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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to develop and implement a comprehensive care plan to include identified trauma-related triggers and individualized trauma-informed care approaches for 2 of 2 residents (R14, R77) who had a history of trauma. Findings include: R14 R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and reported diagnoses of anxiety, depression, bipolar disorder (a mental disorder characterized by episodes of extreme elevated mood, or mania, and depression), and post traumatic stress disorder (PTSD, a psychiatric disorder that some people who have experienced or witnessed distressing or life-threatening event(s) may develop). Per a trauma informed care/vulnerabilities assessment dated [DATE], R14 indicated she had experienced trauma that was so frightening, horrible, tragic, or upsetting she had a hard time not thinking about it. The assessment identified her traumatic experiences and reported she was physically, sexually, and emotionally abused. Raped by an older male relative. Furthermore, the assessment identified she felt angry, sad, isolated, alone, shameful, irritable, and moody because of the experience(s). The assessment identified potential triggers that could cause such feelings to escalate, including being touched, loud noises, not having input/control, someone coming up behind me scares me. I'm disturbed by yelling/swearing [sic] Afternoon and evening are more difficult times for me [sic] Anniversaries - 3/30 (death of mother) and divorce (7/2). Furthermore, the assessment listed activities she identified might help her feel better when she as having a hard time, including listening to Christian music, reading, sitting by the office or nurse, talking, walking, having her hand held, physical exercise, writing, participating in activities, breathing exercises, and lying down. R14's care plan dated 3/25/25, identified her potential for abuse and neglect due to her history PTSD. The care plan directed staff to observe for changes in her mood and behavior, indicated she did not wish to discuss her trauma with her sister and reported she was close with her friend with whom she discussed all issues with. The care plan lacked documentation of triggers that may re-traumatize her and lacked resident-specific interventions to mitigate the risk of re-traumatization. (continued on next page)

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

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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's Kardex dated 4/29/25, was reviewed and lacked identification of triggers and resident-specific interventions to mitigate the risk of re-traumatization. During interview on 4/30/25 at 2:27 p.m., R14 could not recall if staff had asked her about things that set me off, but stated there had been no instances of re-traumatization in the facility. However, she stated, I have bipolar disorder and PTSD, I said something to the director of nursing about they [staff] need to learn how to deal with people who have mental health problems. R14 stated there were times she asked NAs to get a nurse for her treatments and she felt staff responded by scolding her and it bothered her and gives me anxiety. During interview on 4/30/25 at 5:17 p.m., registered nurse (RN)-A expected a resident's trauma and vulnerabilities to be identified on their care plan. RN-A reviewed R14's care plan and confirmed her trauma and trauma-related triggers were not documented on her care plan. RN-A stated, I don't see anything listed, and indicated it would be important for NAs to identify what her triggers were. R77 R77's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had unclear speech that was slurred or mumbled and was unable to complete the cognitive assessment interview. The MDS indicated he was severely impaired in his daily life decision making and had both short- and long-term memory problems. The MDS reported diagnoses including Alzheimer's disease (a progressive brain condition that affects thinking, memory, and behavior), aphasia (a language disorder caused by injury to the brain), depression, post traumatic stress disorder (PTSD, a psychiatric disorder that some people who have experienced or witnessed distressing or life-threatening event(s) may develop), chronic pain, and psychotic disorder (a mental condition characterized by abnormal perceptions and loss of contact with reality). A trauma informed care/vulnerabilities assessment dated [DATE], indicated he had an experience so upsetting he had a hard time not thinking about it and reported his step mom [sic] expressed that resident had been sexually assaulted as a child. The assessment reported, resident may resist bathing because of this trauma. Furthermore, the assessment identified he had severe cognitive impairment and identified his wandering behavior, and his communication limitations made him susceptible to abuse by others or increased his risk of abuse to himself or others. R77's care plan last revised 4/19/24, identified he had a potential for abuse and neglect from himself or others related to his memory impairment and his diagnoses of dementia and depression and directed staff to be mindful of residents [sic] hx [sic, history] of trauma but lacked documentation of potential triggers that may re-traumatize him. The care plan identified he was sexually abused as a child, and indicated he had an alteration in his mood and behavior due to his PTSD. The care plan directed staff to follow American Clinic of Psychiatry (ACP)'s recommended interventions, including having 1-2 staff approach him for cares (cares in pairs), offer him his preferred food or drink or something soft/texture for him to hold, approach him slowly and greet him by name, introduce self and inform him of the cares to be performed and move him to a quiet, less-stimulating environment. The care plan did not identify a preference for male versus female caregivers. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R77's Kardex dated 4/29/25, directed staff to be mindful of his history of trauma but lacked documentation of potential triggers that may re-traumatize him. The Kardex included behavioral interventions including have 1-2 staff approach him for cares (cares in pairs), offer him his preferred food or drink or something soft/texture for him to hold, approach him slowly and greet him by name, introduce self and inform him of the cares to be performed and move him to a quiet, less-stimulating environment. The Kardex did not identify a preference for male versus female caregivers. An ACP progress note dated 4/8/25, indicated under the treatment recommendations care team should be aware that R77's history of childhood sexual abuse could impact his emotional/behavioral responses. The progress note indicated it was possible his resistance and behavioral responses could be related to his trauma history. An ACP progress note dated 12/23/24, indicated the provider interviewed floor staff for updates. The progress note revealed a nursing assistant (NA) reported R77 can become aggressive during cares, and responds better to male caregivers and is typically less aggressive. With female caregivers, he benefits from cares in pairs. Under the treatment recommendations/plan, the progress note indicated staff were encouraged to continue with care planning trauma hx [sic, history] and behaviors/preferences and identified he responded well to male caregivers and benefited from cares in pairs with female caregivers. During interview on 4/30/25 at 10:23 a.m., social services (SS)-A verified completing the mood and behavior assessments and building up that section of the care plan. Additionally, SS-A reported being responsible for reviewing ACP progress notes and transcribing the recommendations into the care plan. SS-A stated behavioral interventions were reviewed during interdisciplinary team (IDT) meetings and occasionally at care conferences if a resident's family or representative(s) asked how they were doing with a behavior. SS-A expected staff to utilize non-pharmacologic interventions prior to implementing or adjusting psychotropic medications and stated, I would hope that's what they're doing. During interview on 4/30/25 at 11:08 a.m., NA-F stated resident-specific behaviors were identified on the Kardex and were reported in daily huddles. NA-F was not able to identify R77's trauma-related triggers, but stated he could sometimes get really strong and grab tight. NA-F stated when staff re-approach for cares, we go with two people. NA-F stated if staff were not paying attention to him during cares, he could go off and hit you. NA-F reported talking to him in a calm manner, offering him chips, leaving him be and re-approaching, and singing to him were effective interventions for him when he became resistive to cares and aggressive. Per interview on 4/30/25 at 1:32 p.m., NA-G reported, I go all over the facility to every floor. NA-G stated resident information could be located on their [Kardex] care card posted inside their closet. NA-G stated this would include resident-specific behaviors, triggers, and interventions. During re-interview on 4/30/25 at 1:58 p.m., SS-A verified responsibility for completing R77's trauma assessment and indicated triggers and interventions should be on the care plan and the Kardex. SS-A stated this information was also passed along via word of mouth, so staff knew about it right away. SS-A stated it was of high importance staff were aware of potential triggers so they could try and avoid re-traumatizing residents with PTSD. SS-A reviewed R77's Kardex and confirmed it lacked documentation of potential triggers. SS-A confirmed staff should be aware of his potential triggers and stated the Kardex doesn't say what it is. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 3:37 p.m., licensed practical nurse (LPN)-C walked into R77's room and showed the surveyor the Kardex care card was located inside the closet doors and stated resident preferences and activities of daily living (ADL) support requirements were located on the Kardex. LPN-C stated everything staff needed to know for R77 was located on the Kardex. Per interview on 4/30/25 at 4:01 p.m., with registered nurse (RN)-B, a resident's care plan would be the first place to look for their trauma or related triggers. Per interview on 4/30/25 at 5:30 p.m., the director of nursing (DON) expected the care plan and Kardex to be updated with anything staff should be aware of regarding a resident's trauma assessment. The DON stated social services completed the trauma assessments and care plans and was usually responsible for reviewing ACP progress notes and ensuring recommendations/interventions were transcribed and updated on the care plan. The DON indicated not having this information available to staff risked not knowing how to care for a resident if they were triggered or re-traumatized. During interview on 5/2/25 at 12:04 p.m., licensed social worker and ACP clinical intern (LSW)-G confirmed working with R77. LSW-G indicated the recommendation for him was to gain more information by paying attention to his body language, his reactions both during approach and during cares, because a thorough root cause analysis of behavior monitoring could identify patterns which may help both behavior and medication management. LSW-G stated his trauma most definitely could be impacting his interactions with staff because, in those moments when there are cares being performed, it might have reminded him of something in the past. LSW-G stated having a better understanding of his trauma and triggers could have mitigated re-traumatization. An undated facility policy titled Trauma Informed Care and Culturally Competent Care indicated its purpose was to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The policy directed staff the develop an individualized care plan that would address past trauma and identify and decrease exposure to triggers that may re-traumatize the resident as well as to incorporate language needs, culture, cultural preferences, normal and values (for example, food preparation and choices; clothing preferences such as covering hair or exposed skin; physical contact or provision of care by a person of the opposite sex; or culture etiquette, such as avoiding eye contact or not raising the voice). Furthermore, the policy directed staff to recognize the relationship between past trauma and current health concerns.

