



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 14, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: September 26, 2024

Dear Administrator:

On September 26, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 26, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 26, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Olivia Restorative Care Center

October 14, 2024

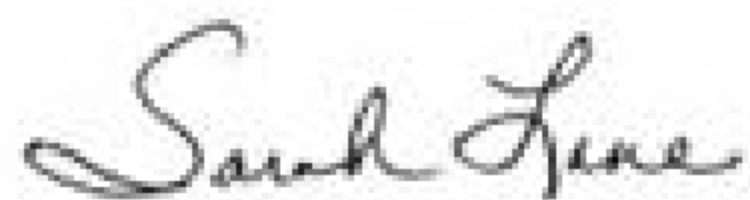
Page 4

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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October 14, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

Re: State Nursing Home Licensing Orders
Event ID: 275011

Dear Administrator:

The above facility was surveyed on September 23, 2024 through September 26, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

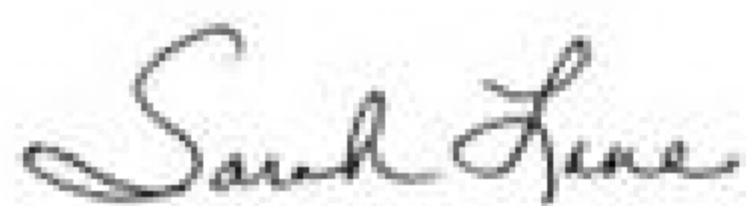
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2024
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	E 000			
	On 9/23/24 through 9/26/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 9/23/24 through 9/26/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed. H52908443C (MN101771) and H52908444C (MN99059). NO deficiencies were cited.				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.				
	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.				
F 550	Resident Rights/Exercise of Rights	F 550			11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2024

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.

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F 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550			

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure residents were assisted with their meal in a dignified manner for 3 of 6 residents (R1, R11, R23) who were dependent on staff to assist them with meal intake. Findings include: Observation on 9/23/24 at 12:10 p.m., while in the center dining room nursing assistant (NA)-B was observed to stand next to R1 and give him bites of food. NA-B left R1 and proceeded to obtain another meal for a different resident at which time NA-A was observed to walk over and stand next to R1 and give him bites of food. NA-B returned with R23's meal and proceeded to stand next to her and support her head (she was shaking) while giving her a bite of her food. NA-B and NA-A were observed to visit amongst each other while standing and giving bites of food to R1 and R23. At 12:24 p.m., NA-C was observed to stand between 2 residents at the table and assist R11 to take a bite of her food. During the meal service NA-A, NA-B, and NA-C were observed to stand the entire time they assisted the residents to eat their meal. R1's 8/3/24, quarterly Minimum Data Set (MDS) identified R1 had functional limitations of bilateral upper and lower extremities, he used a wheelchair, and was dependent on staff for eating and all other cares. R1 had diagnoses of hypertension, peripheral vascular disease, and multiple sclerosis. R1 was on scheduled pain			F 550	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure residents were assisted with their meal in a dignified manner for 3 of 6 residents (R1, R11, R23) who were dependent on staff to assist them with meal intake. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure residents are assisted with their meals in a dignified manner. Nursing Department Staff were re-educated on policy and procedure r/t mealtimes on 10/22/2024 and 10/23/2024. R23 was care planned to allow staff to stand while assisting her during meals to hold her head, if needed d/t tremors. Facility Nursing Department staff will promptly be re-educated on the proper		

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F 550	Continued From page 3 medication, was identified to have loss of liquids/solids from mouth when eating or drinking. R1 had weight loss that was not physician prescribed and had a mechanically altered diet. R1's 4/9/10, nutritional care plan identified R1 would be provided pleasure foods per request. A decline was anticipated with hospice services in place. Staff were to help set up meal, wash his hands, dispense condiments, and allow to eat meal at own pace. Staff were to provide supervision as needed. R1 had a regular diet with puree texture and nectar thick consistency. He used a lipped plate and nosey cups at meals to assist with independence while eating. The care plan had no mention that R1 was dependent on staff to assist him with his meal intake. R11 7/28/24 quarterly MDS identified R11 had severe cognitive impairment, she required substantial assistance for eating and was dependent on staff for all other cares. R11 had diagnoses of hypertension, hyperlipidemia, seizure disorder, anxiety, depression, and Alzheimer's disease. R11 had no nutritional concerns. R11 took a daily antipsychotic and antidepressant. R11's 11/14/19, nutritional care plan identified R11 received assistance as needed at mealtimes. R11 was on a heart healthy diet, regular texture, and regular consistency. R23's 9/13/24, admission MDS identified her cognition was intact, she had no behaviors, she was dependent on staff for eating and all other cares. R23's diagnoses included multiple sclerosis, seizure disorder, malnutrition risk, anxiety, on scheduled pain medication. R23 took	F 550	procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. This will continue to be addressed on-hire, annual training, and as applicable. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be affected. 3.What Systemic changed will occur to ensure that the deficient practice will not occur: Facility Nursing Department staff will promptly be re-educated on the policy for assisting residents with meals to ensure resident dignity is maintained during mealtimes. This will continue to be addressed on-hire, annual training, and as applicable. Promoting/Maintaining Resident Dignity During Mealtimes policy revised. 4.How the facility will monitor its corrective actions/performance: Nursing Management or designee, will conduct weekly audits of staff during mealtimes over the next (6) weeks and then monthly for (2) months to ensure staff are promoting and maintaining resident dignity during mealtimes in accordance with our facility s practice guidelines and regulatory requirements. Audits will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until such time		

