed nurses. During interview on 6/26/24 at 8:18 a.m., director of nursing (DON) stated if a resident expressed pain, they expected the nurse to assess the resident, try non-pharmacological interventions first, and if not helpful, see if any pain medications were available. They stated they did not want to jump right to medications unless they had to since medications could have side effects and potentially cause other issues. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pain Management Program policy dated 5/2018, indicated in collaboration with the resident and/or representative and interdisciplinary team, a goal for pain management will be established and a multidisciplinary care plan written. This will include both pharmacological and non-pharmacological interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure insulin was to be administered to the correct resident and failed to ensure appropriate medication receiving procedures were followed for 1 of 3 residents (R18) observed for insulin administration. Additionally, the facility failed to provide pharmaceutical services to meet each resident's needs which included receiving the correct resident's medications and disposing of a discharged resident's medications. This had the potential to affect all who residents who received insulin residing in the facility. Findings include: R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had moderate cognitive impairment and diagnoses of heart failure, renal failure, diabetes mellitus, and dementia. R18's order summary report dated 6/27/24, directed staff to subcutaneously inject R18 with 5 units of insulin aspart solution 100 unit/mL with meals for diabetes and hold if blood sugar less than 120. During observation on 6/26/24 at 8:45 a.m., RN-D prepared insulin aspart 100 units/mL for R18. The insulin pen contained a label which read a different resident's name (RSG) and listed a different facility's name (STNH). RN-D entered R18's room with insulin pen and alcohol wipe and verified the name and facility on the label, which was not the name of the resident they prepared the insulin for, and stated they did not know about the label, but the medication was the one which R18 was ordered. RN-D proceeded to ask R18 where they wanted their insulin injection and went to turn on the resident's lights so they could see better. When asked again about the insulin label, RN-D stated the insulin came from the pharmacy with the label and labels should have the medication name, expiration date, and date opened. RN-D called licensed practical nurse (LPN)-A from another floor, and LPN-A arrived and verified the label identified RSG from STNH, and the insulin pen was not for R18. LPN-A stated there were more insulin pens in the second-floor refrigerator and brought RN-D to the refrigerator in the medication room. RN-D did not find insulin for R18. During observation and interview on 6/26/24 at 9:22 a.m., LPN-C viewed the insulin pen, and RN-D stated R18 did not have any insulin right now. LPN-C asked if RN-D had called the pharmacy and checked the second-floor refrigerator and medication cart. LPN-C stated the insulin pen was opened the day prior, and resident most likely moved from another nursing facility with the insulin. LPN-C instructed to give the insulin pen until done. RN-D proceeded to R18's room with medication, and trained medication assistant (TMA)-E stopped RN-D and grabbed insulin pen and gave to LPN-C again. LPN-C verified the label identified RSG from STNH. LPN-C instructed RN-D to call the pharmacy. During subsequent interview on 6/26/24 at 9:33 a.m., RN-D stated medication labels should have resident name, medication dose, route of administration, and time of administration. Nurses were to call the supervisor and pharmacy if medication labels were incorrect and not give the medication. RN-D stated residents could have possible side effects if received incorrect medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During subsequent interview at 6/26/24 9:43 a.m., LPN-C stated medication labels should have correct name, medication, and dosage. LPN-C stated there was a risk for medication error and the risk depended on what the medication was. During interview on 6/26/24 at 10:18 a.m., RN-D stated they signed for medication when delivered by the pharmacy and kept intake record. RN-D stated when they needed medication delivered from the pharmacy, they placed the medication refill sticker or wrote in the information on a form they faxed to the pharmacy. The receipts and medication refill requests were kept in a binder and when reviewed showed a refill request for R18's insulin aspart pen 100 unit/mL dated 12/22/23. During interview on 6/26/24 at 10:33 a.m., RN-B stated medications were sent to the floor the resident resided on. Nursing verified medication and then put away. Staff called the pharmacy to see what happened if they received someone's medications who were not on their floor. During interview on 6/26/24 at 11:12 a.m., LPN-C stated staff ensured medication received from the pharmacy was in the resident orders and medication was for the right resident. During interview on 6/26/24 at 12:32 p.m., LPN-A stated medication needed to have the right