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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure wound care orders were followed and implemented for 1 of 3 residents (R27) reviewed for skin conditions. Findings include: R27's annual Minimum Data Set (MDS) dated [DATE], indicated R27 had intact cognition, did not have impairment with range of motion, used a walker, was independent with toileting hygiene, personal hygiene, transfers, and ambulation, and required substantial assistance with showering and bathing. Further, R27 was not on a toileting program, occasionally was incontinent of urine and was always continent of bowels, was not at risk for pressure ulcers and did not have other skin problems including moisture associated skin damage (MASD). R27's Medical Diagnosis form indicated the following diagnoses: retention of urine, muscle weakness, osteoarthritis, and history of falling. R27's care plan dated 3/13/25, indicated R27 had a potential for alteration in skin integrity due to urinary incontinence, skin was intact and R27's goal was to have no breakdown throughout the stay at the facility. Interventions included, daily skin observation with cares, report new or worsening concerns to the nurse immediately, treatment as ordered and observe for changes and report concerns to the physician or nurse practitioner, (NP) as warranted, weekly skin inspection by the licensed nurse. Implement appropriate interventions and update the physician or NP as warranted for worsening or new issues. R27's toileting and continence care plan dated 3/13/25, indicated R27 was independent with toileting and would remain continent of his bowel and bladder. R27's care plan was reviewed and lacked interventions for covering cushions with a cloth pillow case to assist in wicking away moisture. R27's Kardex printed 4/29/25, indicated R27 was independent with toileting, ambulation, bed mobility and used a two wheeled walker. R27's Kardex lacked interventions for covering cushions with a cloth pillow case to assist in wicking away moisture. R27's Kardex printed 4/30/25, was later updated to include an intervention to make sure any cushions/pads underneath R27 were covered with cloth/pillow case to assist with wicking away moisture. R27's physician's orders form indicated the following orders: 4/8/25, IHSS wound NP to evaluate and treat wound to left buttock. 4/24/25, treatment to left buttock, soak with warm, wet compress to gently remove previously applied topicals and or debris (do not rub or scrub to remove). Allow the area to dry for a minute before applying a new thin layer of Calmoseptine. Do not cover with a dressing! Adhesives will rip peeling skin. Topicals and soaking will help to soften and debride dry skin. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's orders were reviewed and lacked orders to ensure cushions and pads were covered with a cloth pillow case to assist with wicking away moisture. R27's nurse practitioner (NP)-C's wound progress note dated 4/16/25, indicated under a heading, Wound Description, indicated R27 had moisture associated skin damage (MASD) to the left medial buttocks and had a previously applied bordered silicone adhesive foam dressing and evidence of previous application of Calmoseptine to the underlying surrounding skin. Under a heading, Procedure Note, indicated Cavilon Advance skin protectant was applied and R27 was at risk for recurrence due to ongoing dry, peeling skin. Further, under the heading, Wound Care Plan, indicated to soak with warm, wet compress to gently remove previously applied topicals, effluent and or debris (Do not rub or scrub to remove), allow the area to dry for about a minute before applying a new thin layer of dimethicone-based topical or petrolatum based topical ie Vaseline or critic aid clear. Do not cover with dressing, adhesives will rip peeling skin and can cause additional trauma, which is not helpful to his healing. Topicals and soaking will help to soften and autolytically debride dry, peeling skin. R27's NP-C's wound progress note dated 4/23/25, indicated under a heading, Wound Description, indicated R27 had MASD to bilateral medial buttocks and a previously applied bordered silicone adhesive foam dressing was in place, along with evidence of previous application of Calmoseptine to the underlying and surrounding skin. Under a heading, Plan, indicated recurrence with increased overall affected area, likely secondary to trapping of moisture between topicals and bordered silicone adhesive foam dressing as well as R27 sitting on a cushion without fabric, increasing humidity and decreasing the ability for moisture to wick away when sitting for long periods of time. Under a heading, Wound Care Plan, indicated to make sure any cushions and pads underneath R27 are covered with a cloth pillow case to assist with wicking away moisture and soak with warm, wet compress to gently remove previously applied topicals, effluent and or debris (don not rub or scrub to remove) allow the area to dry for about a minute before applying a new thin layer of dimethicone based topical or petrolatum based topical for example, Vaseline or Critic-Aid Clear. Do not cover with a dressing-adhesives will rip peeling skin and can cause additional trauma, which is not helpful to healing. R27's nursing progress notes dated 4/21/25 at 2:45 p.m., indicated R27 had a bath and the excoriated areas on R27's buttocks were cleaned and a dressing was applied. R27's Weekly Skin Check form dated 3/31/25, indicated skin was clean, dry, and intact. R27's Weekly Skin Check form in progress dated 4/7/25, lacked information whether R27's skin was intact. R27's Weekly Skin Check form dated 4/21/25, indicated R27 had a bath and the excoriated buttocks were cleaned and a dressing was applied. During interview on 4/28/25 between 2:32 p.m., and 2:43 p.m., R27 stated he had a rash on his bottom for 6 months and the doctor told staff not to put a patch on and the nurse put a patch on two places and it was just getting worse. R27 further stated staff didn't apply cream on his bottom and further stated he was on his own and wanted staff to tell him the area was getting better. R27 was sitting in a recliner with a cushion under him. During observation on 4/29/25 at 8:24 a.m., R27 had a black cushion in his recliner and there was no pillow case located on top of the cushion as directed in the NP note. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 4/29/25 between 8:38 a.m., and 8:44 a.m., nursing assistant (NA)-C stated they looked at the Kardex on the computer every a.m., to know what cares a resident required. NA-C stated they had care sheets, but did not carry one on her. NA-C stated if a resident refused, it was documented in the computer and the nurse is updated. Further NA-C stated R27 was independent and sometimes needed help applying stockings otherwise did not need anything, did not refuse cares, was alert and oriented and a reliable historian. At 8:44 a.m., NA-C viewed R27's cushion in the chair and verified there was no pillow case and R27 stated he did not have one. NA-C stated she would have to ask the manager whether R27 required a pillowcase over cushions. During interview on 4/29/25 at 8:46 a.m., NA-G stated R27 did not want to exercise because he had a rash on his bottom. During interview on 4/29/25 at 8:47 a.m., trained medication aide (TMA)-A stated they applied lotions or creams such as Voltaren gel and Calmoseptine if there was an order, and stated if a resident refused, would let the charge nurse know and the charge nurse would talk with the resident and if they still refused would document the reason. TMA-A stated the charge nurse looked at skin on shower days and stated R27 had a cream that went on his bottom, he did by himself and somedays would call the charge nurse. During interview on 4/29/25 at 8:55 a.m., registered nurse (RN)-D stated he worked at the facility since 2008 and staff looked at the Kardex and on the care plan and if a resident refused, staff reapproached, tried different interventions and if continues to refuse would be documented in a progress note for any staff who can document in the progress note. RN-D stated R27 was followed by a wound doctor on Wednesdays. RN-D viewed R27's cushion and verified there was no cloth or pillowcase on the cushion and applied a cloth that was under the cushion. During interview on 4/29/25 at 9:16 a.m., licensed practical nurse (LPN)-A stated R27 had dry skin and saw the wound doctor on Wednesdays. During interview on 4/29/25 at 9:27 a.m., LPN-A went into R27's room and R27 had a cushion sitting on top of a folded wheelchair with no pillow case and LPN-A stated R27 had not been using the wheelchair. LPN-A washed R27's buttocks with a warm wash rag and the area appeared to have previously applied Calmoseptine located on the buttocks. The area appeared dried over and no angry redness observed. During interview on 4/30/25 at 7:41 a.m., NP-C stated R27 had a sweaty bottom and when moisture sits there, can cause skin breakdown and interventions were in place to keep things dry and stated R27's bottom was getting better and verified staff were using dressings and it was an education process, staff want to apply foam which adds moisture and stated she hoped the intervention of the pillow case over the cushion was careplanned and would check with RN-A. NP-C further stated, R27's MASD wasn't due to incontinence, but due to being sweaty and not having that moisture wick away from him because R27 was ambulatory and continent. During interview on 4/30/25 at 7:51 a.m., RN-D stated it would be important to have the intervention of the pillowcase on top of the cushion on the Kardex and care plan in order for the aide to know and verified the intervention was not on the care plan or the aide Kardex. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 8:46 a.m., the director of nursing (DON) stated she expected orders to be followed, careplanned or placed on the Kardex and expected staff to be aware of the interventions. A policy, Skin Integrity Management Policy, dated 8/27/24, indicated it was the facility policy to properly identify, assess, and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers/injures; to implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care. Further, the policy directed staff to care plan interventions according to the resident assessment and or individual risk factors identified.

