Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 20, 2023

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

RE: CCN: 245290
Cycle Start Date: September 6, 2023

Dear Administrator:

On September 28, 2023, we informed you that were imposing enforcement remedies.

On October 16, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 6, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 6, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 6, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Olivia Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 6, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 6, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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/ltc_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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 28, 2023

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

RE: CCN: 245290
Cycle Start Date: September 6, 2023

Dear Administrator:

On September 21, 2023, we informed you that we may impose enforcement remedies.

On September 13, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

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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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

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CFR § 488.412 and § 488.456.

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Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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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/ltc_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.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE 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 On 9/11/23 through 9/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		10/11/23

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

Electronically Signed | 10/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE 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 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: Refer to K0918 for findings.	E 041	1. It is the policy of Olivia Restorative Therapy and Nursing to perform 2-hour generator load testing on a yearly basis through a contractor. 2. All residents have the potential to be affected in this area. No residents were affected. 3. Yearly generator load testing has been scheduled in TELS, to ensure completion according to regulations. 4. Yearly audit completed by Maintenance Director or Designee to ensure generator load testing is completed by Interstate for regulation compliance. 5. Corrective action: A phone call was completed immediately to schedule generator load testing with Interstate, a contracted vendor. Testing was scheduled and completed on 10/4/2023.	
F 000	INITIAL COMMENTS On 9/11/23 through 9/13/23, 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 with NO deficiencies cited: H52905342C (MN88684), H52905349C (MN89355) and H52905294C (MN89540).	F 000		

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F 000	Continued From page 4 The following complaints were reviewed: H52905322C (MN91532) with a deficiency cited at F684 related to an incidental finding. 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 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		10/11/23

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	245290	A. BUILDING _____ B. WING _____	C 09/13/2023

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F 561	Continued From page 5 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor 1 of 1 (R18) residents' choice for male aid to assist with bathing. Findings include: R18's 6/20/23, quarterly Minimum Data Set (MDS) identified R18 required assist of 1 staff with oversite and encouragement for transfers, toileting, and personal hygiene. R18 had diagnosis of depression, heart failure, obesity, insomnia, and history of alcohol abuse. R18's care plan printed 9/13/23, identified he needed several cues to bath and shower requiring much prompting and encouraging to wash his body and hair, hands on may be required. R18's care plan lacked any indication that he preferred a male staff for assistance with bathing. Interview on 9/11/23 at 12:01 p.m., R18 identified he did not want a female aid to assist him with bathing, he identified he reported this to the social service designee (SSD), "I told her I would not	F 561	1. It is the policy of Olivia Restorative Therapy and Nursing to honor residents' choices. The corrective action with R18 was remedied immediately, while state surveyors were still on site 9/6/23. His care plan has been updated to state that he prefers to have a male staff member assist him with his bath. 2. All residents have the potential to be affected in this area. Nursing staff and CNA staff have been re-educated that it is a resident's right to choose who they want to bathe them. All regularly scheduled staff have been educated as of 9/13/23, while state surveyors were still present. PRN and on call staff will be educated the next time they work by October 11, 2023, which is our next all staff meeting. All staff responsible for writing care plans have also been re-educated to update the care plan right away when they become aware. 3. All staff have been re-educated on residents' right to choose. This will continue to be addressed on hire, at staff	

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F 561	Continued From page 6 shower with a woman". R18 reported SSD told him he would have to work it out "then they mark it as refused, like it's my problem", he identified he did not think it should be his problem, the SSD should be helping me fix this. Interview on 9/12/23 at 8:30 a.m., NA-(A) identified she had not known that R18 preferred a male for bathing assistance and stated "if I needed to know something about a resident preference I would look at there care plan". Interview on 9/12/23 at 9:40 a.m., SSD identified R18 had reported to him that he prefers a male for assistance with showers, she identified that when a resident makes a request, she tells the medication aid and a nurse aid on duty. She agreed that R18 has a right to choose to have a male aid with bathing. SSD further identified that the facility does not have a process for sharing preferences and updating the care plan. Interview on 9/12/23 at 9:57 a.m., DON agreed with the above findings and identified her expectation for all staff was to pass on the information to the appropriate department, a progress note should be entered in the resident chart, and the care plan should be updated as soon as the resident request is made. Review of R18 progress notes had no mention that he had ever requested a male for assistance with bathing. Policy was requested, nothing was provided during the survey period.	F 561	meetings, yearly training, and other times as applicable. 4. Residents will be asked at admission and at every care conference what their preferences are on bathing. The Care Plan will be updated as applicable. A bathing preference audit has been completed by the Social Service Director, interviewing residents about their bathing preference. Corrective action regarding residents' rights was started when the state surveyor was still here 9/12 and 9/13. 5. All regularly scheduled staff signed off on the corrective action by 9/13. PRN employees will all be educated on their next scheduled shift by October11 (all staff meeting). This will be brought to QAPI for review and commendations.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		10/11/23

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F 684	Continued From page 7 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess 1 of 1 resident (R241) following a fall resulting in delayed evaluation and treatment by a physician. Findings include: R241's 9/13/23, Admission Record identified diagnosis of pelvic fracture, COVID-19, emphysema, aspiration pneumonia, spinal stenosis, low back pain, osteoporosis, shortness of breath, weakness, fatigue, abnormal weight loss, other abnormal finding of lungs, wedge compression fractures, and history of falling. R241's 2/26/23, significant Minimum Data Set (MDS) assessment identified R241's cognition was moderately impaired. R241 required extensive assistance of one staff for bed mobility, transfers, walking, toileting, personal hygiene, and dressing. R241 was able to eat independently after setting up assistance. R241 was occasionally incontinent of bowel and bladder, she had one stages one and two stage two pressure ulcers. R241 had pain that she rated a 4 on a scale of 1 to 10 and took an opioid 1 time during the assessment period. R241 used	F 684	1. All residents have the potential to be affected in this area. All nurses have been educated on the process of comprehensively assessing a resident to prevent delay in evaluation and treatment by all nursing staff and a physician. 2. All nurses have been educated on the Acute Condition Changes – Clinical Protocol for assessment and recognition of resident subtle but significant changes. 3. The education will be given on hire, at annual training, and at other times as needed. 4. DON or designee will audit the daily resident reports for any subtle or significant changes to ensure proper identification, documentation, and response to treatment(s). Audits will be completed daily x 6 weeks. Continued feedback, guidance, and education will be given to nursing. 5. Corrective action was accomplished as of 9/15 and will be ongoing as needed.	

