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	05/14/2026

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure 1 of 1 commercial can opener was kept in a clean and sanitary manner and failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk of cross-contamination. These findings had the potential to affect all 80 residents, staff, and visitors who consumed food prepared from the main production kitchen.Findings include:During initial tour with director of culinary services (DCS) on 5/11/26 at 11:10 a.m., a series of 4 white-colored plastic bins were observed in the food preparation area. The wheeled bins were on the floor and were labeled for flour, white sugar, rice and powdered sugar. The flour bin was approximately 1/3 full of white flour and a black-colored scoop was inside, partially covered with flour including the scoop's handle. The bin labeled white sugar had a yellowish-tan dry matter inside the right lateral wall. The inside front wall of the bin had red dry matter 6-7 centimeters (cm) in diameter. Also, the rims around the lids of all 4 bins were dirty with dark like dust particles. DCS verified the findings and stated the scoop should not be left inside the bins and needed to be clean inside and out. Additionally, an [NAME] brand can opener attached to a counter was inspected. The can opener's blade was halfway covered with dry, red-colored matter.During a subsequent kitchen tour on 5/12/26 at 11:35 a.m., the can opener's blade still had dry, red-colored matter, but the red matter had been pushed upward by 0.2 cm, and a small light amber particle was noted right below the red-colored matter.During interview on 5/12/26 at 11:44 a.m., the cook (C)-A stated he used the can opener in the morning to open a can of cream of corn. The cream of corn was used for preparing today's lunch.During interview on 5/12/26 at 11:46 a.m., the DCS verified the presence of dry matter on the can opener. DCS stated the can opener should be washed every time it was used to prevent cross contamination. DCS also stated the dry bins should be cleaned inside and out, and the scoops should never be left inside the containers to prevent cross contamination and food born illnesses.Facility's policy titled Dry Storage Areas dated 2019, indicated the dry storage areas will be maintained to keep food safe and free of infestation or contamination.Facility's policy titled Sample Cleaning Schedule dated 2019, indicated the can openers should be clean after each use.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Mount Olivet Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5517 Lyndale Avenue South Minneapolis, MN 55419	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide a dignified experience for 1 of 2 residents (R20) who was receiving medications. Findings include: R20's annual Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition, inattention, disorganized thinking, verbal behaviors toward others and other behavioral symptoms. It further included diagnoses of dementia (severe with psychotic disturbance), visual hallucinations, general anxiety disorder, post-traumatic stress disorder (PTSD), and delusional disorder. R20's care area assessment (CAA) also dated 3/18/26, triggered for cognitive loss/dementia due to being unable to respond to questions on the Brief Interview for Mental Status (BIMS) assessment due to cognition and had diagnoses of Alzheimer's disease, dementia, visual hallucinations and delusional disorder. R20's care plan dated 3/12/26, indicated R20 had an alteration in mood/behavior/sleep due to diagnoses of Alzheimer's disease, dementia, generalized anxiety disorder, history of paranoia, public outburst and accusations of rape and people throwing meds down her throat. R20 could be agitated and aggressive during cares. R20's care plan included the following interventions:-Redirect and reapproach when resistive/combative. -Offer to go for a walk holding hands if wanting to leave the unit (elevator open, door to stairs/hallway) -Ok to allow resident to come to the dining room when ready. -Provide comfort items when resident is having challenges such as a snack or music- depending on where she is -Provide reassurance that needs will be met.-Calm approach During observation and interview on 5/13/26 8:30 a.m., R20 was in the dining room sitting at the table. Registered nurse (RN)-A brought her medications to administer them. RN-A attempted to pour the medications out of a small plastic medication cup into R20's mouth. R20 removed one of the medications (Divalproex) from her mouth and threw it on the floor. RN-A then attempted to pour the remaining medications in her mouth from the plastic medication cup while R20 was moving her head back and forth and attempting to pull away. In a raised voice, RN-A stated the residents name and told her she needed to take her medications. RN-A then pulled her chair back from the table and picked up the Divalproex from the floor and put it in a separate medication cup and asked R20 why she wouldn't take her medications. R20 replied because you weren't being nice. RN-A walked out of the dining room and back to the medication cart with the remaining medications she had refused to take. RN-A stated R20 would take them later and she always has a behavior when taking her morning medications. During interview on 5/13/26 at 1:41 p.m., RN-A stated if a resident refused to take their medications, they should reapproach at a later time. If they notice a pattern with medication refusals, they should try to figure out why the resident was refusing