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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - 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 to ensure interventions were implemented for 2 of 2 residents (R83, R5) and a root cause analysis was completed for 1 of 2 residents (R5) after a fall. This lead to actual harm for both R83 and R5 when R83 fell and sustained a right hip fracture that required hospitalization and surgery and when R5 fell and sustained a right clavicle fracture that required hospitalization . In addition, the facility failed ensure an elopement risk assessment was completed for 1 of 1 residents (R79) who had attempted to elope and failed to provide monitoring for 1 of 1 residents (R47) who had complaints of coughing during meals. Findings include: R83 R83's quarterly Minimum Data Set (MDS) dated [DATE], indicated R83 had severe cognitive impairment and diagnoses of Alzheimer's Disease and osteoporosis (disease that causes weak bones). R83 required moderate assistance with toileting and supervision or touching assist when walking at least 10 feet and was at risk for falls. R83'S nursing progress note dated 10/4/24 at 9:26 a.m., indicated R83 had an unwitnessed fall at 7:30 a.m. The root cause was R83 slid out of bed onto the floor when trying to get out of bed. The intervention implemented was a perimeter mattress. R83's fall risk management dated 10/4/24, indicated R83 had slid out of bed. R83 was found with one sock on and one barefoot. R83 had impaired memory and was confused. A predisposing factor to the fall was improper footwear. R83's interdisciplinary (IDT) note dated 10/4/24 at 1:35 p.m., indicated R83 slid off the side of her bed onto the floor. Mattress was changed to perimeter and staff to assist R83 to place gripper sock on at bedtime as R83 allows. R83's care plan was reviewed and updated. R83's care plan revised 10/4/24, lacked indication the gripper socks at bedtime was initiated after this fall. R83's electronic medical record (EMR) lacked indication R83 had refused or took off the gripper socks at bedtime. R83's nursing progress note dated 10/30/24 at 7:23 a.m., indicated R83 was found on the floor at 1:00 a.m. The note identified the root cause was R83 slipped out of bed and was wearing slippery socks. R83 had severe pain to their right hip and was sent to the hospital. R83's fall risk management dated 10/30/24, indicated R83 was found on the floor next to their bed. R83 had severe pain and was guarding their right hip. R83 was sent to the emergency room for evaluation. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	R83's IDT note dated 10/30/24 at 10:30 a.m., indicated R83 sustained a fall while transferring out of bed. R83 was sent to the emergency room for evaluation. R83's emergency room provider note dated 10/30/24 at 3:54 a.m., indicated R83 was transferring out of their bed and slipped on their socks. R83 sustained a right femur fracture and required surgical intervention. R83's discharge physical therapy note dated 12/11/24, indicated R83 required assist of one and supervision for all mobility. R83's discharge occupational therapy note dated 12/11/24, indicated R83 required supervision for toileting, peri-cares and clothing management and directed R83 to have assistance with nursing. R83's fall Care Area Assessment (CAA) dated 12/18/24, indicated R83 recently had a right hip hemiarthroplasty (partial right hip replacement) due to a fall with fracture and had continued impaired mobility. Staff were to walk with resident with gait belt and wheelchair to activities and dining. R83's falls assessment dated [DATE], indicated R83 had impaired mobility and used a walker and wheelchair for ambulation. R83's care plan revised on 4/24/25, indicated R83 was at risk for falling due to cognitive impairment, history of falls, weakness and recent hip surgery. Interventions included to keep call light in reach, perimeter mattress, keep walker at bedside when resting, and ensure R83 has proper footwear. R83's care plan further indicated R83 required assistance with mobility due to hip surgery. Interventions included ambulation with supervision/touch assist. Walking in hallway to and from meals required staff assist of 1, gait belt, and a wheelchair to follow. R83's Kardex as of 4/29/25, directed staff R83 required supervision/touch and use of 2 wheeled walker for ambulation and walk resident in hallway with wheelchair to follow with meals. R83 also required supervision with toileting with assist of one. During an observation on 4/28/25 at 4:59 p.m., R83 was standing in the doorway shouting for help. R83 had no walker and one pant leg was pulled up to their knee and the other one was on the floor. R83 was yelling for someone to help them. Registered nurse (RN)-F was seated at the computer across from R83's room and stated I will be there in a minute without looking up from the computer. R83 then said what nobody around to help? RN-F then stood, saw the situation, and got up to assist R83. During an observation on 4/29/25 at 9:03 a.m., R83 was seated in the television area. At 9:36 a.m., activity aide (AA) asked R83 if they wanted to go for a walk in the hallway. AA walked R83 down to the dining room and then back, past the television room towards the birds. AA walked R83 without the transfer belt or a wheelchair behind them. About halfway down to the birds, R83 stated they needed to use the bathroom. AA turned back to go into R83's room and stopped at the bathroom door. At the bathroom door, R83 told AA to stay out. AA closed R83's bathroom door and room door when exiting. At 8:58 a.m., AA told nursing assistant (NA)-B, who was sitting at the desk across from R83's room charting, R83 was in the bathroom. NA-B continued charting and at 10:12 a.m., got up and walked down the hallway towards the dining room and returned at 10:14 a.m., knocked and entered R83's room. R83 was now in bed. R83's walker was in the bathroom and R83 had walked back to bed. NA-B stated oh, she must have already went back to bed. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	When interviewed at 4/29/25 at 10:16 a.m., NA-B stated the Kardex let staff know what kind of assistance residents need. NA-B further said, the nurses will report off who was at risk of falling and stated R83 was a fall risk. R83 was unsteady at times and was confused and still thinks she is independent. NA-B verified R83 required staff to be in with her for the bathroom, but often R83 doesn't want anyone in. NA-B stated usually, they stood right outside the door and listened. When R83 got up or the toilet flushed, then would enter and assist but had not done that this time. NA-verified R83 required a walker for ambulation and walked without it back to their bed. NA-further stated using a wheelchair behind them was more of a therapy thing, and it was an option if R83 was feeling weak. When interviewed on 4/29/25 at 10:28 a.m., AA stated they check with staff and the NA's to know how much an assistance a resident needed. AA further stated as you work with the residents- usually get to know them. When interviewed at 4/29/25 at 10:33 a.m., RN-E sated when a resident falls, an assessment of the resident is completed. Once the resident was deemed ok, a risk management report was completed. The report walks through the situation and what the root cause was and there should be an intervention placed. Nurse managers will put any new interventions in the Kardex and care plan. RN-E verified R83 was a fall risk and further stated R83 transferred independently and used a walker to ambulate. R83 doesn't always use the wheelchair, but maybe for longer distances. RN-E stated if there were any changes in mobility assistance or devices, therapy was usually involved. When interviewed on 4/29/25 at 12:38 p.m., the Director of Therapy (DOT) stated R83 discharged from therapy when they signed up for hospice on 12/11/24. At the time of discharge, R83 was transferring with assistance of one person and ambulating with assist of one with a two wheeled walker. Walking directions to follow with a wheelchair was from therapy and verified that was communicated to nursing on 11/18/24. Nursing could evaluate and change the mobility status if no longer needing the wheelchair or transfer belt. When interviewed on 4/29/25 at 1:43 p.m., RN-B stated when a fall happens, the resident was assessed for injuries and questions asked as to what happened. The nurse will complete a fall risk management report and this was where the root cause of the fall would be listed and any interventions needed. Any nurse can update the care plan or Kardex, however typically the nurse manager would complete. The IDT reviews the fall and will ensue any interventions added were appropriate and ensure the care plan was updated. RN-B verified R83's care plan had not included gripper socks at bedtime. RN-B expected that intervention to be included on the care plan and Kardex so staff were aware of it. Furthermore, RN-B verified R83's care plan and Kardex directed staff to use a walker, transfer belt and a wheelchair to follow for mobility to the dining room. RN-B expected staff to follow those directions. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 4/29/25 at 2:52 p.m., the Director of Nursing (DON) expected staff to assess the resident, complete a risk management form to start the fall investigation, contact family, provider. The risk management form asks about the description of what happened, immediate actions, environment, and any pre-disposing factors. If the nurse knew what the root cause of the fall was, that would also be added. Then IDT meets and reviews the fall. The nurse will implement the immediate intervention, and IDT will determine if that is enough or if more investigation or interventions were needed. The nurse managers are then responsible to implement the interventions into the Kardex and care plan. DON expected R83's identified interventions for a perimeter mattress and gripper socks to be implemented and would need to review these. DON further expected staff to follow the interventions on the care plan and Kardex for mobility. If there were changes, therapy or nursing would evaluate and then update the interventions. A follow up interview at 4/30/25 at 8:51 a.m., the DON stated R83 never had the gripper socks implemented after the fall on 10/4/24. DON stated discussion with staff on the unit, R83 would not keep them on and always took them off and therefore not implemented. DON verified there was no documentation to support this. 42586 R5 R5's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), orthostatic hypotension, and a history of falls. It further indicated impairment on bilateral lower extremities (LE), independent with toileting and mobility, was occasionally incontinent of urine and always continent of bowel. Shortness of breath (SOB) when laying flat, had a fall within the last 2-6 months prior to admission/entry or reentry, and received an antidepressant and diuretic on a routine basis. R5's Care Area Assessment (CAA) triggered for falls from the MDS (11/27/25) for the following reasons: -new admit -advanced age -history of falls -impaired mobility (uses a wheelchair and was able to self-transfer with walker) -COPD with oxygen use as needed (PRN), CHF, bilateral (both sides) LE edema, morbid obesity, chronic pain, Benign Prostatic Hyperplasia (BPH) with occasional urinary incontinence, hypertension (HTN), atrial fibrillation (A-fib), depression, insomnia, restless leg syndrome (RLS), and cerebral aneurysm, non-ruptured. -medications (that may contribute to falls) Trazadone, Cymbalta, and Bumex. He hasn't had had any falls since entry/admission. Proceed to the plan of care that resident will remain safe in environment with interventions in place as evidenced by no falls during the quarter. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	R5's Care plan indicated R5 was at risk for falls related to medical diagnoses and history of falls prior to admission. admitted following transitional care unit (TCU) stay for strengthening following two falls on 12/27/24 (scalp laceration) and 12/30/24 (left clavicle fracture). Spasmodic torticollis. Bilateral lower extremities (BLE) edema with ready wraps daily. All staff to observe and identify for possible hazards in environment to prevent avoidable accidents/falls. It further indicated the following interventions along with the dates they were developed and implemented: -Call light within reach of resident when in room (11/27/24) -Encourage resident to call for assist with transfers and ambulation (1/31/25) -Ensure that resident has proper and non slip footwear (11/27/24) -Need to assist with evacuation in case of emergency (11/27/24) -Offer pharmacological and non-pharmacological interventions for pain when noted (11/27/24) -Physical therapy (PT)/Occupational therapy (OT) referral as needed/ordered (11/27/24) R5's progress note dated 12/27/2024, indicated R5 had an unwitnessed fall at 3:45 a.m. He slid off the commode and struck his head on the floor which resulted in a 6 centimeter (cm) laceration on the left side of his head. He was sent to the ER. R5's progress note lacked indication of a root cause analysis indicating how the fall may have occurred. R5's fall risk management dated 12/27/24, indicated R5 was found lying on his left side in his bathroom beside the commode with a 6 centimeter (cm) long laceration to the left side of his head. He was sent to the ER via non-emergency ambulance. Decreased range of motion (ROM) and gait imbalance were predisposing factors. R5's interdisciplinary team (IDT) note dated 12/30/2024, indicated resident reported that he lost his balance and fell while in the bathroom. Resident was at risk for falls due to impaired gait. Physical Therapy (PT) to evaluate and treat resident due to fall. Care plan reviewed. R5's care plan dated 11/27/24, lacked any new interventions following his fall on 12/27/24, in which he sustained a head laceration, went to the hospital, and received 7 staples in his head. During interview on 4/29/25 at 9:49 a.m., the director of therapy: (DOT) stated they had received a referral for R5 on 11/22/24 for PT. He was enrolled in PT from 12/4/24-12/31/24. The DOT further stated R5 was referred (for PT and OT) after a fall on 12/30/24, and was discharged to the Care View side for increased care on 12/31/24. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	R5's PT progress note dated 12/27/24, indicated R5 had seen progress since start of care (SOC) with reducing bilateral edema. Resident had a fall this morning and sustained a laceration to the head, returned from ER the same day. After education on wraps, resident continued to refuse wraps. Will continue current plan of therapy (POT) for manual lymph drainage and working on strengthening to reduce risk of falls. Resident in agreement. Today hold on exercise due to recent fall and fatigue/headache and hold on manual due to redness noted bilateral and nursing confirmation that patient appears to have cellulitis bilateral. R5's progress notes dated 12/30/24, indicated R5 had an unwitnessed fall at 4:15 p.m. The resident was found on the bathroom floor on his back with his left side against the wall. He was sent to the emergency room (ER) for evaluation. R5 was soaking wet and appeared like he used the toilet before and the floor was wet with urine. The root cause of the fall was R5 was unstable and the new intervention put in place was for him to start PT/OT. R5's risk management dated 12/30/24, indicated R5 was found on the bathroom floor on his back. He had extreme left shoulder/upper neck pain and was sent to the hospital. A wet floor, decreased ROM, gait imbalance, and previous falls were listed as predisposing factors. R5's after visit summary dated 12/30/24, indicated R5 had a fractured left clavicle (collarbone) as a result of a fall and was treated in the ER. R5's IDT note dated 12/31/2024, indicated resident reported that he fell asleep in the chair in his bathroom and fell . Resident has been re-educated to lie down in bed whenever he's tired to prevent falls/injuries. Resident will be transferred to Care View (CV)-TCU for rehab due to fracture of left clavicle. During interview on 4/29/25 at 8:58 a.m., licensed practical nurse (LPN)-A stated when a fall occured, nurses were responsible for trying to figure out why the fall happened and putting in an immediate intervention. Then the nurse managers were responsible for putting in follow up interventions in order to prevent another fall. During interview on 4/29/25 12:46 p.m. the nurse manager registered nurse (RN)-A stated when a fall occurred, the nurses were responsible for filling out an official fall progress note indicating what happened, and putting in an immediate intervention. Then the nurse managers were responsible for coming up with a root cause analysis (RCA). RN-A further stated there should be a new intervention put into place after each fall in order to determine what interventions are working or if there was anything else they could be doing to prevent the fall. RN-A also verified there wasn't a root cause analysis or any new interventions following R5's fall on 12/27/24. RN-A was unable to answer as to how the facility was able to determine whether R5 was safe to transfer and toilet himself following the fall. During interview on 4/30/25 at 10:40 a.m., the director of nursing (DON) stated there was no documentation that a RCA for R5's fall on 12/27/24 had been completed or that a new intervention had been added. This was important in order to prevent another fall. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's policy regarding falls dated 1/24/23, indicated the purpose of the policy was to identify and monitor residents at high risk for falls, minimize the incidence and potential for injury from falls, and ensure that proper assessment, intervention and documentation of incidents are completed. It further indicated all incidents should be assessed for the root cause and care plan modified if possible to prevent further incidents. R79 R79's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses including dementia, intellectual disabilities, and epilepsy. It further indicated R79 was independent with most activities of daily living (ADL) and mobility. R79's medical record lacked documentation an elopement risk assessment had been completed. During interview on 4/29/25 at 12:46 p.m. the nurse manager registered nurse (RN)-A stated they don't fill out elopement risk assessments for residents on the 2nd and 4th floors because they are able to come and go independently. RN-A stated they determine whether a resident can leave the facility independently or not upon admission and by asking the resident's responsible party. During interview on 4/30/25 at 9:02 a.m. the receptionist (RC) who sits at the front desk by the entrance door stated if a resident tried to leave the facility by themselves she would look in the book of photos at her desk that contained pictures of residents who were not able to safely leave the facility by themselves and would not unlock the door to let them out. She would then try to redirect them and call the nurse. The receptionist showed the surveyor the book of photos and there was a picture of R79 in the book. R79's progress note dated 4/27/25, indicated resident attempted to leave the facility without family, was stopped by the receptionist, and educated. During interview on 4/30/25 at 8:37 a.m licensed practical nurse (LPN)-A stated they do not fill out elopement assessments on the 4th floor but if a resident tried to elope, then they would complete one, notify the provider, family member, and supervisor. The surveyor showed LPN-A the progress note from 4/27/25 for R79 and she stated there should've been an elopement risk assessment filled out for R79 and notifications should have been made. During interview on 4/30/25 at 10:40 a.m., the DON stated elopement risk assessments were built into their admission data base, but R79's was not filled out and was unable to find any elopement risk assessments for him and there should have been . A facility policy regarding wandering and elopement dated 11/2022, indicated on admission, each resident will be assessed for elopement risk via completion of Admission Database Assessment. 46885 R47 R47's annual MDS dated [DATE], indicated R47 did not have signs or symptoms of a swallowing disorder, did not have coughing or choking during meals or when swallowing medications. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	R47's Optional State Assessment (OSA) dated 4/8/25, indicated intact cognition, did not reject cares, was independent with bed mobility, transfers, eating, and required supervision support with eating. R47's quarterly MDS dated [DATE], indicated intact cognition, did not have physical or verbal behaviors, did not reject care, had anxiety, depression, and mild cognitive impairment, was independent with ambulation, had coughing or choking during meals or when swallowing medications, was not on a therapeutic diet, mechanically altered diet, and did not have parenteral, IV feeding, or a feeding tube. R47's Medical Diagnosis form indicated R47 had the following diagnoses: mild cognitive impairment, major depressive disorder, other anxiety disorders, gastro-esophageal reflux disease (GERD) (a digestive disorder where stomach acid flows back up into the esophagus) without esophagitis, and disease of digestive system unspecified. R47's Physician's Orders form indicated the following orders: 12/9/19, regular diet, regular texture, and thin liquids consistency. 9/14/22, omeprazole (a medication that reduces the amount of acid your stomach makes) delayed release give 20 milligrams (MG) by mouth. R47's care plan dated 1/15/25, indicated R47 had a history of verbal aggression towards staff and other residents and did not like anyone sitting in her dining room chair and placed notes on the chair to remind other residents not to sit in her chair and because other residents ignored her request, preferred to eat in her room. R47's care plan revised 2/3/25, indicated R47 could feed herself independently and required as needed set up assist. R47's care plan revised on 4/30/25, indicated R47 had an altered nutrition and hydration status due to GERD, depression, anxiety and reported occasional discomfort with swallowing and declined speech therapy at this time. Further, R47 continued to express preferences to eat in her room and was educated on the risks and benefits of eating in the room versus the main dining room and verbalized understanding. Interventions included a regular diet, regular texture, thin liquids, notify dietary professional of changes in oral intake, weight, chew/swallowing, abnormal labs and skin integrity, and the dietician was to follow up as needed. R47's Kardex dated 4/30/25, indicated R47 had a regular diet, regular texture, and thin liquids. Further, R47 ate independently with as needed setup assistance. The Kardex lacked information R47 had difficulty swallowing or that R47 required any supervision. R47's physician progress note dated 4/4/25, indicated R47 had a history of GERD and diverticulitis, had no cough, was known to be lactose intolerant, and had been taking her meals in her room lately. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	R47's dietitian progress notes dated 4/8/25 at 8:12 a.m., indicated R47 ate in her room, had moved tables a few times due to not liking who was sitting with her. Further, R47 noticed when swallowing, sometimes things went down the wrong way, mostly with liquids and reported it was not painful, but more uncomfortable and reported food went down the wrong way and R47 coughed for it to come back up. The dietician explained speech therapy (ST) and R47 did not feel she needed ST and the note indicated to monitor for dysphagia (difficulty swallowing) signs and symptoms, gastrointestinal issues, and weight changes and the dietician would monitor R47's feeding ability and chewing and swallowing ability to provide further interventions as warranted. The note lacked information R47's provider was updated, or whether safety was assessed due to R47 eating in her room. R47's Nutrition Assessment form dated 1/21/25, indicated R47 ate in her room, was on a regular diet, regular textures with thin liquids, occasionally required set up help and did not have any chewing or swallowing difficulties. The note further indicated the dietician would continue to monitor R47's nutritional status including weight trends, meal intakes, labs, gastrointestinal status, feeding ability, and chewing and swallowing ability to provide further interventions as warranted. R47's Nutrition Assessment form dated 4/8/25, indicated R47 was on a regular diet, had regular textures with thin liquids, ate in her room and occasionally required set up help, had coughing or choking during meals or when swallowing medications. The form indicated R47 reported noticed when swallowing, liquids went down the wrong way and reported it was not painful, but more uncomfortable. R47 reported food went down the wrong way and R47 coughed for it to come back up and speech therapy was explained to R47 who did not feel she needed speech therapy and R47 would watch and see if it was needed in the future. Further, no nutritional interventions were in place. A heading, Goals/Recommendations, indicated to monitor for dysphagia signs and symptoms, gastrointestinal issues, and weight changes. During interview and observation on 4/29/25 at 12:33 p.m., R47 was in her room and stated she had not yet had lunch. During interview and observation on 4/29/25 at 1:01 p.m., nursing assistant (NA)-C brought R47's meal tray into her room and stated R47 was having a turkey Swiss wrap for lunch per R47's request. During observation on 4/30/25 at 12:26 p.m., R47 was in her room and stated lunch was served between 12:00 p.m., and 12:30 p.m., downstairs and then food was plated and brought up to rooms. R47 wanted her door closed. During observation on 4/30/25 at 12:21 p.m., a paper sign was located at the nursing station that directed staff regarding meals to ask residents their choice of meals before each meal and indicate the meal choice on the meal ticket. When serving check that the meal tray has condiments, utensils, and other items for the resident and check to make sure all food items are accessible and with in reach of the resident and ask the resident if there was anything else needed before leaving the room. Return to the resident's room shortly after tray pass to make sure they have everything they need, check to make sure all tray items are accessible and within reach and offer refills on drinks, re-warm or replace food as needed and at the end of the meal return to the resident's room to check if they are done eating collect the tray and return to the culinary cart. During observation on 4/30/25 at 12:51 p.m., the meal cart was observed coming down the hallway. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	During interview and observation on 4/30/25 at 12:52 p.m., NA-C stated R47 was going to have chicken salad and knocked on R47's door and introduced herself. NA-C stated they looked at the Kardex to know what cares a resident required and if a resident refused, staff reapproached and the nurse would try and document refusals. NA-C stated a nurse would have to answer what to do if a resident had trouble swallowing and stated therapy worked with residents and did not know whether residents should eat in their rooms if they had difficulty swallowing. NA-C stated R47 was independent and did not complaint of difficulty swallowing and stated her Kardex did not indicate R47 required monitoring with meals. During interview on 4/30/25 at 1:07 p.m., licensed practical nurse (LPN)-A stated they used the care plan to know what cares a resident required and if a resident refused would document. LPN-A stated if a resident reported difficulty swallowing would assess the resident, call the nurse practitioner or the doctor and residents would have speech therapy. LPN-A stated they first had to assess and then call the provider and if they received an order would fax it to the therapy department and further would add to the care plan and Kardex. LPN-A stated residents could not eat in their room if they had a swallowing problem and did not do a risk versus benefits form and added they couldn't force residents, but at the same time they encouraged them. LPN-A stated R47 did not have difficulty swallowing, was alert and oriented, and used to eat in the dining room but somebody sat in her spot and chose not to go down. LPN-A viewed R47's Kardex and verified it lacked information R47 had difficulty swallowing. LPN-A stated she hadn't heard R47 had difficulty swallowing and stated if R47 had difficulty, they had to assess and could not eat in her room. LPN-A viewed R47's nutrition assessment and verified R47 had coughing or choking during meals and stated if the physician was updated, it was documented in the progress notes and added it would be important for nursing to know if R47 had difficulty swallowing because they had to monitor her and was not monitored eating in her room. During interview on 4/30/25 at 1:27 p.m., RN-D stated they would document if a resident had difficulty swallowing and wanted to eat in their rooms the risk versus benefits and would order speech therapy to evaluate and treat and offer a recommendation. If the resident declined speech therapy (ST), ST would document the attempted evaluation and the nurse would update the doctor and stated ST had a waiver if ST saw a resident and the resident declined recommendations. RN-D stated it was a resident's preference if they wanted to eat in their room would tell them the risks versus the benefits of eating in the room and stated R47 did not have difficulty swallowing and had not exhibited the symptoms or reported any symptoms of trouble swallowing. RN-D viewed R47's nutrition assessment and stated he could have the dietician amend the note because he was not aware of any swallowing problems and would follow up with the dietician along with R47 and stated the dietician should have mentioned R47 had difficulty swallowing. RN-D later documented a progress note on 4/30/25 at 1:54 p.m., that indicated the progress note was a follow up note to the dietitian progress note dated 4/8/25 at 8:12 a.m., R47 reported occasional discomfort with swallowing and did not want a speech evaluation, but would let RN-D know if symptoms worsened. R47 continued to express preferences to eat in her room, was educated on risks and benefits of eating in the room versus in the main dining room, and R47's family and primary care provider were updated. Further, the note indicated the care plan was reviewed and updated. During interview on 4/30/25 at 1:39 p.m., dietician (D)-J stated if a resident reported difficulty swallowing would talk to the nurse manager and get ST in place and if the resident didn't want ST, would still follow up with the nurse manager to find a solution. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 4/30/25 at 2:41 p.m., RN-D brought D-I to the conference room. D-I stated RN-D had updated D-I regarding inquiries on R47's swallowing. D-I stated she asked if a resident had difficulty swallowing on every assessment and R47 mentioned she noticed it happened and brought up ST because R47 stated sometimes things went down the wrong way and expected staff monitor R47 and watch for foods and fluids going down the wrong way. When asked how resident would be monitored for choking when eating in her room, D-I stated that could happen and they encouraged everyone to eat in the dining room and R47 preferred to eat in her room. D-I stated she would document if a risk versus benefits was completed and stated she did not discuss with R47 the risks versus benefits of eating in her room and stated she discussed what ST could help with and expected monitoring to be on the care plan and Kardex and verified information was not on the Kardex and stated it would be im [TRUNCATED]