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F 684	Continued From page 8 oxygen and was on isolation during the assessment period. R241's 1/24/23, care plan identified R241 required assistance of one staff when ambulating with her walker. R 241 was on oxygen's therapy continuously at 2-10 liters per minute via nasal cannula for shortness of breath. R241 has pain related to recent pelvic fracture and compression fractures. R241 was at high risk for falls related to history of falls related to weakness and fall prior to admission, staff are to encourage R241 to use her call light for assistance and ensure she wears appropriate footwear. R241's 2/27/23, progress note at 7:46 a.m., identified staff heard R241 calling out and she was found on the floor in her room. R241 was identified as having good range of motion in all her extremities. She was identified as having a scrape of 9 centimeters (cm) by 0.2 cm to her right side. The progress notes further identified that staff assisted R241 up into her recliner. R241 had complained of right-side pain and was given Tylenol with relief noted. R241's 2/27/23, incident report identified at 7:45 a.m., staff heard resident call out and resident was found on floor between bathroom and room door, with her walker besides her. Resident was noted to have and abrasion to her right rear iliac crest (the curved part at the top of the hip) staff assisted R241 up to the recliner. R241 mobility was normal, and she ambulated with assistance. The report identified that R241 was oriented to person, alert but confused. The director of nursing was notified, the physician and the family all timely. There was no mention of R241 complaining of any pain on her right side.	F 684	The audits and education on proper clinical protocols will be reviewed in QAPI for further recommendations.	

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F 684	Continued From page 9 R241's 2/27/23, physician notification identified R241 had been found lying on the floor in her room. She had a scrape to her right side that was 9 cm x 0.2 cm. She had good range of motion. There was no mention of her complaining of any pain. R241's 2/27/23, progress note at 10:50 a.m., identified that R241 forgot to put her call light on this morning and attempted to walk herself to the bathroom and fell onto her right side. R241 initially complained of some discomfort on her right side. The charge nurse had found a 9 cm x 2 cm scrape on her left lateral rib area. R241 had reported it hurt and was given some Tylenol. The nurse documented that R241's lung sounds were somewhat diminished in both bases. The progress note identified R241 was on isolation due to having COVID at this time. R241's 2/27/23, progress note at 2:56 p.m., identified that R241 complains frequently about being short of breath however, this had been since admission for aspiration pneumonia and her oxygen levels were normal. R241's 2/27/23, progress note at 7:04 p.m., identified tramadol 25 milligrams (mg) every 6 hours as needed for severe pain rated 7-10 on pain scale had been given with additional note at 8:59 p.m., that identified the pain medication was effective. R241's February 2023, Medication Administration Record identified an order for tramadol HCL 25 mg by mouth every 6 hours as needed for pain, severe pain rated 7-10 on pain scale. R241 had taken the tramadol on 2/6/23 at 5:05 a.m., when	F 684		

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F 684	Continued From page 10 she rated her pain at a 4 with the medication being documented as effective. She took the tramadol on 2/24/23 at 7:35 p.m., when she rated her pain a 5 with the medication being documented as effective. She also took the tramadol on 2/27/23 at 7:04 p.m., when she rated her pain at a 5 with the medication being documented as effective. All three times she was administered the medication in February she had rated her pain below the identified pain rating of 7-10 per the order. R241's 2/28/23, progress note at 5:50 a.m., identified staff entered R241's room and thought she was not breathing. Staff called the nurse who noted R241 was able to respond to staff calling out her name but was struggling to breath. The nurse called 911 for an ambulance and left a message for family to call the facility. R241 left the facility in the ambulance at 6:01 a.m. R241's 2/28/23, progress note identified as a late entry at 6:12 p.m., revealed that R241 remained in the hospital with diagnosis of 3 rib fractures and a pneumo-thorax. Family was at the hospital and the hospital would keep the facility updated. R241's 3/1/23, progress note at 6:11 p.m., identified the hospital had called with an update revealing R241 was doing better however, she would be staying in hospital yet at this time. R241's 3/2/23, progress note at 2:14 a.m., identified the hospital called with an update that R241 had passed away at 1:39 a.m. Interview on 9/13/23 at 1:22 p.m., licensed practical nurse (LPN)-A identified if a resident has	F 684		

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F 684	Continued From page 11 a fall, the nurse was to assess them before they are assisted off the floor with a mechanical. The nurse would assess range of motion, pain, assess neurological status (neuro's) if they hit their head or if the fall was unwitnessed. The nurse would check vital signs and determine if the resident needed to be evaluated by a provider and/or sent to the emergency department (ED). LPN-A revealed if a resident complained of pain while being checked over after a fall she would have sent a resident seen to the ED as it was "better to be safe" even if it turned out to be nothing verses having it turn into something later. Interview on 9/13/23 at 2:58 p.m., with the director of nursing identified when a nurse does an assessment following a fall they should be documenting what they see at first such as the surrounding, the assessment of the resident, are they hurt, do they have pain, where the pain was, what the residents range of motion was like, what the resident says, what type of assessments the nurse completed such as vitals, neuro's, pain rating, palpitations, what witness reported, if they sent the resident to the ED or not and why, and who they notified. She identified that there was not an actual format for the nurse to follow but that would be the "basics" that she would expect to see documented. She agreed that R241's initial nurses note following her fall lacked detail of the assessment completed by the nurse. She did report hindsight she wished they would have just sent her over to be evaluated initially even if it would have turned out to be nothing at first. Review of March 2018, Acute Condition Changes policy identified the nurse shall collect pertinent information to report the the provider about a resident with an acute change of conditions such	F 684		