especially because there are residents who can't express themselves, so they should try everything to get them to take their medications. There are different things they can try such as putting the medication in ice cream and they should also let the rest of the team know the resident refused. During interview on 5/13/26 at 1:25 p.m., RN-B stated if a resident refused medications, they should reapproach at a later time or let another nurse know so they can try. The resident may just need a different face or a different approach and then they will take them. They also have a right to refuse so if those things don't work, then the nurse should dispose of the medication and document it. During interview on 5/14/26 at 9:40 a.m., trained medication aide (TMA)-A stated if a resident was refusing medications, they would step away and reapproach tree times, waiting in between each time. They would also notify the nurse. If the resident appeared to be upset (even if they couldn't express it/say it) she would walk away and reattempt at a later time stating you can't force them to take their medications. TMA-A further stated R20 would often refuse to take her medications but was usually able to get her to take them by offering her a banana. She also had family members that would visit almost every day, and they were able to convince her to take them. During interview on 5/14/26 at12:40 p.m. the director of nursing (DON) stated if a resident (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was refusing medications, she would expect the nurse to step away and reattempt later if the resident is accepting of it, stating some residents don't want the staff to reattempt. If they still refuse, then the nurse should update the provider and document the refusal. If there is a pattern of refusals the staff should try to figure out the why. The facility policy on resident's rights regarding respect, dignity, and self-determination dated 8/31/21, indicated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Each resident will be treated with respect and dignity and be cared for in a manner that promotes maintenance of his or her quality of life, recognizing each resident's individuality regardless of diagnosis, severity of condition or payment source.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure personal hygiene care (i.e., nail care, hair washing, showers) was provided for 1 of 1 resident (R36) reviewed for activities of daily living (ADLs) and who was dependent on staff for his care. Findings include: R36's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R36 had severe cognitive impairment, verbal behaviors, refused bathing, needed moderate assistance with toileting, and needed supervision/touching assistance to put on shoes, dress his upper body, and for personal hygiene. R36's diagnosis list indicated Alzheimer's disease, parkinsonism and high blood pressure. R36's care plan reviewed 5/11/26, indicated R36 had a potential for alteration in completion of ADLs, due to diagnosis of Parkinson's disease. Care plan's goal indicated R36 will maintain good oral hygiene with/without assistance, and will be neat, clean and odor free. The care plan directed staff to assist R36 with bathing, grooming and lower body dressing. R36's Kardex dated 5/14/26, indicated R36 needed assistance of one with bathing, grooming, and personal hygiene. A review of R36's Weekly Skin checks (completed on shower days) indicated:-on 4/7/26, R36 had a shower and was dependent on staff. -on 4/14/26, 4/21/26, and 5/5/26 R36 refused showers, nail care and shaving. R36's medical record lacked documentation about attempts to reapproach or reschedule his showers. During observation on 5/11/26 at 4:57 p.m., R36 was unable to answer questions related to bathing and personal cares. R36 had oily dull hair, overgrown facial hair and his fingernails were uneven and jagged up to 0.6 cm long. During observation on 5/12/26 at 8:30 a.m., R36's hair was full and oily, his nails were long and uneven, and his facial hair was unshaven. During observation and interview on 5/12/26 at 2:23 p.m., nursing assistant (NA)-A verified R36's dirty hair, and long nails. NA-A stated, he needs to be shaved. During interview on 5/12/26 at 3:10 p.m., registered nurse (RN)-C stated R36's behavior varied day to day and sometimes he would allow staff to help him with personal cares and other days he will not. RN-C stated he needed supervision and verbal redirection. RN-C stated he had his bear done 2-3 weeks ago. RN-C verified documentation regarding, R36 not having a shower since 4/7/26. RN-C stated usually a different NA will attempt to provide cares. RN-C added she knew sometimes he allowed staff's help. During interview on 4/13/26 at 11:34 a.m., with the director of nursing (DON) and the assistant director of nursing (ADON), they stated their expectations were for the staff to re-approach residents, then try to have a different person give the shower or try to give the shower at a different time of the day. DON and ADON stated getting showers, nail care and shaving were important for cleanness and residents' dignity. Facility's policy titled ADL Completion/Cares dated 1/11/23 indicated all staff will follow the residents' plan of care which identifies ADL assistance needed. The policy also indicated the residents have the right to have a choice and the right to refuse. If a resident refuses ADL assistance, ensure that resident is safe and reapproach. If the resident continues to refuse care, NA is to notify the nurse or manager to have them approach the resident.