resident, medication, dose, time, and route to be given. LPN-A stated they were not to give insulin to a resident which had a different resident name and would have to find the insulin pen labeled for R18. LPN-A stated they would give the medication to the manager and contact the pharmacy about the different resident's name and facility. LPN-A stated there was a risk of giving the wrong medication or dose which could cause side effects. During interview on 6/26/24 at 1:25 p.m., LPN-C stated the pharmacy delivered medication to the second floor and the charge nurse checked off the medications and brought the medications to the third-floor nurse. Nurses checked pharmacy receipts when medications delivered and received from pharmacy. During interview on 6/26/24 at 2:17 p.m., pharmaceutical manager (PM) stated medications were labeled at the pharmacy, which included medication and concentration. A second pharmacist verified medications, and then medications were toted. Medications were scanned and placed into delivery bag, and any subsequent scans would block it and not allow medication into tote. Packing slips were associated with the delivery bags and stapled into the bag and listed residents and medications associated with the scanned barcode. Delivery drivers picked up the bags and took to the facility. PM expected nursing home staff to verify the medications as soon as possible. PM stated R18's last insulin pen was done on 5/24/24, and pharmacy had been sending out consistent deliveries so had no reason to think resident was out of insulin. During interview on 6/27/24 at 8:57 a.m., director of nursing (DON) expected staff to follow the six rights of medication administration and three checks before administering medication. DON expected staff to check medications were correct when pharmacy delivered them. DON stated there was a risk of giving the wrong medication to the wrong resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 6/27/24 at 11:03 a.m., consulting pharmacist (CP) expected staff to follow the three-check process when administering medication. CP stated there could be risk of medication error and from there depended on what the medication error was and what medication was given versus what was ordered. CP reviewed medication errors for the facility and gave input as able and did not see trends in medication errors. The facility provided packing slip dated 5/24/24, indicated insulin aspart pen 100 unit/mL for R18 with instructions to deliver to the second floor. The facility's policy and procedure Medication Administration Protocol revised 5/25/22, directed staff to complete three checks before administering a medication and to give the medication according to the specifics of the medication, which included right resident, route, dose, medication, time and documentation. The facility's policy and procedure Medication Ordering and Receiving from Pharmacy: Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy dated 4/1/19, directed licensed nurses to verify each medication against the pharmacy supplied packing slip. Staff were to verify medications received and directions for use with the medication order form and promptly report discrepancies and omissions to the issuing pharmacy and the charge nurse and/or supervisor. 49617 Medication Storage and Labeling Findings include: R291's admission Minimum Data Set (MDS) dated [DATE], indicated he had diagnoses of diabetes and took insulin injections. R291's order summary report for active orders as of 5/1/24 included the following orders: - insulin glargine (Lantus Solostar) subcutaneous solution pen-injector 100 units/milliliter (mL), Inject 62 unit subcutaneously at bedtime for diabetes dated 10/23/23. R291's order summary report for active orders as of 4/1/24 included the following orders: - semaglutide (Ozempic) subcutaneous solution pen-injector 8 milligrams (mg)/3mL, Inject 2mg subcutaneously one time a day every Friday for diabetes dated 10/23/23. R291's care plan last revised 11/8/23, indicated he had altered health maintenance related to his diagnosis of type 2 diabetes and identified interventions included administering insulin as ordered. A progress note dated 5/21/24, indicated R291 had discharged from the facility after needing a higher level of care. A drug disposition record for R291 was reviewed with the following record: Name of Drug Prescription (Rx) # Amount Date in Hazardous Waste Box (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet Home	5517 Lyndale Avenue South Minneapolis, MN 55419