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F 684	Continued From page 12 as vital signs, neurological status, current level of pain, changes in pain level, level of consciousness, and any recent events or illness. A call to the on-call physician should be made and based on the urgency of the situation for example and emergencies, the nurse will call or page the physician and request a prompt response. The nurse and physician will discuss and evaluate the situation and determine if condition can be managed effectively at the facility or if there is a need to be seen in hospital.	F 684		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to develop an individualized care plan to address the emotional and psychosocial needs of 1 of 1 resident (R17) with a history of PTSD and trauma. Findings include: R17's 7/12/23 admission Minimum Data Set (MDS) identified R17 had diagnoses of post traumatic stress disorder (PTSD), insomnia sue	F 742	1. It is the best practice of Olivia Restorative Therapy and Nursing that when a resident displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or PTSD, this is identified, and they receive the appropriate treatment and services to attain the highest practicable mental and social wellbeing.	10/11/23

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F 742	Continued From page 13 to other mental disorders, and anxiety disorder and was being administered antipsychotic medication (Rexulti and Effexor XR) for bipolar disorder and an anti-anxiety medication (diazepam) for her anxiety. R17 had intact cognition, had a mood score indicating severe depression. R17 required limited assistance by staff for the majority of Activities of Daily Living (ADL)with regard to mobility and dressing. R17 was independent with eating. R17 had no behaviors noted within the look-back assessment period. R17's current, undated care plan identified R17 was responsible for meeting her emotional, intellectual, physical and social needs and had an actual or potential nutritional problem due to obesity. There were no other interventions care planned for R17 related to her history of trauma and PTSD or anxiety and bi-polar diagnoses. Further review of R17's electronic medical record (EMR) assessments identified there was no trauma assessment included in R17's EMR. Observation and interview with R17 on 9/11/23 at 3:36 p.m. identified she was prone to quick tempered verbal outbursts if she felt provoked as witnessed when an unidentified male staff member (U-A) knocked on the door and asked R17 if she would like to walk. R17 angrily stated "Can't you see I'm busy?!!". U-A apologized for the interruption. R17 continued her verbal angry outburst towards U-A. U-A then apologized again and closed the door. R17 relayed she doesn't like baths from male staff members. R17 stated she felt safe but was very frustrated some staff spoke broken English. She was especially visibly irritated when speaking about males. Further	F 742	2. All residents have the potential to be affected in this area. The care plan of R17 was updated to reflect psychosocial and emotional needs and/or services of the resident. 3. Education was given to the social services director on individualized needs for emotional and psychosocial needs of residents and the need to document in the individualized care plan for those services / needs. Mental Health needs of residents will be identified on admission and continually to ensure all needs are addressed in a timely manner. Care plans will continue to be re-evaluated quarterly or with significant change at resident care conferences. 4. Audits will be used to monitor documentation accuracy of current care plans. The audits will be completed by the social services director or designee daily x 3 weeks, and weekly x 3 months with the results of the audits brought to the QAPI committee for further recommendations.	

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F 742	Continued From page 14 observations and quick interactions with R17 throughout the day on 9/12/23 and again on 9/13/23 when R17 was either seen in her room or in the hallways identified she was pleasant to this surveyor and female staff but easily disgruntled by male staff. R17's progress notes identified on: 1) 7/19/23, R17 was seen by her primary care physician (MD)-A. MD-A noted the visit was to discuss R17's depression. MD-A noted that day was the anniversary of R17's family member by suicide. R17 had diagnoses listed of PTSD, Bi-Polar disorder, anxiety disorder, and chronic pain syndrome. Her mood was note to be positive. MD-A recommended staff continue her Effexor XR 300 milligrams (mg) daily, diazepam 10 mg daily, diazepam 20 mg daily, and was stable on those medications. 2) 8/17/23, R17 was seen by her rural psych physician (PA)-B via telehealth video conferencing. Staff had reported R17 was compliant with her medications and her mood appeared "even". She reported she was sleeping well and met with the Talk Therapist a couple times per month. Social services was looking for potential assisted living options for R17 and was working on getting an order to restart physical therapy. R17 was starting to do things she enjoyed such as use of essential oils. R17 reported to PA-B she "doesn't belong in a nursing home". She was noted to be normally calm and pleasant, however could be demanding, impatient, needy and particular. She denies suicidal ideation, but does state thoughts of "what is the point of being alive". She had not wished to die or have any intent to do so. She had complained about ongoing chronic pain, complaining it was ineffective. She noted she	F 742		

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F 742	Continued From page 15 wanted to "feel better". Facility staff reported to PA-B R17 told them her family member had committed suicide. A close friend whom she had lived with dies while in their home. After that friend's death, R17 was homeless. Staff also reported R17 had drug-seeking behaviors. She would often become very upset if her medications were not exactly on time. R17 reported she gets high anxiety from being around other people due to becoming "de-socialized" during COVID. She reported she was unable to eat in the dining room due to being around others. She reported a history of trauma and abuse, but had not wished to discuss details and denied hallucinations, paranoia or delusional thoughts. R17 had 2 suicide attempts i the past, one after her family member died and another in the 1990's. R17 reported when her family member committed suicide, she was paranoid and delusional at the time. A full history could not be obtained from R17 due to her desire to discuss her history. PA-B was trying to get copies from her previous mental health provider. PA-B noted R17's Effexor was above the maximum dose in a 24 hour period, however she was made aware of the risks associated and had consented to the higher dose. Rexulti was initiated in an attempt to decrease her Effexor dose. 3) 9/5/23, the social services designee (SSD) visited with R17. R17 reported she was feeling very tired. Her eyes reportedly looked quite heavy during the visit. R17 shared she had more anger towards the loss of her family member. The SSD explored coping options with R17 of journaling or writing a letter to her deceased family member to express her feelings. R17 reported she may start those interventions. 4) 9/12/23, the SSD attempted a visit at 9:30 a.m., but the resident was still in bed. SSD then	F 742		

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OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