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F 550	Continued From page 4 a daily antianxiety, antidepressant, and took antibiotic. R23 was being seen by occupational and physical therapy. R23's revised 9/23/24, nutritional care plan identified R23 was on a regular diet with regular texture and regular consistency. Staff were to assist by holding resident in position to eat. Interview on 9/23/24 at 12:45 p.m., with NA-B identified she stood to feed residents as it made it easier if she had to do something else or assist someone else quick with something. She was unaware of any protocol that staff should sit while assisting residents with eating their meal. Interview on 9/23/24 at 12:53 p.m., with director of nursing (DON) identified she chose not to answer if staff should be seated while assisting residents to eat their meal for a more dignified experience or if staff could stand while assisting resident during the entire meal, and reported she would provide me with the facility's policy. She then reported there "were times" when it would be appropriate for staff to stand and feed a resident such as if the staff are short and the wheelchair was tall. Typically though, she noted, staff should not stand to feed residents. She reported the facility was in process of changing the seating around and "that might have had something to do with" staff standing to feed residents. She reported there were a lot of residents who need assistance with eating, and the facility staff had just "rearranged things" and there might have been some confusion that day and felt that may have played a part in staff standing while feeding residents. Additional interview on 9/26/24 at 11:11 a.m., with DON identified the process for R23 was for staff to stand to assist her with her meal			F 550	consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: November 8th, 2024.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 550	Continued From page 5 intake because of the way staff must support her head while she eats. The DON reported that she added that to R23's care plan. For all other residents staff were to bring them into the dining room and sit down to assist them with their meal intake. Review of undated, Meal Supervision and Assistance policy identified residents would be provided adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. The facility would develop and implement, and individualized care plan based on the resident assessment to address the resident's needs and goals. Staff were not to serve the meal until the attendant was ready to assist the residents. Staff were to feed residents slowly allowing plenty of time between bites. Staff were to provide a relaxing, enjoyable environment during mealtimes. Staff were to encourage the resident to participate with their meal as much as possible. Staff should continue to feed residents until the resident has had enough food or until the meal was finished. There was no mention staff should provide dignity to residents while assisting them with meals.	F 550			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584			11/8/24

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F 584	Continued From page 6 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 carpeted center hall transition space to the center hall wood floor, 1 of 1 center hall wood floor transition space to the north carpeted hall, and 1 of 1 north carpeted hall transition space to resident (R14)'s tile floor was maintained to promote a safe,			F 584	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2024
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277		
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F 584	Continued From page 7 sanitary, and homelike environment. This had the potential to affect 11 residents that ate in the north dining room and/or lived on the north hall. Findings include: Observation and interview on 9/23/24 at 2:33 p.m., of R14's entrance to his room identified it was observed to have broken tile with missing pieces and frayed carpet in the doorway of his room with loose strings hanging. R14 who resided in room reported he had never "hooked" his wheelchair on there "yet". He was unsure of any plan to fix the surface of the doorway. Observation on 9/24/24 at 8:42 a.m. identified the carpeted center hall connected to the wood floor in hallway in front of north dining room was missing the plastic transition piece leaving an uneven surface and exposing the cement floor beneath. Also observed was the wood floor in center hallway that transitioned to the carpeted north hallway was also missing the plastic transition piece with some fraying of carpet noted. Observation and interview on 9/24/24 at 1:46 p.m., with maintenance director reported that staff either verbally report things that need to be fixed or that there was a program work order form that could be filled out. Observation of the areas with the maintenance director revealed he was unaware of the broken and missing tile in doorway of R14's room. He agreed that the carpet leading into doorway of R14's room was frayed with strings hanging and a potential for a staff or resident to get caught on the area and had the potential for injury. He revealed there was an identified issue with keeping the plastic transition pieces in place and he had not figured	F 584	who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 carpeted center hall transition space to the center hall wood floor, 1 of 1 center hall wood floor transition space to the north carpeted hall, and 1 of 1 north carpeted hall transition space to resident (R14)'s tile floor was maintained to promote a safe, sanitary, and homelike environment. This had the potential to affect 11 residents that ate in the north dining room and/or lived on the north hall. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that flooring in the facility is maintained to promote a safe, sanitary and homelike environment. The Maintenance director is working on replacing door thresh-hold strips for the North and Central areas affected and a new tile to replace the broken tiles in R14's room. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be		

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F 584	Continued From page 8 out how to secure them in order to prevent them from coming loose. The plastic transition pieces the facility used were hard for residents and staff to maneuver over and that was the reason he believed they kept getting ripped off. Observation of the transition area between the north hall and the wood flooring in the center hall and also the wood floor in center hall to the carpet in center hall were missing the plastic transition pieces leaving an uneven surface on the one side and exposed cement with frayed carpet. The maintenance director revealed he was "well aware" of the issue and had been trying to "brainstorm" what other types of products he could install for the transition between carpet and wood floor or the tile and felt it "was not a struggle" for residents and staff to go over. Observation and Interview on 9/24/24 at 1:51 p.m., with administrator identified she was aware of the missing plastic pieces between the carpet and tile in the doorways noted above. She was also aware of the missing tile in R14's entry way, however she was unaware of the severity. She agreed R14 had the potential of getting caught on the frayed carpet and becoming injured, and the missing tile was an infection control concern. She further confirmed the uneven surface between the carpeted center hall and the center hall wood floor was a concern as the cement floor was exposed and there was a potential risk for getting caught or tripping. She planned to address the issue immediately. Observation on 9/25/24 at 7:39 a.m., of maintenance director examining the area of the carpeted center hall and transition onto to the center hall wood floor with a outside contractor. The maintenance director reported the facility	F 584	affected. 3.What systemic changes will ensure that the deficient practice will not recur: The Maintenance director will complete a monthly environmental audit r/t flooring in the facility. The Maintenance Director was re-educated on regulations r/t this deficiency. 4.How the facility will monitor its corrective action/performance: The Maintenance Director, or designee will conduct monthly audits for flooring issues in the facility for (3) months to ensure the facility is providing a safe, clean, and comfortable and homelike environment. Audits will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: November 8th, 2024.		

