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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: URFU
Facility ID: 00939

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245290**

2. STATE VENDOR OR MEDICAID NO.
(L2) **228497900**

3. NAME AND ADDRESS OF FACILITY
(L3) **OLIVIA REHABILITATION & HEALTHCARE CENTER**
(L4) **1003 WEST MAPLE**
(L5) **OLIVIA, MN** (L6) **56277**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**

6. DATE OF SURVEY **04/24/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **55** (L18)

13. Total Certified Beds **55** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE-NE II 05/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/11/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245290
April 29, 2018

Ms. Jacqueline Grimm, Administrator
Olivia Rehabilitation & Healthcare Center
1003 West Maple
Olivia, MN 56277

Dear Ms. Grimm:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 20, 2018 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 29, 2018

Ms. Jacqueline Grimm, Administrator
Olivia Rehabilitation & Healthcare Center
1003 West Maple
Olivia, MN 56277

RE: Project Number S5290027

Dear Ms. Grimm:

On March 27, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 15, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 20, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 15, 2018, effective April 20, 2018 and therefore remedies outlined in our letter to you dated March 27, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: URFU
Facility ID: 00939

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245290**

2. STATE VENDOR OR MEDICAID NO. (L2) **228497900**

3. NAME AND ADDRESS OF FACILITY
(L3) **OLIVIA REHABILITATION & HEALTHCARE CENTER**
(L4) **1003 WEST MAPLE**
(L5) **OLIVIA, MN** (L6) **56277**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **02/01/2017**

6. DATE OF SURVEY **03/15/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **55** (L18)

13. Total Certified Beds **55** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Reduction in the number of certified SNF/NF beds from 57 beds to 55 beds, effective February 9, 2018, in accordance with a change in licensure. Due to two beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective February 9, 2018, all 55 facility beds are certified SNF/NF. After this change they currrently have 21 beds on layaway.

17. SURVEYOR SIGNATURE
Lois Boerboom, HFE-NE II
Date : 04/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Alison Helm, Enforcement Specialist
Date: 05/03/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **09/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
March 27, 2018

Ms. Theresa Pridal, Administrator
Olivia Rehabilitation & Healthcare Center
1003 West Maple
Olivia, MN 56277

RE: Project Number S5290027

Dear Ms. Pridal:

On March 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 24, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by June 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 September 15, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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 ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA REHABILITATION & HEALTHCARE 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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted March 12th through March 15, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their policies and procedures	E 026	During survey, maintenance director requested and received a letter from the	3/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/04/2018

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.

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 ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA REHABILITATION & HEALTHCARE 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 026	Continued From page 1 addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 36 clients residing in the facility. Findings include: On 3/15/18, at 3:15 p.m. the facility Emergency Preparedness Plan revised 1/10/18, was reviewed with the maintenance director and administrator. The administrator confirmed the lack of a policy and procedure which identified the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. Both indicated they were unaware of this requirement.	E 026	Southwest Coalition stating Olivia Rehabilitation and Healthcare Center participates in the establishment of an alternative care site to either augment or support the loss of patient care services in the community. This confirms that an 1135 waiver has been granted.	
F 000	INITIAL COMMENTS On March 12th through March 15, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

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 ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA REHABILITATION & HEALTHCARE 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
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine whether it was safe to self-administer medications for 1 of 1 resident (R2) observed during medication pass for the appropriateness of self-administration of medication. Findings include: It was observed on 3/12/18, at 3:00 p.m. that R2 had a nebulizer treatment while resting in bed. No staff were in the area observing the resident during the treatment. On 3/13/18, at 1: 30 p.m. trained medication aide (TMA)-A entered the room with two (2) Lactulose packets to dissolve in grape juice. After informing R2 that is was time for her medication, R2 replied that she had a couple of the packets in her "stuff" which were left from the previous day. R2 sorted through her mail and personal items located on the overbed table to retrieve the extra medication packets. R2 indicated she could not locate them at the moment. TMA-A opened the Lactulose packets she delivered and dumped the contents into a glass of juice to dissolve. After the medication dissolved in the juice, TMA-A left the room to continue the medication pass. R2 took a few sips of the juice and left the remainder of the medication on the overbed table.	F 554	During the survey, R2 had a self-administration assessment completed by the RNAC. It was determined she is safe to self administer her medication and a physician order was secured. The care plan was updated and MAR updated. Any resident who indicates a desire to self administer medication will be assessed to determine for safety and appropriateness. If deemed appropriate, a physician order will be obtained prior to initiation of self administration. Licensed nurses and TMAs have been reeducated on providing self administration for residents only for those deemed safe, have an active physician order, and is on the MAR. Random audits will be conducted by interim DON, RNAC, and licensed nurses. The results will be forwarded to the administrator and forwarded to QAPI for review and recommendation. RNAC is responsible to monitor.	4/20/18

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 ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA REHABILITATION & HEALTHCARE CENTER	**1003 WEST MAPLE OLIVIA, MN 56277**

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F 554	Continued From page 3	F 554		

When interviewed following the observations, on 3/14/18, at 2:00 p.m. registered nurse (RN) -A indicated she was unsure whether R2 had a physician order to self-administer oral medications and/or whether an assessment had been conducted related to the ability to self-administer. RN-A indicated she was unable to self-administer the neb treatments as R2 often falls asleep. When interviewed on 3/15/18, at 3:30 p.m. the nurse consultant confirmed it was the expectation that nursing staff assess each resident for appropriateness of self-administration and obtain a physician's order prior to leaving medications with any resident.