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F 742	Continued From page 16 asked for a later visit which was completed that afternoon. R17 was noted to have had a flat effect (person experiences emotional flattening or blunting) and her eyes looked heavy. R17 denied thoughts of suicidal ideation at that time. There was no mention the SSD was going to update R17's care plan to include known behaviors, triggers for those behaviors, or interventions staff could attempt to assist R17 in coping with her diagnoses. Interview on 9/12/23 at 4:13 p.m. with licensed practical nurse (LPN)-A and LPN-B identified they were aware R17 could have a verbal outbursts and easily became irritable. Staff tried to give her reassurance and provide a calming environment. They were aware she had not liked men bathing her. R17 enjoyed aromatherapy. Both agreed none of those interventions were on R17's care plan and both were unsure about details surrounding her past diagnoses of PTSD and traumatic life experiences. Interview on 9/12/23 at 4:20 p.m., with the social services designee (SSD) and the talk therapist identified both agreed a comprehensive assessment and identified interventions related to R17's trauma and PTSD were critical in ensuring her psychosocial well-being. The SSD agreed R17's care plan lacked any detail surrounding those events, what may trigger reoccurrence, or how to manage behaviors R17 may exhibit. Review of the August 2022, Trauma-Informed and Culturally Competent Care policy identified nursing staff were to be trained on trauma screening and assessment tools. Traumatic events which may affect residents may include physical, sexual or emotional abuse,	F 742		

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F 742	Continued From page 17 interpersonal violence, and serious injury or illness. Trauma survivors transitioning to an institutional setting with loss of independence could trigger profound re-traumatization. Common triggers included experiencing a lack of privacy or confinement in a small space, exposure to loud noises, sounds, smells and physical touch. Staff were to select the Trauma-Informed Care Screening and Assessment toolkit for further resources and establish an environment of physical and emotional safety. Screening was to include their trauma history, type, severity, duration, depression, concerns with sleep, behavioral concerns, and physical health concerns. Residents were to have a developed individualized care plan that addressed their past trauma in collaboration as appropriate. Staff were to also recognize any relationship between past trauma and current health concerns.	F 742		
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(g). 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.	F 755		10/11/23

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F 755	Continued From page 18 §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 review the facility failed to follow nursing standards of practice for 1 of 25 medication administrationobservations. The facility also failed to follow the 5 rights of medication administration to ensure staff dispensed the correct dose of diazepam 2.5 milligrams, for 1 of 1 resident (R142). The facility also failed to check the medication administration record against the medication label prior to giving medication for 4 of 17 residents (R17, R19, R20, and R142). The facility also failed to ensure 1of 1 resident (R31) had medication available for administration. Findings include: Observation and interview on 9/12/23 at 8:54 a.m., with trained medication aide (TMA)-A obtained R17's diazepam 10 milligrams (mg) from the double locked box on the north medication cart. The order on the electronic	F 755	1. It is the best practice of Olivia Therapy and Nursing to follow nursing standards regarding medication administration. Corrective action was accomplished by matching the label to the MAR. Nursing staff and TMAs were re-educated on nursing standard of practice for medication passing, including the 5 rights of medication passing. TMAs and nursing staff were re-educated on the NO meds available policy implemented in February 2023. 2. All residents have the potential to be affected by this. Residents will be protected by the systemic changes listed in #3. 3. Immediate education was completed. Further, in-person training will be completed at the facility staff meeting on	

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F 755	Continued From page 19 medication administration record (MAR) identified: Diazepam 10 mg give 1 tablet in morning related to anxiety. TMA-A removed the diazepam blister pack from the locked box and opened the narcotic count book double checked the count and punched out a pill into the medication cup. She then handed the diazepam blister pack to this writer to review the label. The label identified diazepam 10 mg give 2 tablets at bedtime. When writer questioned the label TMA-A reported R17 did get 2 tablets at night and then pulled out a sticker and said when the label was wrong staff were to put a sticker on the label. TMA-A applied the sticker which indicated "change in direction" and continued to dish up the rest of R17's medications. TMA-A finished and charted the medication administration and moved onto the next resident never stopping to verify the order with the charge nurse. Interview on 9/12/23 at 9:24 a.m., with licensed practical nurse (LPN)-B identified the pharmacy would not send out new labels if the facility found that a label was incorrect. The facility was to place a change in direction sticker on the label until a new blister card was sent out. For R17 she should have a blister pack card for the morning dose and a blister pack card for the evening dose as she had two different doses. Staff should be taking the dose from the correct blister pack and letting the charge nurse know when it is getting close to empty so it could be re-ordered. She indicated the morning card most likely ran out and staff probably started to just take from the pm card which they should not have done. Observation and interview on 9/12/23 at 9:56 a.m., with trained medication aide (TMA)-A of the north medication cart. Verification of the double	F 755	October 11. R17 immediately had a sticker placed on labels of the two medications in question; diazepam and hydrocodone-acetaminophen stating change in direction and had a new card with correct labeling ordered immediately reflecting correct dosages for am & pm administration. R19 direction change sticker was placed on medication card for the medication hydrocodone-acetaminophen to reflect appropriate administration times. R20 change of direction sticker placed on medication card for oxycodone to reflect appropriate administration. R142's 5mg card of diazepam was removed immediately and a new card was ordered with the correct administration directions of 2.5mg. R31's nebulizer medication was ordered immediately, staff educated on the policy "No Med Policy" that was created February 2023. 4. Medication pass audits will be completed. The RN supervisor or designee will do a medication pass audit twice weekly for 6 weeks and then weekly for 4 weeks with re-education completed as applicable. 5. Corrective action was completed by 9/13. Education, competencies, and audits will be brought to QAPI for further review and recommendations.	

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F 755	Continued From page 20 locked narcotic medications located in the north medication cart against the narcotic bound book and the electronic medication administration record (MAR) identified the following: 1) R17 had the following order: Hydrocodone-acetaminophen 5-325 milligrams (mg) give 2 tablets by mouth at bedtime for pain and Hydrocodone-acetaminophen 5-325 mg 1 tab every 8 hours as needed (prn) for pain. The label on R17's Hydrocodone-acetaminophen 5-325 mg blister pack identified Hydrocodone-acetaminophen 5-325 mg give 2 tablets by mouth at bedtime for pain, there was no mention of the PRN order on the label. The PRN Hydrocodone-acetaminophen 5-325 mg had been given 11 times so far in September. 2) R19 had the following order Hydrocodone-acetaminophen 5-325 mg give 1 tablet every 12 hours PRN for pain. The label on R19's Hydrocodone-acetaminophen 5-325 mg blister pack identified Hydrocodone-acetaminophen 5-325 mg give 1 tablet every 8 hours. The PRN Hydrocodone-acetaminophen 5-325 mg had been given 17 times so far in September. 3) R20 had the following order Oxycodone HCl 5 mg PRN for severe pain no more than 2 tablets in one day, doses must be at least 4 hours apart. The label on R20's Oxycodone HCl blister pack identified Oxycodone HCl 5 mg three times a day. The PRN Oxycodone HCl 5 mg had been given 11 times so far in September. TMA-A revealed that staff were to read the order, check the label as part of medication administration and confirmed that R17, R19, and R20's medication labels were incorrect. She confirmed that the incorrect labels should have been caught and reported to the charge nurse. TMA-A revealed that the charge nurse should	F 755		