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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to ensure identified triggers were documented in the comprehensive care plan and individualized trauma-informed approaches were utilized for 2 of 2 residents (R14, R77) who had a history of trauma. Findings include: R14 R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and reported diagnoses of anxiety, depression, bipolar disorder (a mental disorder characterized by episodes of extreme elevated mood, or mania, and depression), and post traumatic stress disorder (PTSD, a psychiatric disorder that some people who have experienced or witnessed distressing or life-threatening event(s) may develop). Per a trauma informed care/vulnerabilities assessment dated [DATE], R14 indicated she had experienced trauma that was so frightening, horrible, tragic, or upsetting she had a hard time not thinking about it. The assessment identified her traumatic experiences and reported she was physically, sexually, and emotionally abused. Raped by an older male relative. Furthermore, the assessment identified she felt angry, sad, isolated, alone, shameful, irritable, and moody because of the experience(s). The assessment identified potential triggers that could cause such feelings to escalate, including being touched, loud noises, not having input/control, someone coming up behind me scares me. I'm disturbed by yelling/swearing [sic] Afternoon and evening are more difficult times for me [sic] Anniversaries - 3/30 (death of mother) and divorce (7/2). Furthermore, the assessment listed activities she identified might help her feel better when she as having a hard time, including listening to Christian music, reading, sitting by the office or nurse, talking, walking, having her hand held, physical exercise, writing, participating in activities, breathing exercises, and lying down. R14's care plan dated 3/25/25 identified her potential for abuse and neglect due to her history PTSD. The care plan directed staff to observe for changes in her mood and behavior, indicated she did not wish to discuss her trauma with her sister and reported she was close with her friend with whom she discussed all issues with. The care plan lacked documentation of triggers that may re-traumatize her and lacked resident-specific interventions to mitigate the risk of re-traumatization. R14's Kardex dated 4/29/25, was reviewed and lacked identification of triggers and resident-specific interventions to mitigate the risk of re-traumatization. During interview on 4/30/25 at 1:41 p.m., nursing assistant (NA)-H verified familiarity with R14's care. NA-H stated if a resident had a specific behavior or trigger, it would be identified on staff's PointOfCare (POC) charting. NA-H was unable to identify trauma-related triggers. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 2:27 p.m., R14 could not recall if staff had asked her about things that set me off, but stated there had been no instances of re-traumatization in the facility. However, she stated, I have bipolar disorder and PTSD, I said something to the director of nursing about they [staff] need to learn how to deal with people who have mental health problems. R14 stated there were times she asked NAs to get a nurse for her treatments and she felt staff responded by scolding her and it bothered her and gives me anxiety. During interview on 4/30/25 at 4:16 p.m., NA-I stated R14 did not have much patience and wanted everything right away. NA-I stated she had a lot of anxiety and a lot of worry. NA-I stated if staff were able to get her everything set up right away, then she was okay. NA-I was unable to identify any trauma-related triggers for R14 but stated if she had any or behaviors, they would be on the care sheet. During interview on 4/30/25 at 5:17 p.m., registered nurse (RN)-A expected a resident's trauma and vulnerabilities to be identified on their care plan. RN-A reviewed R14's care plan and confirmed her trauma and trauma-related triggers were not documented on her care plan. RN-A stated, I don't see anything listed, and indicated it would be important for NAs to identify what her triggers were. R77 R77's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had unclear speech that was slurred or mumbled and was unable to complete the cognitive assessment interview. The MDS indicated he was severely impaired in his daily life decision making and had both short- and long-term memory problems. The MDS reported he had no hallucinations or delusions, displayed physical and verbal behaviors 1-3 during the lookback period, rejected care 1-3 days during the lookback period and had wandering behavior. The MDS indicated he took antipsychotic and antidepressant medications and identified diagnoses including Alzheimer's disease (a progressive brain condition that affects thinking, memory, and behavior), aphasia (a language disorder caused by injury to the brain), depression, post traumatic stress disorder (PTSD, a psychiatric disorder that some people who have experienced or witnessed distressing or life-threatening event(s) may develop), chronic pain, and psychotic disorder (a mental condition characterized by abnormal perceptions and loss of contact with reality). The MDS reported R77 required extensive assistance with two staff for toileting and grooming cares but was independent with ambulation. A trauma informed care/vulnerabilities assessment dated [DATE], indicated he had an experience so upsetting he had a hard time not thinking about it and reported his step mom [sic] expressed that resident had been sexually assaulted as a child. The assessment reported, resident may resist bathing because of this trauma. Furthermore, the assessment identified he had severe cognitive impairment and identified his wandering behavior, and his communication limitations made him susceptible to abuse by others or increased his risk of abuse to himself or others. An undated order summary reviewed 4/29/25 at 2:06 p.m., included the following orders: - citalopram hydrobromide oral tablet, Give 10 milligrams (mg) by mouth one time a day for depression, dated 4/14/25. - Risperdal oral tablet, Give 1mg by mouth one time a day for psychotic disorder, dated 3/24/25. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Risperdal oral tablet, Give 0.5mg by mouth at bedtime for psychotic disorder, dated 4/10/24. R77's care plan last revised 4/19/25, identified he had a potential for abuse and neglect from himself or others related to his memory impairment and his diagnoses of dementia and depression and directed staff to be mindful of residents [sic] hx [sic, history] of trauma but lacked documentation of potential triggers that may re-traumatize him. The care plan identified he was sexually abused as a child, and indicated he had an alteration in his mood and behavior due to his PTSD. The care plan directed staff to follow American Clinic of Psychiatry (ACP)'s recommended interventions, including having 1-2 staff approach him for cares (cares in pairs), offer him his preferred food or drink or something soft/texture for him to hold, approach him slowly and greet him by name, introduce self and inform him of the cares to be performed and move him to a quiet, less-stimulating environment. The care plan did not identify a preference for male versus female caregivers. R77's Kardex dated 4/29/25, directed staff to be mindful of his history of trauma but lacked documentation of potential triggers that may re-traumatize him. The Kardex included behavioral interventions including have 1-2 staff approach him for cares (cares in pairs), offer him his preferred food or drink or something soft/texture for him to hold, approach him slowly and greet him by name, introduce self and inform him of the cares to be performed and move him to a quiet, less-stimulating environment. The Kardex did not identify a preference for male versus female caregivers. An ACP progress note dated 4/8/25, indicated under the treatment recommendations care team should be aware that R77's history of childhood sexual abuse could impact his emotional/behavioral responses. The progress note indicated it was possible his resistance and behavioral responses could be related to his trauma history. An ACP progress note dated 12/23/24, indicated the provider interviewed floor staff for updates. The progress note revealed a nursing assistant (NA) reported R77 can become aggressive during cares, and responds better to male caregivers and is typically less aggressive. With female caregivers, he benefits from cares in pairs. Under the treatment recommendations/plan, the progress note indicated staff were encouraged to continue with care planning trauma hx [sic, history] and behaviors/preferences and identified he responded well to male caregivers and benefited from cares in pairs with female caregivers. Per provider progress note dated 4/1/25, nursing staff reported R77 was combative with cares and had a very long unkempt beard and long hair that he wouldn't let staff wash and comb. The progress note indicated he wouldn't allow staff to perform peri-cares, incontinence cares, and displayed aggressive behaviors. The progress note revealed he was taking risperidone (antipsychotic medication) 0.75mg in the morning and 0. 5mg in the evening and it was increased in 3/2025 due to combative with cares. An email correspondence dated 4/1/25 with the subject line orders faxed fyi, indicated R77 was becoming more agitated, and his risperidone was increased and an order to start an antidepressant medication was provided. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 10:23 a.m., social services (SS)-A verified completing the mood and behavior assessments and building up that section of the care plan. Additionally, SS-A reported being responsible for reviewing ACP progress notes and transcribing the recommendations into the care plan. SS-A stated behavioral interventions were reviewed during interdisciplinary team (IDT) meetings and occasionally at care conferences if a resident's family or representative(s) asked how they were doing with a behavior. SS-A expected staff to utilize non-pharmacologic interventions prior to implementing or adjusting psychotropic medications and stated, I would hope that's what they're doing. During interview on 4/30/25 at 11:08 a.m., NA-F stated resident-specific behaviors were identified on the Kardex and were reported in daily huddles. NA-F stated staff were expected to document resident behaviors in PointOfCare (POC) charting and report them to the nurse, however, stated NAs could not document details or interventions attempted NA-F was not able to identify R77's trauma-related triggers, but stated he could sometimes get really strong and grab tight. NA-F reported talking to him in a calm manner, offering him chips, leaving him be and re-approaching and singing to him were effective interventions for him when he became resistive to cares and aggressive. NA-F stated when staff re-approach for cares, we go with two people. NA-F stated if staff were not paying attention to him during cares, he could go off and hit you. Per interview on 4/30/25 at 11:35 a.m., NP-E expected staff to be aware of a resident's trauma history and utilize non-pharmacologic interventions prior to implementing or adjusting psychotropic medications. NP-E stated a root cause analysis of a resident's behaviors would be helpful information before adding or adjusting a psychotropic medication. NP-E indicated assessing baseline symptoms, diagnoses, and history would be helpful to review for a resident residing on a memory care unit because they may be unable to articulate their preferences for cares. NP-E confirmed seeing R77 and agreed with the medication changes made prior to their encounter. NP-E stated the goal was to reach a therapeutic dose of his citalopram and gradually taper him off the risperidone. NP-E reviewed the ACP note dated 12/23/24 and expected staff to have attempted the interventions recommended but stated, it was my understanding he was quite aggressive with cares; it wasn't just being resistive. NP-E did not believe there was evidence of oversedation or chemical restraint with the increased dose of risperidone. Per interview on 4/30/25 at 1:32 p.m., NA-G reported, I go all over the facility to every floor. NA-G stated resident information could be located on their [Kardex] care card posted inside their closet. NA-G stated this would include resident-specific behaviors, triggers, and interventions. During re-interview on 4/30/25 at 1:58 p.m., SS-A verified responsibility for completing R77's trauma assessment and indicated triggers and interventions should be on the care plan and the Kardex. SS-A stated this information was also passed along via word of mouth, so staff knew about it right away. SS-A stated it was of high importance staff were aware of potential triggers so they could try and avoid re-traumatizing residents with PTSD. SS-A reviewed R77's Kardex and confirmed it lacked documentation of potential triggers. SS-A confirmed staff should be aware of his potential triggers and stated the Kardex doesn't say what it is. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 3:37 p.m., licensed practical nurse (LPN)-C walked into R77's room and showed the surveyor the Kardex care card was located inside the closet doors and stated resident preferences and activities of daily living (ADL) support requirements were located on the Kardex. LPN-C stated everything staff needed to know for R77 was located on the Kardex. LPN-C was not able to identify his trauma or related triggers. LPN-C stated he got along with regular staff well but did not believe there was a preference for male or female caregivers. Per interview on 4/30/25 at 4:01 p.m. with registered nurse (RN)-B, a resident's care plan would be the first place to look for their trauma or related triggers. During interview on 4/30/25 at 4:11 p.m., NA-E was unable to identify trauma-related triggers for R77. NA-E stated he sometimes refused cares but holding his hand and offering him a snack of chips were often effective interventions. NA-E was not aware of a male or female caregiver preference for R77, but stated when he refused cares, we need two staff. Per interview on 4/30/25 at 4:21 p.m., medical doctor (MD)-F stated it was not possible to determine why R77 was having behaviors because he was aphasic, so he can't articulate his thoughts, and when he became reactive during personal cares, MD-F indicated it would be difficult to determine if it was due to anxiety or delusions. MD-F expected staff to attempt non-pharmacologic interventions before moving to medications and believed the recommendations from ACP progress notes should be available for staff to utilize. MD-F stated knowing about his past trauma and triggers could have changed staff's approach towards his cares, but MD-F could not determine if it would have changed the outcome. MD-F believed staff were utilizing recommended interventions they were aware of, including re-approaching with different staff members. MD-F was supportive of the medication changes and stated prior to adjusting medications, we review progress notes, ACP notes, we interview staff and residents if we're able. Sometimes we'll talk to families if that's appropriate. We don't just start or increase psychotropics because of staff reports. Per interview on 4/30/25 at 5:30 p.m., the director of nursing (DON) expected the care plan and Kardex to be updated with anything staff should be aware of regarding a resident's trauma assessment. The DON stated social services completed the trauma assessments and care plans and was usually responsible for reviewing ACP progress notes and ensuring recommendations/interventions were transcribed and updated on the care plan. The DON indicated not having this information available to staff risked not knowing how to care for a resident if they were triggered or re-traumatized. The DON stated it could have been beneficial for staff to be aware of R77's potential triggers and all interventions recommended by ACP in theory. Per interview on 4/30/25 at 6:10 p.m., NP-D stated because of R77's aphasia, we don't know what exactly is going through his head and we can't determine what his thought process is. NP-D stated the goal of care was to decrease the level of anxiety surrounding his agitated behaviors. NP-D confirmed awareness of his trauma history and stated, he hasn't spoken, right? So, it's all from a third party, and indicated he was estranged from his family for [AGE] years. NP-D was not totally convinced what could have triggered his behaviors, however, believed staff were doing what they can and doing a good job with him. NP-D believed staff had familiarity with him and his history and believed, despite being unaware of his potential triggers and ACP recommended interventions related to male and female caregivers, staff had exhausted all non-pharmacologic interventions. NP-D stated it would not be feasible to have a male provide cares all the time and maybe that wouldn't have made a difference. We can't tell that because he can't tell us. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/25 at 12:04 p.m., licensed social worker and ACP clinical intern (LSW)-G confirmed working with R77. LSW-G explained PTSD generally as, a re-experiencing of trauma, a flashback of something that occurred to them. LSW-G stated this re-experiencing of a traumatic event may present differently for everyone, but someone could be escalated and fearful with big movements. Furthermore, LSW-G explained a person could be very emotional, distraught, or they could be completely frozen and fearful, even dissociate. LSW-G stated someone who was aphasic and had PTSD, like R77, could express being triggered through being resistive and combative or aggressive with cares. LSW-G indicated the recommendation for him was to gain more information by paying attention to his body language, his reactions both during approach and during cares, because a thorough root cause analysis of behavior monitoring could identify patterns which may help both behavior and medication management. LSW-G stated, we want to see staff trialing all non-pharmaceutical interventions before medications. LSW-G stated his trauma most definitely could be impacting his interactions with staff because, in those moments when there are cares being performed, it might have reminded him of something in the past. LSW-G stated having a better understanding of his trauma and triggers could have mitigated re-traumatization. LSW-G believed thorough behavior monitoring and utilizing all recommended interventions may have altered the need for medication changes, however, did not believe there was harm and stated, I do believe R77 is safe and the care he receives is safe. Per facility policy titled Psychotropic [psychoactive] Drugs reviewed 4/21/25, psychopharmacologic drugs may be used only after non-pharmaceutical approaches have been attempted and failed to sufficiently modify a resident's maladaptive behavior, mental status or mood. The policy identified antipsychotics and antidepressants as psychotropic drugs. An undated facility policy titled Trauma Informed Care and Culturally Competent Care indicated its purpose was to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The policy directed staff the develop an individualized care plan that would address past trauma and identify and decrease exposure to triggers that may re-traumatize the resident as well as to incorporate language needs, culture, cultural preferences, normal and values (for example, food preparation and choices; clothing preferences such as covering hair or exposed skin; physical contact or provision of care by a person of the opposite sex; or culture etiquette, such as avoiding eye contact or not raising the voice). Furthermore, the policy directed staff to recognize the relationship between past trauma and current health concerns.