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F 584	Continued From page 9 was able to get a contractor in to look at potential options for repair. Review of 8/13/24, Work Order Request policy identified staff were to make request in writing through the online work logbook. All verbal requests would be given low priority and be handled after written request were completed. There were no work order requests submitted for review during the survey related to the above concerns. There was no policy related to providing a safe and sanitary environment provided by the end of the survey.	F 584			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect a discharge record for 1 of 12 residents (R37) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose to offer clear guidance on how to use (i.e., code) the RAI which was divided in multiple sections. The manual outlined, "Section A: Identification Information and within	F 641	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to		11/8/24

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F 641	Continued From page 10 that section under A2105," directed an intent to record the discharge status location. The manual outlined Home/Community, Nursing Home, skilled nursing facility, short-term general hospital, long-term hospital, inpatient rehabilitation facility, inpatient psychiatric facility, intermediate care facility, hospice home, hospice facility, critical access hospital, home under care of organized home health services organization, and deceased, as options. R37's 9/3/24, discharge-return not anticipated MDS identified in section A2105 discharge status marked as resident discharged to a short-term general hospital. R37's 8/21/24, care plan identified she wished to move back home and live in her with spouse, in the meantime R37 may need to transfer to another skilled nursing facility to be closer to home. Interview on 9/24/24 at 2:23 p.m., with registered nurse (RN)-A who identified she was responsible for completing the MDS. She reported R37 discharged to an Assisted Living facility. She revealed she must have "miss coded" the MDS and checked discharge to the hospital verses assisted living. She reported that she would need to complete a correction on that MDS to identify R37 discharged to an assisted living and re-submit that. Interview on 9/26/24 at 11:11 a.m., with administrator identified she would expect the MDS to be accurate and reflect the status of the resident. There was no policy related to accuracy of the	F 641	reflect a discharge record for 1 of 12 residents (R37) reviewed for MDS accuracy 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that the MDS is accurately coded to reflect discharge orders of residents. MDS completed a modification to R37 s MDS and re-submitted. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: MDS will be re-educated promptly of MDS 3.0 policy, regarding regulations r/t this deficiency. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: MDS Coordinator or designee will complete weekly audit for (6) weeks focused on discharges that occur to ensure MDS is accurately coded reflect discharge orders of residents. Then monthly x2 months. This plan of correction will be monitored at the monthly Quality Assurance meeting		

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F 641	Continued From page 11 MDS provided by the end of survey.	F 641	until such time consistent substantial compliance has been met.		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review, the facility failed to ensure that 1 of 1 resident (R29) had hearing aids appropriately replaced when staff failed to remove her hearing aid during bathing, causing it to be damaged by water, and assist R29 with replacement due to staff negligence. Findings include: R29 had an admission date of October 2023. Review of R29's 10/25/23, Nurse Admission-Readmission and baseline care plan identified she was hearing impaired and had used	F 685	Corrective action completion date: November 8th, 2024. Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review, the	11/8/24	

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F 685	Continued From page 12 bilateral hearing aids. Review of R29's 6/15/24, quarterly Minimum Data Set (MDS) identified she had a severe cognitive impairment and had a diagnosis of Post Traumatic Stress Disorder (PTSD), anxiety and depression. Section O under the MDS identified she had hospice services. There was no mention that R29 had impaired hearing and used hearing aids. Observation and interview on 9/23/24 at 3:59 p.m., with R29 identified she had worn bilateral hearing aids during her stay at the facility and had purchased the hearing aides for \$3,000.00. She was assisted in the shower room (unknown date) by a staff member (unknown), who did not take out her right hearing aid during her shower and had caused it to get wet. R29 voiced concerns she was upset that she could not hear well out of her right ear. R29 picked up a blue and white tin near her bedside table, that stored her left hearing aid and battery. She stated the right was no longer in her possession and she was unsure where the right hearing aid was located. Interview on 9/24/24 at 1:52 p.m., with the social services designee identified R29 had informed her that she had a hearing aid missing and was under hospice services but was unsure when R29 had made the initial comment. She stated she had informed the administration and was unsure if administration had addressed R29's concern. She stated she was not aware if an inventory sheet had been completed for R29 upon admission to the facility. Interview on 9/25/24 at 1:00 p.m., with director of nursing (DON) stated R29 had a single hearing	F 685	facility failed to ensure that 1 of 1 resident (R29) had hearing aids appropriately replaced when staff failed to remove her hearing aid during bathing, causing it to be damaged by water, and assist R29 with replacement due to staff negligence. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that residents treatment/devices are maintained for hearing. Grievance was completed. R29 had an Audiology appointment on October 7th, 2024, for a hearing screening and an appointment on October 22nd, 2024 at TC Audiology to be fitted and pick up new hearing aids. On 10/23/2024, the care plan was updated to reflect hearing aids. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be affected. 3.What systemic changes will ensure that the deficient practice will not recur: Nursing admission/re-admission assessment was updated to reflect question pertaining to if resident has hearing aids with them upon admission. Education to be completed promptly with Nursing department staff r/t Policy of: Care and Use of Hearing Aids.		

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F 685	Continued From page 13 aid when she was admitted to the facility and was informed by R29's family, R29 does not wear her hearing aids on a routine basis. The facility did not provide a personal inventory sheet during admission for R29 and was not aware of the duration of time that had lapsed when R29 had made the complaint. She informed R29's hospice services of her missing hearing aid and did not have a facility procedure in place for damage of resident hearing devices in place when she was informed of R29's concern. She stated she would put a plan in place to provide education to staff of handing and storing hearing aids for residents. In addition, she stated the facility would pay for R29's hearing aids to be replaced. Interview on 9/25/24 at 3:20 p.m., with administrator stated her expectations would be for any resident who make a report of missing items to staff to file a grievance on behalf of the resident, so the facility would complete a thorough investigation of the lost items, and if not found the facility the facility would replace the residents' missing items in a timely manner. Interview on 9/25/24 at 3:27 p.m., with the activity director identified they were unaware R29 had worn hearing aids. Review of 8/2022 Personal Property policy identified the facility representative would advise the resident prior to or upon admission the amount of personal clothing and possession that the resident would keep in his or her room. In addition, complaints of misappropriation or mistreatment of resident property would be promptly investigated. There was no policy related to hearing provided	F 685	4.How the facility will monitor its corrective actions/performance: Nursing management or designee will complete weekly audit x6 to ensure that nursing department staff are compliant with Care and Use of Hearing Aids Policy during cares of x1 resident bath/shower day. Corrective action completion date: November 8th. 2024.		