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F 755	Continued From page 21 have verified the order and a change in direction sticker should have been added to the label until the new blister pack arrived. Observation and interview on 9/12/23 at 10:39 a.m., with LNP-A of the south medication cart. Verification of the double locked narcotic medications located in the south medication cart against the narcotic bound book and the electronic MAR identified the following: 1) R142 had the following order: diazepam 5 mg give 1/2 tab every 6 hours. The label on R142's diazepam 5 mg blister pack identified diazepam 5 mg 1 tablet twice a day PRN. The PRN diazepam 5 mg had been given 5 times so far in September. LPN-A confirmed that the label did not match the order and that the diazepam 5 mg had been given 5 times and should have been caught before today. LPN-A confirmed staff were to review the order in the electronic medication administration record (MAR) then check the label on the medication prior to giving the medication. Interview on 9/13/23 at 8:33 a.m., with LPN-A identified if the TMA giving medication found that an order and a medication label did not match, the TMA should be coming to the charge nurse to have the order verified before giving the medication. Interview on 9/13/23 at 2:58 p.m., with the director of nursing identified that staff working the medication cart should be checking the MAR against the medication label prior to giving the medication to ensure it was correct. If staff found a discrepancy, they should be going to the charge nurse to have the order clarified and place a direction change sticker on the label as the pharmacy will not send out new labels. She	F 755		

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F 755	Continued From page 22 confirmed that the TMA should place a sticker on the label identifying that there was a change in direction after checking with the charge nurse. For R142 she reported that the ER had initially sent the order to the pharmacy prior to R142 arriving at the facility and the medications were later delivered. Staff should have caught the discrepancy the first time the diazepam was used as the order R142 arrived with was not the same as what the pharmacy had received and therefore the label was not correct. She confirmed had the nurse checked the label against the order it would have been caught. She further confirmed that R142 had received a full dose of 5 mg verse a 1/2 dose of 2.5 mg all 5 time he was given the diazepam PRN medication. She identified that there was a need for additional training, and she would be moving forward with that. Review of February 2023, Medication Labeling and Storage policy identified nursing staff was responsible for maintaining medication storage in a safe manner. Controlled substance are separately locked distributions systems in which minimal and a missing dose can be readily detected are used. If a medication has an improper or incorrect label staff are to contact the dispensing pharmacy for instructions regarding returning or destroying these items. Only the dispensing pharmacy may alter the label on a medication package. Review of November of 2022, Accepting Delivery of Medications policy identified nurse accepts each medication delivery first by verifying the order. If there are any discrepancies the nurse will notifies the agent and note them on the delivery ticket, returning the incorrect medication. The nurse and the delivery agent must sign the	F 755		

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F 755	Continued From page 23 ticket and the dispensing pharmacy, consultant pharmacist, and director of nursing are notified. Review of April 2019, Administering Medication policy identified the nurse giving the medication should be checking the label to ensure the right dose, the right medication, the right time, and method before giving a medication. R31's 6/16/23, Significant change Minimum Data Set (MDS) identified R31 need extensive assistance with bed mobility, dressing, transfers, and personal hygiene. He had diagnosis of asthma, weakness, ataxia, and Chronic obstructive pulmonary disease (COPD). R18's brief interview for mental status (BIMS) assessment identified he had a severe cognition deficit. R31's care plan printed 9/13/23, identified he had respiratory difficulty related to diagnosis of asthma and staff should ensure R31 had his scheduled nebulizer treatments administered as scheduled to avoid complications with breathing. Interview on 9/11/23, at 5:12 p.m., R31 identified that the facility often runs out of his "asthma medications" R31 reported they tell him that the pharmacy ran out and they must wait until they can get a refill. Review of R31's 9/1/23-9/30/23 medication administration record identified R31 is to be	F 755		

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F 755	Continued From page 24 administered a pulmicort inhalation treatment and ipratropium-albuterol inhalation treatment twice daily. The administration record further identified R31 did not receive either of these treatments on 9/9, in addition was not administered either dose of his pulmicort inhalation treatment on 9/11. Review of R31's pharmacy re-ordering details report identified R31's ipatropium-albuterol medication had not been ordered until 9/10/23, the day after the medication had run out. Interview on 9/13/23 at 2:46 p.m., DON agreed with the above findings and identified it was her expectation that staff would re-order medication 3-4 days prior to running out. If the medication is out, she would expect staff to notify the pharmacy and "they will send a runner to deliver the medication", she reported R31 should not have missed any doses of his asthma medication, staff did not follow the process correctly. Review of the undated policy for no medication in house provided by facility identified the nurse should call the pharmacy and enter a progress note.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		10/11/23

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F 757	Continued From page 25 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor for side effects for 1 of 5 residents (R25) reviewed for unnecessary medications. Findings include: R25's 9/13/23, Admission Record identified the following diagnosis of hemiplegia, epilepsy, liver cell carcinoma, dementia with behavioral disturbance, dysphagia, biliary cirrhosis, and glaucoma. R25's care area assessment (CAA) identified R25 took a scheduled antidepressant, sertraline. Care plan considerations will be addressed to minimize or slow decline, avoid complication, maintain functioning, and minimize risks. No other information identified, no mention of the antipsychotic medication Seroquel. R25's 8/11/23, quarterly Minimum Data Set (MDS) assessment identified R25 had moderate cognitive impairment, had verbal behaviors 1 to 3 days, had other behaviors not directed at others 1 to 3 days and required total assistance from 2	F 757	1. It is the policy of Olivia Restorative Therapy and Nursing that each resident s drug regimen must be free from unnecessary drugs. 2. All residents have the potential to be affected in this area. All nursing staff are currently educated on unnecessary medication use. 3. All nursing staff are re-educated on importance of AIMS assessments for residents who have an order for antipsychotic drugs. Collaboration will continue with Polaris Pharmacy monthly, to ensure accurate review of all resident medications. AIM's assessment for R25 was completed immediately to monitor for side effects and complications and moving forward are scheduled quarterly. 4. An audit will be completed monthly x 6 months by facility RN supervisor or designee, to review AIMS assessment	