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Carvedilol 1040986 9 1/30/24 Icosapent 1040990 4 1/30/24 Escitalopram 1040986 9 1/30/24 Primidone 2050782 7 3/4/24 R291's electronic health record (EHR) lacked a discharge drug disposition form. During observation on 6/26/24 at 10:21 a.m., the second-floor medication storage room was reviewed. There was a locked refrigerator with unopened insulin pen-injectors and a locked medication cart with opened insulin pen-injectors. In the refrigerator, there were two unopened Lantus Solostar insulin glargine pen-injectors with a prescription label and R291's name on them. In the medication cart, there was an Ozempic box with a prescription label and R291's name on it. Inside the box was a semaglutide pen-injector and a label with an open date of 4/26/24. The prescription label stated to discard the medication 56 days after opening. During interview on 6/26/24 at 10:54 a.m., registered nurse (RN)-B stated R291 had recently discharged from the facility. RN-B stated when a resident discharged , the normal process was to clear their medications out of the medication cart and storage room and follow the medication destruction procedure. RN-B stated there was a primary nurse manager responsible for this process. RN-B stated because R291 was private pay and the facility was still in contact with his family, they were keeping his medications in case the family wanted to collect them. RN-B stated if his family wanted to take a medication past the discard date on the label, such as the Ozempic pen-injector, education would be provided on the risks. RN-B stated there was not a routine auditing process of medication storage rooms or carts. RN-B stated, this is an ongoing process staff were expected to do during administration. RN-B expected staff to review expirations dates during medication administration and if staff found expired medications, they were expected to follow the facility's medication destruction procedure. During interview on 6/26/24 at 11:07 a.m., licensed practical nurse (LPN)-A stated when a resident discharged , a medication disposition form was filled out and their medications were put into the medication destruction box in the medication storage room. LPN-A stated a manager was responsible for destroying the medications. LPN-A stated they did not keep medications for residents who discharged and their return was not anticipated because they would most likely expire and they would not have anything to do with those medications. During interview on 6/26/24 at 12:46 a.m., the consultant pharmacist stated there were no pharmacy audits of the facility's medication storage rooms or medication carts. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 6/26/24 at 3:32 p.m., the director of nursing (DON) stated during a discharge, two nurses were expected to sign off on medications being destroyed on a disposition form. The DON stated this process was expected to be done as soon as possible to reduce the risk of error and save space. The DON stated this process applied to injectable medications, such as insulin. The DON stated it would not be appropriate to keep a discharged resident's medications with current residents' medications. Furthermore, the DON did not endorse providing medications to the resident or family after discharge. The DON stated it would have been more appropriate to give the unopened medications back to the pharmacy for billing purposes. A request for R291's discharge medication disposition was requested but not received. A facility policy titled Destruction of Non-controlled Drugs dated 8/9/19, stated its purpose was to safely dispose of medications that were discontinued, expired or resident was discharged . The policy indicated any medication that could be returned to pharmacy for credit would be returned. Additionally, the policy indicated all other medications that were unable to be returned and needed to be disposed of were to be itemized on the Drug Disposition Record and placed in the chart. This included the name of the drug, the prescription number, the amount, and what was done with the medication, for example, disposed into the hazardous waste box, sent with the resident, or returned to the pharmacy. Finally, the signatures of two nurses or a nurse and trained medication aide (TMA). The policy guided staff on how to dispose of medications that were not controlled in the Medsafe.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review the facility failed to ensure nonpharmacological interventions were utilized before use of an as needed (PRN) antipsychotic medication and failed to ensure PRN antipsychotic medication was ordered for 14-day use for 1 of 1 residents (R9) reviewed for PRN antipsychotic medication use. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 was cognitively intact and had diagnoses of anxiety disorder and bipolar disorder (mood disorder). Furthermore, R9 had exhibited no behaviors and routinely took an antipsychotic medication (medication used to treat mental/mood disorders). R9's provider order dated 6/4/24, indicated R9 required Seroquel 12.5 milligrams (mg) (antipsychotic medication used to treat mental/mood disorders) for every 12 hours PRN anxiety/bipolar disorder. This order had no end date. R9's medication administration record (MAR) and treatment administration record (TAR) dated 6/4/2024, indicated R9 did not require behavior interventions as no behaviors were exhibited. However, at 8:07 p.m., R9 received Seroquel 12.5mg PRN. R9's MAR/TAR dated 6/5/2024, indicated R9 did not require behavior interventions as no behaviors were exhibited. However, at 5:46 p.m., R9 received Seroquel 12.5mg PRN. R9's nursing progress note dated 6/4/24 at 8:07 p.m., indicated R9 received 12.5mg of Seroquel PRN. R9's progress note lacked behaviors exhibited by R9/reasoning why R9 was administered the PRN Seroquel and indication nonpharmacological