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F 685	Continued From page 14	F 685			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 755		11/8/24	
			Preparation and/or execution of this plan		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2024
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F 755	Continued From page 15 review, the facility failed to obtain and administer ordered pain medication patched (lidocaine) medication for 1 of 6 residents (R189). Findings include: R189's face sheet identified she was admitted to the facility in September of 2024, with diagnosis of Wernicke's encephalopathy (a disease that affects the brain), chronic pain syndrome, and dementia. Observation and interview on 9/25/24 at 8:32 a.m., with the medication aide (TMA)-A, who was preparing R189's medication identified he was unable to locate R189's lidocaine (pain) patches. He looked in the medication cart drawers and checked the medication room. TMA-A identified that R189's lidocaine patches had not been delivered. R189 had not received her lidocaine patches for the past 9 days. R189's administration record identified staff were to apply 4 lidocaine 4% external patches daily at 8:00 a.m., for chronic pain syndrome. The administration record documentation reflected there were no patches available on 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24. R189's administration record pain assessments for the previously mentioned dates revealed no pattern of increased pain. Interview on 9/25/24, at 10:00 a.m., with licensed practical nurse (LPN)-A identified she was not aware that R189 had no supply of lidocaine patches. If the medication is not available the medication aide should notify the nurse, if the medication is not available in the emergency	F 755	does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain and administer ordered pain medication patched (lidocaine) medication for 1 of 6 residents (R189). 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure residents' medications are ordered, obtained and administered per doctors orders. Immediate corrective action taken on 9/25/2024 the pharmacy was contacted and the patch for (R189) was sent out and received by the facility during the pharmacy's med run that night. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be affected.		

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F 755	Continued From page 16 medication kit, the nurse would call the pharmacy to see when it would be delivered. If the medication could be delivered or if the resident was going to miss a dose, she would notify the resident doctor. LPN-A identified she had not been notified that R189 had no supply of her lidocaine patches, and she was unable to locate any documentation to indicate anyone at the facility had followed up with the pharmacy, notified a physician, or completed an incident report of the 9 missed doses. Interview on 9/25/24 at 1:07 p.m., with the director of nursing (DON) identified that she agreed with the above findings. She would have expected the nurse to follow up with the pharmacy to see if the medication could be delivered at the time of the first missed dose. If the medication could not be delivered causing the resident to miss a dose, she would expect the nurse to notify the physician for guidance and complete an incident report. A facility policy was requested; however, nothing was provided by the end of the survey.	F 755	3.What systemic changes will ensure that the deficient practice will not recur: Education for licensed nurses and TMA s will be started promptly related to the facilities policy of No Meds in House. 4.How the facility will monitor its corrective actions/performance: Nursing Management will pull and audit the Progress Note Report for Order Administration Notes in PCC Monday-Friday(daily) x6 weeks, then weekly x4 weeks to check for notes regarding no available medications noted by nurses or TMAs to follow up and ensure medications are ordered as needed and any that do not arrive are addressed, promptly, to ensure compliance. Corrective action completion date: November 8th, 2024.		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756			11/8/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page 17 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon pharmacy recommendations to modify administration times and limit potential interaction and/or side effects for medication administered to 1 of 3 residents (R34). Findings include: Review of R34's 9/07/24, Significant change	F 756	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.		

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F 756	Continued From page 18 Minimum Data Set (MDS) identified she had a diagnosis of schizoaffective disorder, anxiety, chronic kidney disease, thyroid disorder and had a moderate cognitive impairment. Review of R34's 6/11/24, Consultant Pharmacist Medication Regimen Review, identified the pharmacist noted Fibercon and calcium carbonate medication may interact with levothyroxine (thyroid) medication. It is recommended that the medications be separated by 4 hours and had been administered between 7:30 a.m. and 8:00 a.m. Consider moving Fibercon to later in the day, also consider giving calcium at noon, supper, and bedtime to avoid interactions with the levothyroxine. There was no mention of how the calcium carbonate medication was to be adjusted. Review of R34's, Order Summary report identified she had taken Oyster shell calcium + D (calcium carbonate) 500-5 milligram (mg)- microgram (mcg) and was to take 1 tablet three times a day for supplement use and Levothyroxine 150 mcg give 1 tablet in the morning for hypothyroidism (low thyroid levels), both with a start date of 5/17/24. Review of R34's, 6/01/24 to 6/30/24 Medication Administration Record (MAR) identified R34 had taken 30 doses of calcium carbonate at 8:00 a.m. Review of R34's, 7/01/24 to 7/31/24 MAR identified R34 had taken 31 doses of calcium carbonate at 8:00 a.m. Review of R34's, 8/01/24 to 8/31/24 MAR identified R34 had taken 31 doses of calcium carbonate at 8:00 a.m.	F 756	This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon pharmacy recommendations to modify administration times and limit potential interaction and/or side effects for medication administered to 1 of 3 residents (R34). 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure/ act upon pharmacy recommendations to modify administration times and limit potential interaction and/ or side effects for medications administered. Corrective Action: DON changed time of administration for Fibercon and calcium carbonate to be 4 or more hours apart from thyroid mediation for affected Resident R34. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be affected. 3.What systemic changes will ensure that the deficient practice will not recur: Education given to DON regarding following proper protocol for following pharmacy recommendations and all pharmacy recommendations including nurse recommendations will be double		

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F 756	Continued From page 19 Review of R34's, 9/01/24 to 9/31/24 MAR 25 doses of calcium carbonate at 8:00 a.m. Interview on 9/25/24 at 11:11 a.m., with the clinical pharmacist stated her recommendation for both calcium carbonate and levothyroxine medication would cause potential interaction if continued long term. Interview on 9/25/4 at 12:55 p.m., with director of nursing stated staff should have clarified the pharmacy recommendation and make necessary changes under the direction of the clinical pharmacist. Review of 5/14/24 Gradual Dose Reduction of Psychotropic Drugs policy identified pharmacy medication reviews occurred monthly, in addition, medication modification opportunities would depend on factors, including the coexistence of medications, individual risk factors and pharmacological characteristics of those medications. Lastly, medication consideration to continue, discontinue or modify medications was an acceptable standard of practice to minimize or prevent adverse consequences related to medication interactions.	F 756	checked by another nurse. 4.How the facility will monitor its corrective actions/performance: Monthly audits will be completed x3 months by DON or designee to ensure pharmacy recommendations are followed and double checked. Audits will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: November 8th, 2024.		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883			11/8/24

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F 883	Continued From page 20 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883			

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F 883	Continued From page 21 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R24 and R33) were offered pneumococcal PCV-15 or PCV-20 vaccination or declination form, per Centers for Disease Control (CDC) recommendations, reviewed for vaccinations. Findings include: R24's, 8/14/24 Significant Change Minimum Data Assessment (MDS) identified R24 was 70 years old was admitted May 2023. R24's MDS under Section O- Special Treatments and Programs indicated R24's pneumococcal vaccinations were up to date. R24's vaccination record identified he received PCV-13 on 12/21/15 followed by the PPSV-23 on 12/20/18. There was no documentation to support R24 had been offered or declined the PCV-15 or PCV-20 to ensure he was up to date with the current CDC guidelines. R33's, 7/26/24 Significant Change MDS identified R33 was 54 years old and was admitted May 2024. R33's MDS under Section O- Special Treatments and Programs indicated R33's pneumococcal vaccinations were not up to date. However, the record lacked evidence R33 had received the PCV vaccines despite the consent for it being obtained May 2024.	F 883	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R24 and R33) were offered pneumococcal PCV-15 or PCV-20 vaccination or declination form, per Centers for Disease Control (CDC) recommendations, reviewed for vaccinations. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to offer residents pneumococcal PCV-15, or PCV-20, PCV-21 vaccination as directed by primary physician, per Centers for Disease Control (CDC).		