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F 757	Continued From page 26 staff for all cares. R25 required extensive assistance of 1 staff for eating. R25 had a life expectancy of 6 months or less to live and was receiving hospice services. R25 took a daily antipsychotic medication. R25's undated, current care plan identified behavior problem of making accusations against staff and others as well as being verbally inappropriate. Interview on 9/13/23 at 2:58 p.m., with the director of nursing identified typically the nurse enters an order to complete abnormal involuntary movement scale (AIMS) assessment when a resident was taking an antipsychotic medication. She would expect that residents receiving antipsychotics such as Seroquel would have an AIMS assessment (used to monitor for involuntary movements known as tardive dyskinesia (TD). These side effects can develop after long-term use of antipsychotic medications). Review of March 2019, Behavioral Assessment, Intervention and Monitoring policy identified residents that are treated with antipsychotic medications would be monitored for side effects, complications such as abnormal involuntary movements, or lethargy. The facility will monitor for dose reductions to minimize side effects while maintaining therapeutic effectiveness.	F 757	completion for residents who are taking antipsychotic drugs to ensure compliance. 5. Corrective action: AIMS assessment for resident (R25) was completed immediately on 9/13/2023 and are scheduled quarterly for all residents as needed. Audits will continue monthly x 6 months and brought to QAPI for further recommendations.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		10/11/23

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F 761	Continued From page 27 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to verify and document lorazepam 1 milliliter (ml) vials located in the facilities emergency kit kept in the medication room refrigerator. Findings include: Observation and interview on 9/12/23 at 10:22 a.m., with licensed practical nurse (LPN)-A identified the emergency kit in the refrigerator contained Ativan injection 1ml vial (lorazepam injection 1 ml vial 2mg/ml) injectable quantity 2 vials. The e-kit was closed with a red plastic tag with number 1489960. LPN-A reported that since the facility switched to using a different pharmacy	F 761	1. It is the best practice of Olivia Restorative Therapy and Nursing that all controlled substances be stored in a double locked compartment and maintain compliance with documentation and verification of controlled substances. 2. All residents have the potential to be affected in this area. Nursing staff and TMAs are re-educated on nursing standard of practice for storage, verification, and documentation of controlled substances. 3. Nursing staff have been educated on verification and documentation of	

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F 761	Continued From page 28 service the nurses no longer were verifying and documenting the red lock tab on the emergency kit in the refrigerator to ensure the controlled medicaiton was accounted for. Interview on 9/12/23 at 10:25 a.m., director of nursing identified that she thought the nurses had been verifying the red lock tab on the e-kit in the medication refrigerator. She revealed that the nurses had not documented the red tab lock since 3/13/23, for 5 months. She agreed that the nurses should have been verifying the red lock tab on the e-kit in the medication room refrigerator since it contained lorazepam, and she was unsure why they would have ever stopped. She confirmed there was risk for diversion due to the lorazepam and the e-kit red tab lock needed to be verified each shift and the facility would resume verifying immediately. Review of February 2023, Medication Labeling and Storage policy identified nursing staff was responsible for maintaining medication storage in a safe manner. Controlled substance are separately locked distributions systems in which minimal and a missing dose can be readily detected are used. If a medication has an improper or incorrect label staff are to contact the dispensing pharmacy for instructions regarding returning or destroying these items. Only the dispensing pharmacy may alter the label on a medication package.	F 761	controlled substances located in the facilities emergency kit to maintain medication storage in a safe manner, including verification of red lock tab on emergency kit in medication room refrigerator. 4. Audits involving verification and documentation of controlled substances will be audited by DON or designee 2 x weekly x 6 weeks and then 1 x weekly x 4 weeks. 5. Corrective action: Corrective action was completed on 9/13/2023 when surveyors were present at the facility to ensure proper storage of controlled substance. Education and audits will be reviewed in QAPI.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		10/11/23

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	245290	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

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F 880	Continued From page 29 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 30 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a comprehensive IC surveillance program that included employee illness and criteria to return to work. There facility also failed to ensure existing policies were reviewed annually to ensure they were updated and complete. This had the ability to affect all 41 residents. Findings include: Review of the June, July, August, and September 2023 infection control (IC) surveillance data identified there were no staff illness' included in with the surveillance.	F 880	1. It is the policy of Olivia Restorative Therapy and Nursing to have comprehensive IC surveillance program and ensure existing policies are reviewed annually to ensure they are updated and complete. 2. All residents have the potential to be affected in this area. All staff are re-educated in infection prevention and control and the importance of following the employee illness criteria to return to work within the policy. 3. All staff have been re-educated on	

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F 880	Continued From page 31 Interview and staff illness document review with the director of nursing and IC preventionist (IP) identified the ICP kept staff call in's on separate forms in her office. The ICP identified she was not tracking any staff illnesses as part of her comprehensive IC surveillance. The DON and IP agreed staff illness tracking was critical to mitigate and prevent potential infectious illness from staff to residents and identify potential exposure and determine when staff would be able to return to work. The IP stated she had no algorithm to follow as to when staff illnesses would set parameters for when they would be allowed to return to work. Staff illness logs showed some staff had complaints of nausea and vomiting (N&V). There was no indication when those staff were able to return to work or if any criteria was used to determine that date. The DON and IP agreed if per say, a kitchen staff person had N&V and called in to be off work or developed symptoms at work, they could be infected with a potentially highly transmittable disease process such as Noro-virus, and must remain out of work symptom free for 72 hours to prevent potential transmission. Review of the August 2013, Employee Infection and Vaccination Status policy identified employees were required to report symptoms of illness. The medical director and IP were to collaborate to determine if significance of any employee health condition would require restrictions regarding direct resident contact. Review of the September 2017, Surveillance for infections policy identified there was no mention employee illnesses were to be incorporated into the facility's IC surveillance program.	F 880	infection prevention and control and the importance of following the protocols within the policy. All staff will be educated by 10/11/23. An employee line listing and resident line listing has been integrated into our IC surveillance program. 4. All employee illnesses will be audited by the facilities Infection Preventionist to ensure compliance. Existing policies are reviewed and updated and scheduled for review annually. The audit will be completed daily x 3 weeks and the monthly x 3 months. The audit for ensuring existing policies are reviewed and updated annually will be completed yearly x 1. 5. Corrective action: Line listing correction was completed, education completed, and audits are in place. These will brought to QAPI for review and further recommendations.	