interventions were attempted prior to R9 receiving the PRN Seroquel. R9's nursing progress note dated 6/5/24 at 5:46 p.m., indicated R9 received Seroquel 12.5mg PRN as R9 requested the medication. R9's progress note lacked indication nonpharmacological interventions were attempted prior to R9 receiving the PRN Seroquel. R9's care plan dated 6/24/24, indicated R9 can have issues with anxiety and trauma history and will have scattered thoughts during times of anxiety. Interventions included encouragement of calming activities such as latch hook, phone calls with family, and quiet time. Further interventions include facilitating time with husband, reminiscing about family, and one to one interaction. R9's care plan further indicated R9 received Seroquel for psychotic disorder and directed staff to observe and document behaviors and use the minimum effective dose of medications per policy. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/25/24 at 11:26 a.m., licensed practical nurse (LPN)- B stated when a resident was having behaviors or feeling anxious, staff would try to redirect the resident and determine what was happening or why they felt anxious. Interventions to try were included in the resident's care plan and sometimes the orders. LPN-B further stated if there were behaviors exhibited, nurses would use document the behaviors and what interventions were done. LPN-B stated some residents have PRN medications to help and stated other interventions should be used before giving a PRN medication. LPN-B stated R9 didn't always follow directions for safety and sometimes yells and screams. LPN-B further stated R9 could be redirected at times and liked to talk about family. LPN-B verified R9's PRN Seroquel order and stated R9 sees an outside provider and medication orders change often. LPN-B verified R9's order did not have a stop date and stated sometimes PRN orders have a stop date and sometimes they did not, and it depended on what the provider wanted. LPN-B verified there was no documentation of behaviors R9 was having or nonpharmacological interventions in place during the times R9 received PRN Seroquel. LPN-B further stated if R9 asked for the medication, then it was given. When interviewed on 3/25/24 at 3:16 p.m., registered nurse (RN)-B stated staff were expected to attempt nonpharmacological interventions before giving a PRN medication. Staff also need to document resident behaviors and the nonpharmacological interventions provided before giving the PRN medication. RN-B verified R9's PRN Seroquel did not have an end date. RN-B stated antipsychotic medications could be ordered for longer durations with provider documentation and R9 had a follow up appointment in the upcoming weeks. RN-B verified R9's medical record did not have behaviors or nonpharmacological interventions documented and further stated residents can ask for PRN medications and staff can always offer PRN medications to help residents. When interviewed on 6/25/24 at 3:16 p.m., the consulting pharmacist (CP) stated PRN antipsycotic medications had to be limited to 14 days and should be ordered with a stop date. Furthermore, the CP expected nursing to help manage PRN use of antipsycotic medications and ensure the end date was there. When interviewed on 6/26/24 at 1:16 p.m., the Director of Nursing (DON) expected nurses to be aware of the 14-day end date for antipsychotic medications and if an order was provided without an end date the provider should be notified to adjust. DON further stated staff were expected to document behaviors and nonpharmacological interventions attempted prior to giving a PRN medication, even if a resident requested the PRN medication. This was important to ensure PRN medications were given when needed. A facility policy titled Psychotropic Drugs revised 10/2020, directed staff to consider the behaviors or mood of the resident which maybe met by recognizing and responding with interventions to eliminate the need for the drug. Furthermore, the policy directed PRN antipsychotic medications must be ordered for no longer than 14 days. The provider then must do a face-to-face visit and provide documentation to extend for additional 14 day periods.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview and document review, the facility failed to ensure insulin pens were labeled in accordance with professional standards for 2 of 3 residents observed during insulin administration. Furthermore, the facility failed to ensure insulin pen-injectors were stored in a locked compartment. This had the potential to affect all 31 residents residing on the locked memory care unit. Findings include: R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had moderate cognitive impairment and diagnoses of heart failure, renal failure, diabetes mellitus, and dementia. R18's order summary report dated 6/27/24, directed staff to subcutaneously inject R18 with 5 units of insulin aspart solution 100 unit/mL with meals for diabetes and hold if blood sugar less than 120. R53's quarterly MDS dated [DATE], indicated R53 had intact cognition and diagnoses of diabetes mellitus and dementia. R53's order summary report dated 6/27/24, directed staff to subcutaneously inject R53 with 6 