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F 883	Continued From page 22 Interview on 9/26/24 at 11:26 a.m., with director of nursing stated the facility would plan to offer the vaccine for residents. Review of 4/08/24 Pneumococcal Vaccine policy identified the facility would determine eligibility of residents PCV status and would offer the vaccine within 30 days of admission, unless medically contraindicated or the resident was previously vaccinated and would receive information and education of the benefits and potential side effects of the vaccine. Lastly, the facility would administer vaccines or re-vaccinate in accordance with current Centers for Disease Control and Prevention (CDC) recommendations.	F 883	R24- Resident is being rounded on with provider on 10/24/2024. Nurse completing rounding will review this with provider to discuss with resident. R33- Nursing offered pneumococcal vaccine to resident on 9/30/2024 for signature to obtain consent, however resident declined vaccine, signature was obtained on declination form. Licensed Nurses and Social Services will be educated, promptly, on proper protocol when a resident consents to a pneumococcal vaccine upon admission and/or during their stay. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: The facility has determined that all residents have the potential to be affected. 3.What systemic changes will ensure that the deficient practice will not recur: Protocol for Consent for Vaccination upon admission was reviewed with Licensed Nurses and SSC. IP/DON will review residents listing of pneumovax history monthly and when residents are admitted. IP/DON will add resident, promptly, upon admission to the resident listing. Pneumococcal vaccine will be offered to residents as they become eligible. 4.How the facility will monitor its corrective actions/performance: Nursing management will complete monthly audits x6 months to ensure residents listing r/t pneumococcal		

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F 883	Continued From page 23	F 883	immunization is updated/ reviewed and/or offered to resident if applicable to ensure compliance. Corrective action completion date: November 8th, 2024.		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/23/26 through 9/26/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/23/24

Minnesota Department of Health

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2 000	Continued From page 1 the survey: H52908444C (MN101771) and H52908444C (MN99059). NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements;	2 540			11/8/24

Minnesota Department of Health

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2 540	Continued From page 2 F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect a discharge record for 1 of 12 residents (R37) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose to offer clear guidance on how to use (i.e., code) the RAI which was divided in multiple sections. The manual outlined, "Section A: Identification Information and within that section under A2105," directed an intent to record the discharge status location. The manual outlined Home/Community, Nursing Home, skilled nursing facility, short-term general hospital, long-term hospital, inpatient rehabilitation facility, inpatient psychiatric facility, intermediate care facility, hospice home, hospice facility, critical access hospital, home under care of organized home health services organization, and deceased, as options. R37's 9/3/24, discharge-return not anticipated MDS identified in section A2105 discharge status	2 540	CORRECTED		

Minnesota Department of Health

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2 540	Continued From page 3 marked as resident discharged to a short-term general hospital. R37's 8/21/24, care plan identified she wished to move back home and live in her with spouse, in the meantime R37 may need to transfer to another skilled nursing facility to be closer to home. Interview on 9/24/24 at 2:23 p.m., with registered nurse (RN)-A who identified she was responsible for completing the MDS. She reported R37 discharged to an Assisted Living facility. She revealed she must have "miss coded" the MDS and checked discharge to the hospital verses assisted living. She reported that she would need to complete a correction on that MDS to identify R37 discharged to an assisted living and re-submit that. Interview on 9/26/24 at 11:11 a.m., with administrator identified she would expect the MDS to be accurate and reflect the status of the resident. There was no policy related to accuracy of the MDS provided by the end of survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine	2 540			

Minnesota Department of Health

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2 540	Continued From page 4 compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter	21530			11/8/24

Minnesota Department of Health

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21530	Continued From page 5 must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon pharmacy recommendations to modify administration times and limit potential interaction and/or side effects for medication administered to 1 of 3 residents (R34). Findings include: Review of R34's 9/07/24, Significant change Minimum Data Set (MDS) identified she had a diagnosis of schizoaffective disorder, anxiety, chronic kidney disease, thyroid disorder and had a moderate cognitive impairment. Review of R34's 6/11/24, Consultant Pharmacist Medication Regimen Review, identified the pharmacist noted Fibercon and calcium carbonate medication may interact with levothyroxine (thyroid) medication. It is recommended that the medications be separated by 4 hours and had been administered between 7:30 a.m. and 8:00 a.m. Consider moving Fibercon to later in the day, also consider giving calcium at noon, supper, and bedtime to avoid interactions with the levothyroxine. There was no mention of how the calcium carbonate medication was to be adjusted. Review of R34's, Order Summary report identified	21530	CORRECTED		