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F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based of interview and document review, the facility failed to perform antibiotic stewardship to include antibiotic use protocols and a system to monitor antibiotic usage and determine if the prescribed antibiotics resolved the identified infectious process for 15 of 41 sampled residents (R2, R6, R9, R10, R12, R24, R26, R27, R31, R34, R35, R37, R244, R245, and R246) identified in the facility's infection control surveillance. This had the potential to affect all 41 residents who were or may receive antibiotic therapy in the future. Findings include: Review of the June, July, August and September 2023 infection control (IC) surveillance identified for the month of: 1) June 2023, 7 residents were receiving antibiotic treatment (R9, R27, R31 x 2, R34, R35, R244, and R245). R31 was treated for the same symptoms on 6/1/23 and again on 6/27/23. There was no mention of any cultures being obtained from any resident's potential source of infection, nor was there any indication staff had re-assessed the residents following completion of	F 881	1. It is the policy of Olivia Restorative Therapy and Nursing to have an established infection prevention and control program (IPCP) that must include, at a minimum, and antibiotic stewardship program that includes antibiotic protocols and a system to monitor antibiotic use. 2. All residents have the potential to be affected in this area. All nursing staff are re-educated on 72-hour time outs and daily infection charting. 3. All staff are re-educated on 72-hour time outs and daily infection charting. Nursing staff have been educated. 4. The antibiotic timeouts will be audited by Infection Preventionist or designee to ensure compliance regarding 72-hour time outs are being completed accordingly and daily infection charting is being completed to ensure compliance. The audit for 72-hour time outs will be completed weekly x 3 weeks and monthly x 3 months. The audit for daily infection	10/11/23

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F 881	Continued From page 33 the therapy or notified their physicians to identify if symptoms had truly resolved or there was a potential need to alter or continue treatment. 2) July 2023, 9 residents were receiving antibiotic treatment (R2, R6, R10, R12, R24, R31, R35, R37 and R246). R31 had received 1 month of the same antibiotic therapy beginning 6/27/23 and ending 7/26/23. Of those 9 residents, only R24's potential source of infection had been cultured to determine susceptibility to the antibiotic prescribed. R24's culture that was obtained resulted in a negative finding of bacteria present. R24's physician determined the need to keep R24 on the antibiotic without identifying the true cause of R24's infection was to determine if the right antibiotic was being used, or if R24 required antibiotic therapy. 3) August 2023, 7 residents were receiving antibiotic treatment (R6, R10, R12, R26, R37, R244, and R246). There was no mention of any cultures being obtained from any resident's potential source of infection, nor was there any indication staff had re-assessed the residents following completion of the therapy or notified their physicians to identify if symptoms had truly resolved or there was a potential need to alter or continue treatment. 4) September 2023, 2 residents (R10 and R12) were receiving antibiotic therapy. There was no mention of any cultures being obtained from any resident's potential source of infection, nor was there any indication staff had re-assessed the residents following completion of the therapy or notified their physicians to identify if symptoms had truly resolved or there was a potential need to alter or continue treatment. Interview and document review on 9/13/23 at 12:07 p.m. with the director of nursing (DON) and	F 881	charting will be completed daily x 3 weeks and then weekly for x 3 weeks. 5. Education and audits will be brought to QAPI for further recommendations.	

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F 881	Continued From page 34 infection control preventionist (IP) identified the DON agreed there was no active antibiotic surveillance included in with the IP's surveillance. The IP indicated she was not trained to capture or perform antibiotic stewardship after assuming her role as IP several months prior. The DON agreed it was her expectation this had been performed as part of their antibiotic stewardship program. Review of the 4/28/18, Antibiotic Stewardship Policy identified widespread antibiotic use has resulted in antibiotic resistant infections and was an increased risk in acquired Clostridium difficile ((C-Diff) opportunistic bacterial infection caused by antibiotic use). Physicians, nursing, and pharmacy departments were responsible for promoting and overseeing antibiotic stewardship-specific drug expertise. Staff were to monitor use and outcomes associated from antibiotic use and provide feedback to prescribing physicians, nursing staff, and others. The IP was to complete monthly chart reviews on all ordered antibiotics for residents and record that data in the facility IC surveillance and present that data to the QAPI program. The consulting pharmacist was to complete a monthly review for indications and justification to verify ordered antibiotics were used in accordance with the Centers for Disease Control (CDC). An antibiotic time out was to occur 72 hours after initiation of therapy for each resident on need, duration, selection, and de-escalation potential. The time out was to be recorded in the resident record. There was no mention the policy had been reviewed or revised yearly, nor was the any indication this element should be incorporated into the facility IC program.	F 881		
F 883 SS=E	Influenza and Pneumococcal Immunizations	F 883		10/11/23

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F 883	Continued From page 35 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 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	F 883		

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F 883	Continued From page 36 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 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 5 of 5 residents (R2, R6, R17, R33 and R144) were offered and/or administer vaccination for pneumonia upon admission or when eligible. Furthermore, the facility failed to update their policy and educate staff to ensure the facility offered and/or provided any initial or updated pneumococcal vaccine to residents per Centers for Disease Control (CDC) vaccination recommendations. This had the ability to affect all 41 residents. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below:	F 883	1. It is the policy of Olivia Restorative Therapy and Nursing a resident or residents' representative has been provided education regarding benefits of influenza and pneumococcal vaccines and have the opportunity to be administered the immunization if eligible or refuse the immunization. Also, appropriate documentation is documented in the resident chart. 2. All residents have the potential to be affected in this area. We will continue to provide Influenza and Pneumovax VIS' upon admission. Immunization consent has been updated to reflect changes in Pneumovax formulation. 3. Processes and procedures have been in place and revisited to ensure acknowledgment and understanding of	