units of Lantus SoloStar Solution pen-injector 100 unit/mL one time a day for diabetes. During observation on 6/26/24 at 7:22 a.m., registered nurse (RN)-D got out a caddy basket which contained which contained items such as a glucometer, lancets, alcohol wipes, test strips, and insulin pens. The caddy basket was in the lower drawer behind the nursing station which the nurse did not have to unlock to get to. RN-D completed blood sugar checks and returned the caddy basket to the drawer which was closed and unlocked. During observation on 6/26/24 at 8:34 a.m., RN-D did not have to unlock the door to get behind the nursing station or the drawer which had the caddy basket with insulin pens. RN-D prepared Lantus SoloStar for R53. The insulin pen stated Lantus and contained a sticker which covered up concentration information. The sticker contained information such as resident name, date of birth, and provider and did not reference the order for administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 6/26/24 at 8:45 a.m., RN-D prepared insulin aspart 100 units/mL for R18. The insulin pen contained a label which read a different resident's name (RSG) and listed a different facility's name (STNH). RN-D entered R18's room with insulin pen and alcohol wipe and verified the name and facility on the label, which was not the name of the resident they prepared the insulin for, and stated they did not know about the label, but the medication was the one which R18 was ordered. RN-D proceeded to ask R18 where they wanted their insulin injection and went to turn on the resident's lights so they could see better. When asked again about the insulin label, RN-D stated the insulin came from the pharmacy with the label and labels should have the medication name, expiration date, and date opened. RN-D called licensed practical nurse (LPN)-A from another floor, and LPN-A arrived and verified the label identified RSG from STNH, and the insulin pen was not for R18. LPN-A stated there were more insulin pens in the second-floor refrigerator and brought RN-D to the refrigerator in the medication room. RN-D did not find insulin for R18. During observation and interview on 6/26/24 at 9:22 a.m., LPN-C viewed the insulin pen, and RN-D stated R18 did not have any insulin right now. LPN-C asked if RN-D had called the pharmacy and checked the second-floor refrigerator and medication cart. LPN-C stated the insulin pen was opened the day prior, and resident most likely moved from another nursing facility with the insulin. LPN-C instructed to give the insulin pen until done. RN-D proceeded to R18's room with medication, and trained medication assistant (TMA)-E stopped RN-D and grabbed insulin pen and gave to LPN-C again. LPN-C verified the label identified RSG from STNH. LPN-C instructed RN-D to call the pharmacy. During subsequent interview at 9:33 a.m., RN-D stated medication labels should have resident name, medication dose, route of administration, and time of administration. Nurses were to call the supervisor and pharmacy if medication labels were incorrect and not give the medication. RN-D verified R53's insulin concentration was covered by the facility's label, and the facility's label did not have the order directions such as prescribed dose. RN-D stated residents could have possible side effects if received incorrect medication. During subsequent interview at 9:43 a.m., LPN-C stated medication labels should have correct name, medication, and dosage. LPN-C stated there was a risk for medication error and the risk depended on what the medication was. During interview on 6/26/24 at 10:18 a.m., RN-D stated they did not think the swinging door of the nursing station locked, and the TMA had the key to the unlocked drawer where the caddy basket with insulin pens were kept. During interview on 6/26/24 at 12:32 p.m., LPN-A stated insulin should be labeled with the right patient, medication, dose, time, and route. Nursing should not give insulin with incorrect medication labels and find one with the correct information. Incorrect labels on medication put residents at risk of getting the wrong medication or wrong dose and have possible side effects. LPN-A stated they would give the medication to the manager and contact pharmacy if the medication label was incorrect or had the incorrect facility name. LPN-A stated medication labels should not cover the dose and concentration of medication and should not be placed over medication information. LPN-A stated they would take the label off and place a new one if a medication label covered medication information, since they needed to see the amount of medication they were giving. (continued on next page)