Minnesota Department of Health

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21530	Continued From page 6 she had taken Oyster shell calcium + D (calcium carbonate) 500-5 milligram (mg)- microgram (mcg) and was to take 1 tablet three times a day for supplement use and Levothyroxine 150 mcg give 1 tablet in the morning for hypothyroidism (low thyroid levels), both with a start date of 5/17/24. Review of R34's, 6/01/24 to 6/30/24 Medication Administration Record (MAR) identified R34 had taken 30 doses of calcium carbonate at 8:00 a.m. Review of R34's, 7/01/24 to 7/31/24 MAR identified R34 had taken 31 doses of calcium carbonate at 8:00 a.m. Review of R34's, 8/01/24 to 8/31/24 MAR identified R34 had taken 31 doses of calcium carbonate at 8:00 a.m. Review of R34's, 9/01/24 to 9/31/24 MAR 25 doses of calcium carbonate at 8:00 a.m. Interview on 9/25/24 at 11:11 a.m., with the clinical pharmacist stated her recommendation for both calcium carbonate and levothyroxine medication would cause potential interaction if continued long term. Interview on 9/25/4 at 12:55 p.m., with director of nursing stated staff should have clarified the pharmacy recommendation and make necessary changes under the direction of the clinical pharmacist. Review of 5/14/24 Gradual Dose Reduction of Psychotropic Drugs policy identified pharmacy medication reviews occurred monthly, in addition, medication modification opportunities would depend on factors, including the coexistence of	21530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00939	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2024
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277			
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21530	Continued From page 7 medications, individual risk factors and pharmacological characteristics of those medications. Lastly, medication consideration to continue, discontinue or modify medications was an acceptable standard of practice to minimize or prevent adverse consequences related to medication interactions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon ASAP. Audits should be developed to monitor timeliness of action from physician, using appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21530			
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by:	21550			11/8/24

Minnesota Department of Health

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21550	Continued From page 8 Based on observation, interview, and document review, the facility failed to obtain and administer ordered pain medication patched (lidocaine) medication for 1 of 6 residents (R189). Findings include: R189's face sheet identified she was admitted to the facility in September of 2024, with diagnosis of Wernicke's encephalopathy (a disease that affects the brain), chronic pain syndrome, and dementia. Observation and interview on 9/25/24 at 8:32 a.m., with the medication aide (TMA)-A, who was preparing R189's medication identified he was unable to locate R189's lidocaine (pain) patches. He looked in the medication cart drawers and checked the medication room. TMA-A identified that R189's lidocaine patches had not been delivered. R189 had not received her lidocaine patches for the past 9 days. R189's administration record identified staff were to apply 4 lidocaine 4% external patches daily at 8:00 a.m., for chronic pain syndrome. The administration record documentation reflected there were no patches available on 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24. R189's administration record pain assessments for the previously mentioned dates revealed no pattern of increased pain. Interview on 9/25/24, at 10:00 a.m., with licensed practical nurse (LPN)-A identified she was not aware that R189 had no supply of lidocaine patches. If the medication is not available the medication aide should notify the nurse, if the medication is not available in the emergency	21550	CORRECTED		

Minnesota Department of Health

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21550	Continued From page 9 medication kit, the nurse would call the pharmacy to see when it would be delivered. If the medication could be delivered or if the resident was going to miss a dose, she would notify the resident doctor. LPN-A identified she had not been notified that R189 had no supply of her lidocaine patches, and she was unable to locate any documentation to indicate anyone at the facility had followed up with the pharmacy, notified a physician, or completed an incident report of the 9 missed doses. Interview on 9/25/24 at 1:07 p.m., with the director of nursing (DON) identified that she agreed with the above findings. She would have expected the nurse to follow up with the pharmacy to see if the medication could be delivered at the time of the first missed dose. If the medication could not be delivered causing the resident to miss a dose, she would expect the nurse to notify the physician for guidance and complete an incident report. A facility policy was requested; however, nothing was provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550			

Minnesota Department of Health

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21695	Continued From page 10	21695	CORRECTED		11/8/24
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 carpeted center hall transition space to the center hall wood floor, 1 of 1 center hall wood floor transition space to the north carpeted hall, and 1 of 1 north carpeted hall transition space to resident (R14)'s tile floor was maintained to promote a safe, sanitary, and homelike environment. This had the potential to affect 11 residents that ate in the north dining room and/or lived on the north hall. Findings include: Observation and interview on 9/23/24 at 2:33 p.m., of R14's entrance to his room identified it was observed to have broken tile with missing pieces and frayed carpet in the doorway of his room with loose strings hanging. R14 who resided in room reported he had never "hooked" his wheelchair on there "yet". He was unsure of any plan to fix the surface of the doorway. Observation on 9/24/24 at 8:42 a.m. identified the carpeted center hall connected to the wood floor in hallway in front of north dining room was missing the plastic transition piece leaving an				

Minnesota Department of Health

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21695	Continued From page 11 uneven surface and exposing the cement floor beneath. Also observed was the wood floor in center hallway that transitioned to the carpeted north hallway was also missing the plastic transition piece with some fraying of carpet noted. Observation and interview on 9/24/24 at 1:46 p.m., with maintenance director reported that staff either verbally report things that need to be fixed or that there was a program work order form that could be filled out. Observation of the areas with the maintenance director revealed he was unaware of the broken and missing tile in doorway of R14's room. He agreed that the carpet leading into doorway of R14's room was frayed with strings hanging and a potential for a staff or resident to get caught on the area and had the potential for injury. He revealed there was an identified issue with keeping the plastic transition pieces in place and he had not figured out how to secure them in order to prevent them from coming loose. The plastic transition pieces the facility used were hard for residents and staff to maneuver over and that was the reason he believed they kept getting ripped off. Observation of the transition area between the north hall and the wood flooring in the center hall and also the wood floor in center hall to the carpet in center hall were missing the plastic transition pieces leaving an uneven surface on the one side and exposed cement with frayed carpet. The maintenance director revealed he was "well aware" of the issue and had been trying to "brainstorm" what other types of products he could install for the transition between carpet and wood floor or the tile and felt it "was not a struggle" for residents and staff to go over. Observation and Interview on 9/24/24 at 1:51 p.m., with administrator identified she was aware	21695			

Minnesota Department of Health

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21695	Continued From page 12 of the missing plastic pieces between the carpet and tile in the doorways noted above. She was also aware of the missing tile in R14's entry way, however she was unaware of the severity. She agreed R14 had the potential of getting caught on the frayed carpet and becoming injured, and the missing tile was an infection control concern. She further confirmed the uneven surface between the carpeted center hall and the center hall wood floor was a concern as the cement floor was exposed and there was a potential risk for getting caught or tripping. She planned to address the issue immediately. Observation on 9/25/24 at 7:39 a.m., of maintenance director examining the area of the carpeted center hall and transition onto to the center hall wood floor with a outside contractor. The maintenance director reported the facility was able to get a contractor in to look at potential options for repair. Review of 8/13/24, Work Order Request policy identified staff were to make request in writing through the online work logbook. All verbal requests would be given low priority and be handled after written request were completed. There were no work order requests submitted for review during the survey related to the above concerns. There was no policy related to providing a safe and sanitary environment provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative	21695			

