STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. Building B. Wing	11/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to identify the indication for the administration of narcotic medications and failed to ensure non-pharmacological interventions were attempted/offered and documented prior to the administration of as needed (PRN) narcotic medications for 2 of 3 residents (R2, R3) reviewed for pain. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE] indicated severely impaired cognition with diagnoses including stroke and dementia. The MDS identified R2 had received scheduled pain medication but no PRN pain medication.R2's pain assessment dated [DATE] indicated R2 was unable to rate his pain and was not exhibiting any signs or symptoms of pain. R2 had not received any PRN pain medication. No non-medication interventions used to manage pain that have been effective were listed. R2's care plan dated 10/25/25 had a focus of alteration in/potential for alteration in comfort related to disease progression with interventions including but not limited to: provide comfortable room temperature or remove/add blanket, apply non-pharmacological approaches for comfort/pain reduction, provide quiet environment, collaborate with provider if pain control measures currently ordered are ineffective, combine non-pharmacological interventions with pharmacological interventions, communicate with and involve family/responsible party in interventions, medication/treatments as ordered, monitor pain control documentation with PRN analgesics to determine effectiveness, and observe for verbal/non-verbal indicators of pain. The care plan also had a focus of opioid use with interventions including observe for tolerance and report to provider if the medication is no longer effective in managing pain.R2's provider order dated 4/14/25 instructed Morphine (a narcotic pain-relieving medication) Solu tab 5 milligrams (mg). Give every 1 hour as needed for pain/shortness of breath (SOB)/dyspnea (difficult and uncomfortable breathing).R2's medication administration record for November 2025 indicated R2 received PRN Morphine the following 4 times:- 11/11/25 at 12:51 a.m., R2 received PRN Morphine which was recorded as E [effective]. A corresponding progress note dated 11/11/25 identified the medication was administered but did not include any recorded symptoms R2 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-11/12/25 at 11:52 p.m., R2 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/12/25 identified the medication was administered but did not include any recorded symptoms R2 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-11/13/25 at 4:30 a.m., R2 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/13/25 identified the medication was administered but did not include any recorded symptoms R2 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-11/17/25 at 1:00 a.m., R2 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/17/25 identified the medication was administered but did not include any recorded symptoms R2 was experiencing or what, if any, non-pharmacological interventions had been attempted or (continued on next page)

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

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered prior to the narcotic being provided.R3's admission MDS dated [DATE] indicated severely impaired cognition with diagnoses included Alzheimer's disease and hypertension (high blood pressure). R3's pain assessment dated [DATE] indicated R3 demonstrated facial indicators of pain 1 to 2 days during the look-back period and had received non-medication interventions for pain as well as scheduled and PRN pain medication. Non-medication interventions used to manage pain that have been effective were repositioning, Broda chair, and ice cream.R3's care plan dated 10/22/25 had a focus of alteration in/potential for alteration in comfort related to end stage disease progress with interventions including but not limited to: provide comfortable room temperature or remove/add blanket as needed, observe for objective signs/symptoms of pain, report to hospice any signs/symptoms of pain or discomfort. The care plan also had a focus of opioid use. Morphine is used due to end-stage disease processes to promote comfort and symptom management related to pain with interventions including but not limited to: monitor and report constipation, sedation and cognitive impairment (new or worsening), respiratory depression, dizziness and falls, and urinary retention; and observe and report to provider is medication is no longer effective in managing pain.R3's provider order dated 11/12/25 and discontinued on 11/14/25 instructed Morphine Solu tab 2.5 mg. Give 1 tablet sublingually (under the tongue) every 4 hours as needed for pain or SOB.R3's current provider order dated 11/14/25 instructed Morphine Solu tab 5 mg. Give 1 tablet by mouth every 2 hours as needed for pain or SOB. R3's medication administration record for November 2025 indicated R3 received PRN Morphine the following 5 times:-11/13/25 at 10:59 a.m., R3 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/13/25 identified the medication was administered for pain/SOB but did not include a pain assessment and what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-11/13/25 at 3:05 p.m., R3 received PRN Morphine which was recorded as I [ineffective]. A corresponding progress note dated 11/13/25 identified the medication was administered but did not include any recorded symptoms R3 was experiencing and what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided. The follow-up note did not include indication as to why the medication was deemed ineffective.-11/14/25 at 7:34 a.m., R3 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/14/25 identified the medication was administered but did not include any recorded symptoms R3 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-11/16/25 at 7:49 a.m., R3 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/16/25 identified the medication was administered but did not include any recorded symptoms R3 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-11/16/25 at 10:40 p.m., R3 received PRN Morphine which was recorded as E. A corresponding progress note dated 11/16/25 identified the medication was administered but did not include any recorded symptoms R3 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.During an interview on 11/18/2025 at 2:10 p.m., registered nurse (RN)-A stated non-pharmacological interventions should be tried before administering a PRN medication. Non-pharmacological interventions included offering food or drink, repositioning, offer activity or toileting. If those interventions are unsuccessful then a PRN could be administered. When documenting a PRN medication administration, the nurse should include what interventions were tried prior to and the specific reason the medication was administered for. If the medication was for pain, a pain number should be included in the note. If RN-A needed to follow up on a PRN medication that was administered by the previous nurse, RN-A would look for a progress note to indicate why the medication was administered so (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she could accurately assess the resident for medication effectiveness.During an interview on 11/18/2025 at 2:19 p.m., RN-B stated when a resident was in pain, the nurse should assess the resident then try appropriate non-pharmacological interventions. Non-pharmacological interventions included offering food or drink, repositioning, or toileting. If the pain continued, PRN pain medication could be administered. A progress note should be written to include the residents pain level and pain location. When the nurse went back to assess if the medication worked, they should compare the before and after pain ratings and ask how the location of the pain was currently feeling. If the previous nurse administered the medication and there was no specific information, it would be difficult to assess whether or not the medication was effective. During an interview on 11/18/2025 at 12:32 p.m., nurse practitioner (NP)-A stated when administering a PRN medication, the nurse should document what signs and symptoms the resident was displaying that indicated the need for the PRN medication. If the PRN medication is for pain, the note should include a pain rating and location. Proper documentation is needed to assure the medication is being utilized correctly and to determine if medication changes are needed. During an interview on 11/18/2025 at 4:12 p.m., the director of nursing (DON) stated non-pharmaceutical interventions should be attempted prior to PRN medication administration. When documenting PRN medication administration, the nurse should include any non-pharmacological interventions tried and the signs and symptoms the resident was displaying that indicated the need for the medication. If the PRN medication is for pain, a pain rating should be included utilizing the numerical or non-verbal pain scale. Proper documentation is important so effectiveness of the medication can be determined.The Administration of Medications policy dated 2024 instructed PRN medications are documented on MAR with a progress note as to non-pharmacological attempts prior to medication administration along with effectiveness.