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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 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. 51577 Based on observation, interview, and document review, the facility failed to ensure food items were labeled and dated, three of three kitchenettes were not properly cleaned per facility policy and cleaning log manual. This had the potential to affect all residents whom consumed beverages from the kitchenettes. During the initial observation of kitchenette on 2nd floor on 4/28/25 at 2:04 p.m., there was one filled frozen dixie cup no name or label in freezer, and one 20-ounce bottle of Gatorade one third opened no name or label in refrigerator. The ice/water machine had white flaky substance on back by dispenser. Folgers coffee machine had scant amount of brown tinged dried brown liquid on bottom of grate. Observed on 4/28/25 at 2:14 p.m., dietary aide-A verified refrigerator/freezer temperatures and documented findings on the log, removed labeled and covered food items from refrigerator, did not observe cleaning of any machines. Interview on 4/28/25 at 2:25 p.m. with NAR -A, confirmed the observation of the machines. They stated all items are to be labeled and dated in refrigerator and freezer. The machines should be clean and should not have water drippings and stains on them. During observation of kitchenette on 2nd floor on 4/30/25 at 7:42 a.m., all food and beverages labeled in refrigerator and freezer. Folgers coffee machine had scant amount of brown tinged dried brown liquid on bottom of grate. The ice/water machine had white flaky substance on back by dispenser. Interview with NAR-C confirmed findings, stated the machines should not have any liquid in the grates or water scales on ice/water machine. During the initial observation of kitchenette on 3rd floor on 4/28/25 at 2:18 p.m., on top of refrigerator there was one uncovered, no name or label cupcake in bowl and a wrapped Resees Peanut Butter Cups candy, no name or label. The ice/water machine had white flaky substance on the back of machine, where the dispenser is located and standing water under the grate. The juice machine had black substance in the corners of machine where juice is dispensed and grate. Interview on 4/28/25 at 2:30 p.m., NAR-B verified observation and stated the machines should be clean and all food and beverages need to be covered, dated and labeled. During observation of kitchenette on 3rd floor on 4/30/25 at 8:13 a.m., no food on top on refrigerator, no unlabeled or uncovered food or beverages in refrigerator or freezer. The ice/water machine had white flaky streaks on back side of machine where the dispenser is located. The juice machine has a black substance in corners where juice is dispensed and grate. Interview on 4/30/25 at 9:10 a.m., assistant culinary director confirmed observation. They stated the culinary staff is responsible for the cleaning of every beverage machine, refrigerators/ freezers, and microwaves in every kitchenette. There is a schedule and sign off sheet for cleaning tasks in a logbook in main kitchen area. During initial observation of kitchenette on 4th floor on 4/28/25 at 2:37 p.m., Folgers coffee machine had standing brown liquid with dark brown flakes under grate. The ice/water machine had white flaking streaks, where the dispenser is located. Interview on 4/28/25 at 2:40 p.m., LPN-B, confirmed the observation and stated the machines are supposed to be cleaned. They did not know which department was responsible for the cleaning. Interview on 4/28/25 at 2:45 p.m., housekeeping -A stated housekeeping department was responsible for the kitchenette space, not the machines. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation of kitchenette on 4th floor on 4/30/25 at 9:12 a.m., Folgers coffee machine had standing brown liquid under grate, ice/water machine had white flaky substance streaked on the back of machine where dispenser is located. Interview with on 4/30/25 at 9:24a.m., NAR-D confirmed observation. They stated the machines should be cleaned because they can pass germs or illness onto residents. During an interview on 4/29/25 at 9:39 a.m., culinary director stated the culinary staff oversees cleaning refrigerator/freezers and verify the food and beverages are covered and labeled properly. All the beverage machines, microwaves and countertops are to be cleaned by culinary staff. A sign off log is located in main kitchen for the schedule and completion of cleaning in kitchenettes. The policy and procedure manual, Cleaning Instructions: Coffee, Beverage, Juice, Frozen Yogurt, or Ice cream Machines, stated coffee makers, urns, juice machines, frozen yogurt and/or ice machines will be cleaned thoroughly.

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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to collaborate with hospice for the development, implementation, and revision of the coordinated plan of care for 1 of 1 residents (R34) reviewed for hospice services. Findings include: R34's significant change Minimum Data Set (MDS) dated [DATE], indicated she had severely impaired cognition and received hospice care. The MDS identified diagnoses of Alzheimer's disease (a progressive brain condition that affects thinking, memory, and behavior), non-Alzheimer's dementia (symptoms characterized by problems with memory, thinking, and behavior), depression, and anxiety. R34's care plan revised 4/7/25, identified she was on hospice care related to her Alzheimer's dementia diagnosis and directed staff to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met. R34's hospice plan of care dated 4/4/25, identified coordination of care between the facility, hospice team, and her and her children was a goal of care. The hospice plan of care indicated staff met with her family and reviewed hospice services and philosophy and they are in agreement with both. The plan of care reported paperwork was signed and placed in the chart. A care conference report dated 1/22/25, indicated the R34 was not present during the meeting however her family was invited and present for the care conference. The summary of care conference indicated her decline was discussed and hospice option was reviewed. The summary indicated her family was very interested and would be reviewed further when family returned from out of town. A review of R34's electronic health record (EHR) on 4/28/25 at 3:12 p.m. revealed a lack of documentation of a care conference since 1/22/25. Per interview on 4/28/25 at 3:29 p.m. with family member (FM)-A, staff reported there would be a meeting after R34 signed onto hospice care, but FM-A stated there had not been a care conference since before February when the unit's previous manager left. FM-A stated, we haven't sat down to talk with her team in several months now. FM-A expressed concern and stated without having a primary person, I just feel like I don't know what's going on. I really don't think they are collaborating with hospice. During interview on 4/30/25 at 9:34 a.m., hospice registered nurse (RN)-C confirmed familiarity with R34's hospice care and services. Hospice RN-C stated a resident should have a care conference within the first 30 days of them admitting to hospice. Hospice RN-C verified R34 admitted to hospice on 3/26/25 and stated, I don't see we've had a care conference yet. Hospice RN-C confirmed the last care conference for R34 was in January 2025 and did not see one scheduled for the upcoming week. Hospice RN-C reported the facility was responsible for arranging the care conference and inviting the hospice team, resident and family or representatives and other healthcare providers. (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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 10:10 a.m., social services (SS)-A verified responsibility for coordinating care conferences between the facility, hospice team and resident and families/representatives. SS-A stated care conferences should take place within 21 days of a resident's admission to hospice. SS-A confirmed R34 did not have a care conference after her admission to hospice when she should have and verified the deficient practice. Per interview on 4/30/25 at 3:50 p.m., RN-B indicated SS coordinated care conferences between the facility, hospice team and resident and families/representatives. Per interview on 4/30/25 at 5:23 p.m. with the director of nursing (DON), care conferences were expected to be held at least within 21 days of a resident's admission to hospice. A facility policy titled Care Conferences revised 1/8/21, indicated the frequency of care conferences followed the MDS schedule and included significant change MDS's. The policy identified the social worker would set the date for the care conference in conjunction with the MDS dates and invite the resident and family and interdisciplinary team (IDT). A Hospice Services Agreement dated 7/8/14, indicated hospice and the facility would work together to care for the same patient. The agreement indicated the facility agrees that family involvement is desirable in caring for patients in the hospice program. The agreement included a facility policy titled Hospice at Mount [NAME] Home / Mount [NAME] Careview Home dated 7/2012, which indicated care would be coordinated between facility staff and hospice staff.