Minnesota Department of Health

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21695	Continued From page 13 maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695	CORRECTED		11/8/24
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure residents were assisted with their meal in a dignified manner for 3 of 6 residents (R1, R11, R23) who were dependent on staff to assist them with meal intake. Findings include: Observation on 9/23/24 at 12:10 p.m., while in the center dining room nursing assistant (NA)-B was observed to stand next to R1 and give him bites of food. NA-B left R1 and proceeded to obtain another meal for a different resident at which time	21805			

Minnesota Department of Health

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21805	Continued From page 14 NA-A was observed to walk over and stand next to R1 and give him bites of food. NA-B returned with R23's meal and proceeded to stand next to her and support her head (she was shaking) while giving her a bite of her food. NA-B and NA-A were observed to visit amongst each other while standing and giving bites of food to R1 and R23. At 12:24 p.m., NA-C was observed to stand between 2 residents at the table and assist R11 to take a bite of her food. During the meal service NA-A, NA-B, and NA-C were observed to stand the entire time they assisted the residents to eat their meal. R1's 8/3/24, quarterly Minimum Data Set (MDS) identified R1 had functional limitations of bilateral upper and lower extremities, he used a wheelchair, and was dependent on staff for eating and all other cares. R1 had diagnoses of hypertension, peripheral vascular disease, and multiple sclerosis. R1 was on scheduled pain medication, was identified to have loss of liquids/solids from mouth when eating or drinking. R1 had weight loss that was not physician prescribed and had a mechanically altered diet. R1's 4/9/10, nutritional care plan identified R1 would be provided pleasure foods per request. A decline was anticipated with hospice services in place. Staff were to help set up meal, wash his hands, dispense condiments, and allow to eat meal at own pace. Staff were to provide supervision as needed. R1 had a regular diet with puree texture and nectar thick consistency. He used a lipped plate and nosey cups at meals to assist with independence while eating. The care plan had no mention that R1 was dependent on staff to assist him with his meal intake. R11 7/28/24 quarterly MDS identified R11 had	21805			

Minnesota Department of Health

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21805	Continued From page 15 severe cognitive impairment, she required substantial assistance for eating and was dependent on staff for all other cares. R11 had diagnoses of hypertension, hyperlipidemia, seizure disorder, anxiety, depression, and Alzheimer's disease. R11 had no nutritional concerns. R11 took a daily antipsychotic and antidepressant. R11's 11/14/19, nutritional care plan identified R11 received assistance as needed at mealtimes. R11 was on a heart healthy diet, regular texture, and regular consistency. R23's 9/13/24, admission MDS identified her cognition was intact, she had no behaviors, she was dependent on staff for eating and all other cares. R23's diagnoses included multiple sclerosis, seizure disorder, malnutrition risk, anxiety, on scheduled pain medication. R23 took a daily antianxiety, antidepressant, and took antibiotic. R23 was being seen by occupational and physical therapy. R23's revised 9/23/24, nutritional care plan identified R23 was on a regular diet with regular texture and regular consistency. Staff were to assist by holding resident in position to eat. Interview on 9/23/24 at 12:45 p.m., with NA-B identified she stood to feed residents as it made it easier if she had to do something else or assist someone else quick with something. She was unaware of any protocol that staff should sit while assisting residents with eating their meal. Interview on 9/23/24 at 12:53 p.m., with director of nursing (DON) identified she chose not to answer if staff should be seated while assisting residents to eat their meal for a more dignified	21805			

Minnesota Department of Health

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21805	Continued From page 16 experience or if staff could stand while assisting resident during the entire meal, and reported she would provide me with the facility's policy. She then reported there "were times" when it would be appropriate for staff to stand and feed a resident such as if the staff are short and the wheelchair was tall. Typically though, she noted, staff should not stand to feed residents. She reported the facility was in process of changing the seating around and "that might have had something to do with" staff standing to feed residents. She reported there were a lot of residents who need assistance with eating, and the facility staff had just "rearranged things" and there might have been some confusion that day and felt that may have played a part in staff standing while feeding residents. Additional interview on 9/26/24 at 11:11 a.m., with DON identified the process for R23 was for staff to stand to assist her with her meal intake because of the way staff must support her head while she eats. The DON reported that she added that to R23's care plan. For all other residents staff were to bring them into the dining room and sit down to assist them with their meal intake. Review of undated, Meal Supervision and Assistance policy identified residents would be provided adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. The facility would develop and implement, and individualized care plan based on the resident assessment to address the resident's needs and goals. Staff were not to serve the meal until the attendant was ready to assist the residents. Staff were to feed residents slowly allowing plenty of time between bites. Staff were to provide a relaxing, enjoyable environment during mealtimes. Staff were to encourage the resident to participate with their	21805			

Minnesota Department of Health

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21805	Continued From page 17 meal as much as possible. Staff should continue to feed residents until the resident has had enough food or until the meal was finished. There was no mention staff should provide dignity to residents while assisting them with meals. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2024
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/24/2024. At the time of this survey, Olivia Restorative Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/23/2024

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.

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Olivia Restorative Care Center was constructed as follows: The original building was constructed in 1955, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1st addition was constructed in 1963, is one-story in height, has no basement, is fully fire	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2024
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K 000	Continued From page 2 sprinkler protected and was determined to be of Type II(000) construction; The 2nd addition was constructed in 1967, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 3rd addition was constructed in 1976, is one-story height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 36 at the time of the survey.	K 000			
K 321 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		11/8/24	

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FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 275021 Facility ID: 00939 If continuation sheet Page 4 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2024
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K 321	Continued From page 4	K 321	1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that all doors leading to hazardous areas latch and are self-closing. For the door on the soiled utility room 13, the Maintenance Director tightened the closing pump. For the Fire Door in Kitchen, the Maintenance Director changed the hinges and sanded down rough edges. As of 10/18/2024 both doors close appropriately. (Please see attached picture for door in kitchen) 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: All residents have the potential to be affected in this area. No residents were affected 3.Systemic changes will ensure that the deficient practice will not recur: The maintenance Director will follow monthly door audits in TELS to ensure doors close appropriately. The maintenance Director re-educated on regulations r/t to doors closing and latching appropriately per compliance. 4.How the facility will monitor its corrective actions/performance: The Maintenance Director will complete a monthly audit x3 months to ensure door		