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	24E102	A. Building B. Wing	06/27/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During follow-up interview on 6/26/24 at 1:20 p.m., LPN-C stated medications came labeled from the pharmacy and would have to peel back a label and check the medication information if the label was covering it. LPN-C stated the facility had their own labels which they used for doctor appointments, visit notes, and consent forms. LPN-C verified R53's insulin pen label was the facility's made label and covered medication information and did not specify order information. LPN-C stated the half-door of the nursing station was busted and the drawer which contained the insulin pens could lock but the TMA with the key was on break. LPN-C stated there was a risk of someone getting the insulin pens who should not if they were not locked up, and noted the nurse was currently at the nursing station. During interview on 6/27/24 at 8:57 a.m., director of nursing (DON) expected staff to check medication labels were correct when following the six rights of medication administration and three checks before administering medication. DON expected staff to check medications were labeled correctly when pharmacy delivered them. DON expected medication labels would not cover medication dose and other pertinent information which needed to be seen to see what administering. DON expected medication labels to have resident name, date of birth, dose, times of administration and medication order. DON expected staff to write order on label if grabbing from chart or can call pharmacy and have them send a label. There was a risk of residents getting the wrong dose or medication or medication at incorrect times which could lead to adverse effects if medication labels were incorrect or if labels covered medication information. DON expected insulin pens to be locked up. DON stated somebody could take medication and could use on wrong person or other incorrect use if not locked. During interview on 6/27/24 at 11:03 a.m., consulting pharmacist (CP) stated insulin pens would come in boxes which had labels with full information such as resident name, provider name, directions, etc. CP stated boxes with full information did not need to be kept with insulin pen and was okay for insulin pens to have general information, such as resident name, facility name, prescription number, and opened date, and staff could refer to the electronic medication administration record for full medication directions. CP stated there could be risk of medication error and from there depended on what the medication error was and what medication was given versus what was ordered. A facility policy titled Medication Storage in the Facility dated 4/1/19, indicated medications and biologicals were to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply was only to be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. All medications dispensed by the pharmacy were stored in the container with the pharmacy label, but the policy did not specify what information was on the pharmacy label. Furthermore, the policy indicated medication storage containers are monitored on a regular basis by the facility on a regular basis by the facility and corrective action taken if problems identified. 49617 Findings include: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During continuous observation on 6/27/24 between 7:41 a.m. and 8:18 a.m., a plastic caddy was observed in the nurse's station in an opened and unlocked drawer. There were no staff nearby and the swinging half door was open and unlocked. There were four insulin pen injectors, lancets, blood glucose test strips, gauze, and alcohol wipe pads. There was a box of safety needles for the insulin pen-injectors in the drawer next to the caddy. At 7:41 a.m., licensed practical nurse (LPN)-C stated this was the normal spot to keep insulin pens and stated both the door and drawer could be locked. LPN-C walked away from the nurse's station without securing the insulin pens. At 7:46 a.m., registered nurse (RN)-C stated, we keep the supply kit here. RN-C stated there was only one supply room and there was not one on that unit. RN-C walked back and forth between the nurse's station and various resident rooms between 7:52 a.m. and 8:12 a.m. The plastic caddy containing the insulin pens remained unlocked. At 8:12 a.m., the half door was closed but unlocked and the drawer with the caddy was closed but unlocked. Between 7:41 a.m. and 8:18 a.m., five residents walked past the unattended nurse's station. At 8:18 a.m., the plastic caddy remained unchanged and unlocked. No residents or staff were nearby. During interview on 6/24/24, the director of nursing (DON) stated insulin pens were considered medications and should be locked up because someone could take them and use them on the wrong person. A facility policy titled Medication Storage in the Facility dated 4/1/19, indicated medications and biologicals were to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply was only to be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. All medications dispensed by the pharmacy were stored in the container with the pharmacy label, but the policy did not specify what information was on the pharmacy label. Furthermore, the policy indicated medication storage containers are monitored on a regular basis by the facility on a regular basis by the facility and corrective action taken if problems identified.