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F 883	Continued From page 37 a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose Review of 5 sampled residents for vaccinations identified: 1) R2 was 73 years old and was admitted to the facility in September 2015. R2 was administered the PCV-13 on 10/8/16 and the PCV-23 on 12/20/19. R2 should have been offered and/or provided the PCV-20 at least 1 year after prior PCV-13 OR the PPSV-23 at least 1 year after prior PCV-13. 2) R6 was 68 years old and admitted to the facility in April 2021. R6 had the PCV-13 on 5/31/21 and the PCV-23 in March 2020. R6 should have been offered and/or administered the PCV-20 at least 1 year after prior PCV-13 OR the PPSV-23 at least 1 year after prior PCV-13. 3) R17 was 65 years old and was admitted to the facility in June 2023. R17 had previously declined	F 883	processes and procedures. 4. Audits are completed by the Infection Preventionist or designee to confirm appropriate vaccinations are offered when eligible to ensure compliance. 5. Corrective action completed by 10/11 and education and audits brought to QAPI for review and recommendations.	

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F 883	Continued From page 38 the PCV-13 and PCV-23, however, R17 was not offered a PCV-20 vaccination. 4) R33 was 91 years old and was admitted to the facility in November 2011. R33 had previously declined the PCV-13 and PCV-23, however, in November 2022, R33 had accepted to receive her PCV-13 and PCV-23. No immunization report was identified to note R33 had been administered either vaccine or offered the updated PCV-20. 5) R144 was 77 years old and was re-admitted to the facility in September 2023. R144 had received the PCV-13 in March 2022 and the PCV-23 in August 2017. R144 was eligible to be offered and/or administered the PCV-20 vaccine. Review of the March 2022, Pneumococcal Vaccine policy identified prior to admission, residents were to be assessed for eligibility to receive the vaccine series and when indicated, and be offered in accordance with the CDC recommendations. Interview on 9/13/23 at 12:07 p.m. with the director of nursing identified she was unaware of the updated guidance for pneumococcal vaccine. She expected the IP and nursing staff to have been aware of the updated guidance from CDC and offer appropriate vaccinations.	F 883		

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	245290	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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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 09/13/2023. 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 IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/05/2023

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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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 sprinkler protected and was determined to be of Type II(000) construction;
The 2nd addition was constructed in 1967, is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	**1003 WEST MAPLE** **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
K 000	Continued From page 2 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 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		10/11/23

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	245290	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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K 321	Continued From page 3 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3 and 8.4.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/13/2023 at 11:00 AM, it was revealed by observation the maintenance repair shop shows signs of needing repair/replacement and did not close properly when tested. 2. On 09/13/2023 at 11:32 AM, it was revealed by observation that the maintenance repair shop room door was being held open by a kickdown door stopper causing the door to not self-close. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 321	1. It is the policy of Olivia Restorative Therapy and Nursing to ensure all hazardous areas are protected by a 1-hour fire resistance rating self-closing door. 2. All residents have the potential to be affected in this area. No residents were affected. 3. Maintenance contacted the vendor regarding ordering a 1-hour fire resistance self-closing door to ensure compliance. 4. Weekly audit x 3 weeks and monthly audit x1 completed by Director of Maintenance or Designee to ensure that the buildings (4) fire resistance doors close appropriately. 5. Corrective action: A phone call was completed immediately to order appropriate door and vendor came to the facility for measurements and quote on 10/04/2023.	

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K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 918	1. It is the policy of Olivia Restorative	10/11/23

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K 918	Continued From page 5 and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2, and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2023 at 10:30 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Director of Maintenance, that the facility could not provide documentation of an annual load bank test at the time of the survey. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 918	Therapy and Nursing to perform 2-hour generator load testing on a yearly basis. 2. All residents have the potential to be affected in this area. No residents were affected. 3. Load testing has been scheduled in TELS, to ensure completion according to regulations. 4. Yearly audit completed by Maintenance Director or Designee to ensure generator load testing is completed by Interstate for regulation compliance. 5. Corrective action: A phone call was completed immediately to schedule generator load testing. Load testing was completed on 10/4/2023. This will be brought to QAPI for review	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920		10/11/23

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K 920	Continued From page 6 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 09/13/2023 between 09:00 AM and 12:30 PM, it was revealed by observation there was a resident bed plugged into a power strip in room S3 and S7. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 920	1. It is the policy of Olivia Restorative Therapy and Nursing that power strips in the patient care vicinity may not be used for non-PCREE, except in long-term care resident rooms that do not use PCREE. 2. All residents have the potential to be affected in this area. No residents were affected. 3. Non-compliant power-strips have been removed and replaced with compliance appropriate power strips containing a UL rated sticker. All staff have been educated. 4. Audit to be completed weekly x3 weeks and monthly x 1 by Director of Maintenance or designee to ensure that power strips in patient care area are being used in accordance with regulations. 5. Corrective action: Non-compliant power-strips were removed and replaced with compliance appropriate power-strips containing UL rated sticker. This will be	

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K 920	Continued From page 7	K 920	brought to QAPI for review.	
K 923 SS=E	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 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	K 923		10/11/23

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K 923	Continued From page 8 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 storage of an oxygen tank per NFPA 99 (2012 edition), Health Care Facilities Code, 11.6.2.3. These deficient findings could have an patterned impact on the residents within the facility. Findings include: On 09/13/2023 at 12:04 PM, it was revealed by observation in resident rooms S3 and S13, one oxygen tank was stored in the resident room and was not secured for tip resistance. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 923	1. It is the policy of Olivia Restorative Therapy and Nursing that oxygen cylinders are stored safely and securely. 2. All residents have the potential to be affected in this area. No residents were affected. 3. Nursing staff re-educated on oxygen cylinder storage to be in compliance with regulations. 4. Weekly audit x 6 weeks will be completed by Director of Maintenance or designee to ensure oxygen cylinders are properly stored and secured to be in compliance with regulations. 5. Corrective action was started immediately on 9/13 to ensure all oxygen cylinders were properly stored and secured to be in compliance with regulations. This will be brought to QAPI for review.	