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K 321	Continued From page 5	K 321			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for	K 353	audit in TELS is being completed to meet compliance. Audit results will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until substantial compliance has been achieved as determined by the committee. Corrective action completion date: November 8th, 2024 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its	11/15/24	

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K 353	Continued From page 6 the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2. These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 09/24/2024 between 9:15 and 11:45 AM it was revealed by review of documentation and observation that the following conditions were discovered during the annual fire sprinkler system testing and inspection and confirmed by the surveyor at the time of the survey and have not yet been corrected: a. Room N10 had a bent deflector b. Tub Room 14 sprinkler head was showing signs of corrosion c. In the north corridor, sprinkler heads were showing signs of corrosion d. In the north dining room, two sidewall sprinklers had bent deflectors and showed signs of corrosion 2. On 09/24/2024 between 9:15 and 11:45 AM it was revealed by observation that sprinkler heads in the following locations had paint on them: Dietary office off of dining room, Administrators Office, Room N5, and the Activities Office. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This requirement is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2. These deficient findings could have a widespread impact on residents within the facility. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that sprinkler heads maintain good working condition and are free of dents, corrosion, and paint. Summit Fire Protection has been contacted and approval for quote to complete services related to replacement of sprinkler heads was done on 10/17/2024. Awaiting confirmation when services will be completed. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: All residents have the potential to be		

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K 353	Continued From page 7	K 353	affected in this area. No residents were affected 3.Systemic changes will ensure that the deficient practice will not recur: The Maintenance director will complete a monthly check through the electronic system TELS to ensure that sprinkler heads are in good condition. The Maintenance Director was re-educated on regulations r/t this deficiency to ensure compliance. 4.How the facility will monitor its corrective actions/performance: The Maintenance Director will complete a monthly audit x3 months to ensure sprinkler head check in TELS is being completed to meet compliance. Audit results will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until substantial compliance has been achieved as determined by the committee. Please see attached for time waiver request due to extension needed on parts arrival through vendor and installation. Please see email thread with Summit Fire. Corrective action completion date: November 15th, 2024.		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363			11/8/24

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K 363	Continued From page 8 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA	K 363	Preparation and/or execution of this plan do not constitute admission or agreement		

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K 363	Continued From page 9 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/24/2024 between 9:15 and 11:45 AM, it was revealed by observation the door to resident room S13 did not latch when the door was pulled shut. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that corridor doors are able to latch when shut. The maintenance director replaced closing latch on resident room door s13 on 10/11/2024. Door now latches appropriately. (Please see attached picture) 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: All residents have the potential to be affected in this area. No residents were affected 3.Systemic changes will ensure that the		

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K 363	Continued From page 10	K 363	deficient practice will not recur: The Maintenance Director will follow monthly door audits in TELS to ensure doors close appropriately. The Maintenance Director was re-educated on regulations r/t this deficiency to ensure compliance. 4.How the facility will monitor its corrective actions/performance: The Maintenance Director will complete a monthly audit x3 months to ensure door check in TELS is being completed to meet compliance. Audit results will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until substantial compliance has been achieved as determined by the committee Corrective action completion date: November 8th, 2024.		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		11/8/24	

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K 372	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/24/2024 between 9:15 and 11:45 AM, it was revealed by observation that there were red, white, and blue cables going through the south smoke barrier wall above the smoke barrier doors without fire caulking filling the hole. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 372	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to maintain smoke barriers per Life Safety Code ensuring that fire caulking is used to fill holes on fire walls after work has been completed by contracted service providers. The Maintenance Director filled the hole with fire caulking on the South Smoke Barrier wall on 10/11/2024. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected:		

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K 372	Continued From page 12	K 372	All residents have the potential to be affected in this area. No residents were affected. 3.Systemic changes will ensure that the deficient practice will not recur: The Maintenance Director will complete a monthly Smoke Barrier Check in TELS, to ensure compliance. The Maintenance Director has been re-educated on regulations r/t this deficiency. 4.How the facility will monitor its corrective actions/performance: The Maintenance director will complete monthly audits x3 months to ensure the monthly TELS Smoke Barrier check is being completed to maintain compliance. Corrective action completion date: November 8th, 2024		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible	K 923			11/8/24

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K 923	Continued From page 13 construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on residents within the faciility. Findings include: On 09/24/2024 between 9:15 and 11:45 AM, it was revealed by observation that empty and full oxygen cylinders were stored in the oxygen storage room without being separated from each other.	K 923	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This requirement is not met as evidenced by: Based on observation and staff		

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K 923	Continued From page 14 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on residents within the facility. 1.How the corrective action will be accomplished for identified affected individuals: It is the policy of Olivia Restorative Therapy and Nursing to ensure that full and empty oxygen cylinders stored in the oxygen room are separated from each other. On 10/18/2024 The Maintenance Director placed a Divider in the Oxygen Room to separate the full cylinders from the empty cylinders. The signage of where to place empty and full cylinders is also in the room. 2.How will other individuals with the potential to be affected or in similar situations be identified and protected: All residents have the potential to be affected in this area. No residents were affected. 3.Systemic changes will ensure that the deficient practice will not recur: The Maintenance Director will complete a monthly check through the electronic System TELS to ensure empty/full cylinders are placed appropriately. The Maintenance Director was re-educated on regulations r/t this deficiency to ensure compliance.		

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K 923	Continued From page 15	K 923	Licensed Nurses and TMA's are the only facility floor staff who have access oxygen storage room. They will be promptly educated on this process by the Maintenance Director. 4.How the facility will monitor its corrective actions/performance: The Maintenance Director will complete a monthly audit for x3 months to ensure the Oxygen cylinder placement check in TELS is being completed to meet compliance. Audit results will be reviewed by the Risk Management/Quality Assurance Committee, monthly, until substantial compliance has been achieved as determined by the committee Corrective action completion date: November 8th, 2024.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: September 26, 2024

Dear Administrator:

On November 5, 2024, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On November 11, 2024, November 18, 2024, and December 10, 2024, the Minnesota Departments of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine that your facility is back in compliance.

Also, as authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 26, 2024 did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

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Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

Re: Reinspection Results
Event ID: I9L712

Dear Administrator:

On November 11, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 26, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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