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44647 Based on observation, interview, and record review the facility failed to ensure proper sanitization of dishware used for meal prep and resident service when the high temperature sanitizing dishwasher was not reaching adequate wash and rinse temperatures. This had the potential to impact all 92 residents who reside in the facility. Findings include: Ecolab EC-66HH specifications sheet dated 2012, indicated the dishwasher operating temperatures for high temp wash was 160 degrees F. The operating temperature for sanitizing rinse was 180 degrees F. A facility document titled Culinary Services Dish Washer Temperature Log dated 6/2024, indicated logged final rinse temperatures hit 180 degrees F one time from 6/1/24-6/26/24. An observation on 6/26/24 at 7:46 a.m., dietary aide (DA)-A started to wash breakfast prep dishes. The dishwasher was from Ecolab. There were two temp gauges one for wash and one for rinse. On the wash temp dial was a small sticker stated wash temp 150 and on the other temp dial was a small sticker stated final rinse temp 180. The first rack of pans went through. An electronic thermostat connected to the dishwasher indicated the wash temp was 145 degrees F and the rinse was 175 degrees F. At 7:56 a.m., the alarm was sounding on the electronic thermostat indicating low rinse temperatures, however the alarm was not acknowledged by DA-A. DA-A then moved a second rack through of cups and bowls and the alarm was no longer sounding. At 7:59 a.m., the electronic thermostat again went on this time indicating a low wash temp of 140.1 degrees F. DA-A did not acknowledge the alarm and continued to prepare dishes to move through the dishwasher. When interviewed on 6/26/24 at 8:03 a.m., DA-A stated he was not aware the alarm was going off and didn't monitor the temperatures when washing dishes. DA-A stated other issues come up when items get stuck inside the dishwasher, then it gets cleaned out. DA-A further stated he made sure the soap was filled. DA-A was not sure what the wash and rinse temperatures needed to be. When interviewed on 6/26/24 at 8:10 a.m., the Culinary Director (CD) verified the alarm and reset it and verified the low temperature readings. A temperature puck was obtained and placed through the dishwasher. The puck indicated the wash temperature was 142 degrees F and the rinse was now 200 degrees F. CD verified the dishwasher used heat for sanitizing dishes and verified the temperatures gauges indicated wash needed to be 150 degrees F and rinse 180 degrees F. The CD wasn't sure why the temperatures were not reaching what they should be. CD further stated Ecolab was here almost weekly to service and calibrate the dishwasher. When the facility temperature logs were reviewed, CD acknowledged rinse temperatures documented below 180 degrees. CD stated the first thing in the morning, the cooks do a test of dishwasher temps to ensure the temperatures are high enough. The temperatures were then written on the log. CD further stated if there was an issue with the temperatures not reaching 150 degrees F for wash and 180 degrees F for rinse and expected staff to notify a supervisor or himself for follow up. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 6/26/24 at 10:53 a.m., Ecolab representative stated technicians come out monthly for maintenance and noted the last time the facility called with an issue was on 5/20/24 and some valves were replaced at that time. When interviewed on 6/26/24 at 11:54 a.m., the assistant administrator expected dishwasher temperatures to be monitored to ensure sanitization was occurring. If found not to be running at the required temperatures, the CD should be notifying maintenance or Ecolab for assistance and to determine if alternative measures such as paper plate use was needed. A facility policy titled Dish Machine Temperature Log dated 1/2000, directed staff to monitor and record dish machine temperatures to ensure proper sanitization of dishes. Furthermore, the policy directed the dietary manager to spot check the logs and ensure staff monitoring and appropriate temperatures maintained. A facility policy titled Sanitation of Dishes Manual Washing dated 1/2000, directed staff to when using a mechanical dish machine using hot water to sanitize temperatures must be at or above 180 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48299 Based on observation, interview, and document review, the facility failed to ensure hand hygiene and glove change occurred between dirty and clean tasks and a shared glucometer (blood glucose meter) was disinfected between 3 of 3 residents (R53, R18, R28) observed during blood sugar checks. Findings include: R53's order summary report dated 6/27/24, directed staff to check R53's blood glucose at 7:00 a.m. and 5:00 p.m. every other day and 11:00 a.m. and 8:00 p.m. the opposite days. R18's order summary report dated 6/27/24, directed to staff to check R18's blood glucose before meals and at bedtime. R28's physician's orders, directed staff to check R28's blood glucose before meals and at bedtime with revised date of 3/21/24. During observation on 6/26/24 at 7:23 a.m., RN-D entered R53's room with a caddy basket which contained items such as a glucometer, lancets, alcohol wipes, test strips, and insulin pens. RN-D completed hand hygiene and donned gloves. RN-D wiped R53's finger with an alcohol wipe and pricked R53's finger with a lancet. RN-D squeezed blood from R53's finger but little came out, and RN stated the blood sample was not enough. RN-D used the same gloves to grab an alcohol wipe from the group of wipes in the caddy basket and wiped another one of R53's fingers. RN-D grabbed another lancet from the group of lancets in the caddy basket and pricked R53's finger. RN-D grabbed a test strip from the test strip bottle, still with the same gloves, and placed in glucometer to get a blood sugar reading. RN-D stated there was an error message and grabbed another test strip out of the bottle with the same gloves and placed the test strip into the glucometer and got a reading of 185. RN-D placed the glucometer back in the caddy, took gloves off, and wrote 185 on nurse sheet. RN-D performed hand hygiene at nursing station and donned gloves and brought caddy basket to R18. RN-D used alcohol wipe to wipe R18's finger, grabbed test strip from bottle and put in glucometer, used lancet to obtain blood sample and reading of 145. RN-D placed glucometer back in caddy basket next to the lancets, doffed gloves, wrote blood sugar down on paper, and performed hand hygiene at nursing station. RN-D approached R28 and donned gloves. RN-D took test strip out of bottle and placed into glucometer, opened alcohol wipe, and wiped R28's finger, pricked R28's finger with lancet and squeezed finger for blood sample. RN-D placed test strip to blood to obtain reading, but the glucometer showed an error message. RN-D removed the test strip and threw into garbage, used the same gloves to grab alcohol wipe from stack in caddy basket, took test strip out of bottle and placed in glucometer, wiped R18's finger with alcohol swab, took lancet from the stack of multiple in the caddy basket, pricked R18's finger and obtained blood sugar reading of 157. RN-D wiped R18's finger with gauze square and threw away gauze square when doffing gloves. RN-D took pen to write on paper, placed paper in caddy basket, and washed hands with soap and water. RN-D returned the caddy basket to the nursing station and took the paper from the caddy basket and placed onto the nursing station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E102	A. Building B. Wing	06/27/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/24 at 7:52 a.m., RN-D stated they disinfected the glucometer at night to ensure it was ready for use in the morning. RN-D stated the morning shift was too busy to disinfect the glucometer, so it would be disinfected again by the evening or night shift. Then RN-D stated the glucometer would be disinfected between the morning and lunch rounds of blood sugar checks. RN-D verified they had not disinfected the glucometer between residents and would be good to do for infection prevention. RN-D stated they performed hand hygiene before and after cares, between glove changes, and after touching dirty items and before touching clean items. RN-D verified they had touched clean items with dirty gloves and hands and should have performed hand hygiene before touching their pen and getting clean items from the test strip bottle and caddy basket. RN-D stated there was a risk of infecting other residents when the same materials were used for multiple residents. During interview on 6/26/24 at 9:46 a.m., licensed practical nurse (LPN)-C stated shared glucometers should be disinfected after every single use. LPN-C stated there was a risk of spreading germs when blood glucometers were not disinfected between resident use. LPN-C stated hand hygiene should be performed before a procedure, after a task like toileting, and before touching clean products. LPN-C stated hand hygiene and glove change should have been performed after trying to obtain blood sample and before getting clean materials from caddy basket to try to obtain blood sugar reading again. LPN-C stated there was a risk of cross contamination with lack of hand hygiene and glove change. On 6/26/24 at 4:17 p.m., both infection preventionists (IP-E and IP-F) were interviewed. IP-E expected Sani clothe wipes to be used to disinfect shared glucometers after every use. IP-F stated there could be drops of blood near machine, and IP-E stated the risk to the residents would probably be small but not zero. During interview on 6/27/24 at 8:55 a.m., director of nursing (DON) stated glucometers should be disinfected between residents with Sani wipes. The risk of not disinfecting shared glucometers were contamination and risk for infection. DON expected staff to doff gloves, perform hand hygiene, and don clean gloves before grabbing clean supplies from the caddy basket. There was risk of infection and cross contamination of germs when not changing gloves and performing hand hygiene when needed. The facility's policy and procedure Infection Control- Handwashing revised 7/8/21, directed staff to complete hand hygiene after situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions, or excretions. The policy indicated gloves should be worn when contact with blood and all body fluids, secretions, and excretions, and hands should be washed even when gloves were worn. The facility's policy and procedure Blood Glucose Testing and Glucometer Cleaning- Continuous Glucose Monitoring revised 5/22/24, directed staff to clean and disinfect the glucometer between each resident.