The admission date noted on the Order Summary Report for R2 was identified as 11/24/17, with a diagnoses of malignant lung cancer. A physician order for Kristalose Packet (Lactulose) 30 gram by mouth every day shift for constipation [give 20 gram packet with 10 gram packet to total 30 gram daily; dissolve in 4-8 oz. fluid] was started on 1/5/18. In addition, a physician order for DuoNeb Solution 0.5-2.5 (3) mg/3 ml (Ipratropium-Albuterol) 1 vial inhale orally three times a day related to unspecified bacterial pneumonia was ordered with a start date of 2/2/18. A physician order to self-administer any medications was lacking nor was an assessment related to self-administration evident in the electronic and/or paper medical record.

Review of the admission Minimum Data Set (MDS) assessment dated 12/1/17, identified that R2 had a Brief Interview of Mental Status (BIMS) of 15, indicating intact cognition.

A policy was requested but none was submitted.

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F 641	Continued From page 4	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the limited range of motion status for 1 of 2 residents (R35) reviewed for range of motion (ROM). Findings include: R35's current diagnoses according to the face sheet dated 3/15/18 included: cerebral vascular accident (CVA), dementia without behavioral disturbance, syncope/collapse and transient ischemic attack (TIA). R35's quarterly MDS assessment dated 2/28/18, indicated severe cognitive impairment and identified that R35 required total assistance of staff with bed mobility, locomotion, dressing, and grooming. R35, who was admitted on 8/30/17, had a physical therapy (PT) plan of care dated 9/1/17. The reason for referral documented: a 79 year old male who presents with multiple active medical conditions that have recently impacted function, including Lewy Body dementia and Alzheimer's left sided severe weakness, fainting starting in February 2016, and severe dementia following a syncopal attack. Due to weakness, this will require skilled physical therapy in order to	F 641	During survey, an OTR came to evaluate R35 regarding a ROM program. The RNAC updated the resident's care plan and care sheets to include PROM program as prescribed by OTR. All residents who receive recommendations from rehabilitation therapy for PROM programs will have this integrated into their plan of care. Therapy and nursing staff have been reeducated regarding therapy evaluations, treatments, and handoff to nursing staff regarding PROM programs. Nursing staff has been reeducated on performing PROM. Random audits will be conducted by the therapy director, RNAC, and interim DON to assure all rehabilitation programs handed off from therapy services will be implemented and added to care plans and care sheets. Random MDS audits will be conducted to ensure. Results of the audits will be forwarded to the administrator. Results will be forwarded to QAPI for review and recommendations.	4/20/18

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F 641	Continued From page 5 regain standing and use of right hand. PT orders included therapy three times/week for 4 weeks for ultrasound, therapeutic exercise, neuromuscular re education, and manual therapy. Goals identified: Patient and caregiver to be independent in range of motion and tone reducing techniques to back, neck, left extremity program. A 7 page form was attached and titled, Passive Range of Motion (PROM) Exercises- Caregiver education, had R35's name written on the document. During observation on 3/13/18, at 6:38 p.m. R35 had his left hand clenched tightly, fingers pressing into palm of hand. Family member (FM)-A was present and indicated staff attempt to give R35 objects to hold in his left hand. FM-A stated, "I don't know if he still gets exercises like he used to"; "The fingers press into his hand". FA also expressed concern about potential skin breakdown. When interviewed on 3/14/18, at 11:11 a.m. nurse manager (NM)-A reviewed and confirmed the exercise program for PROM had not been implemented. When the most recent MDS dated 2/28/18, was reviewed, NM-A confirmed the functional limitations of the left upper and lower extremity were not identified on the MDS and confirmed it was present at the time of the assessment, so was inaccurate.	F 641	Both RNAC and therapy director will monitor.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		4/20/18

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	245290	A. BUILDING ______ B. WING ______	03/15/2018

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F 688

Continued From page 6

range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide passive range of motion (PROM) services as recommended by the therapist for 1 of 4 residents (R35) reviewed with limited range of motion (ROM).

Findings include:

R35's current diagnoses according to the face sheet dated 3/15/18, included: cerebral vascular accident (CVA), dementia without behavioral disturbance, syncope/collapse and transient ischemic attack (TIA).

R35's quarterly Minimum Data Set (MDS) assessment dated 2/28/18, indicated severe cognitive impairment and required total assistance of staff with bed mobility, locomotion, dressing, and grooming.

R35's care plan, last revised 3/14/18, identified an alteration in self care ability. The care plan also identified that R35 required total assist of one to

F 688

The 7-page ROM program indicated was never handed off to the nursing staff and 6 of the pages were blank.

Registered OTR was called in to evaluate R53. The resident has not been given a PROM program to nursing as of this time. Therapy is presently seeing the resident.

All residents that receive recommendations from therapy for PROM programs that are handed off to nursing will be added to the plan of care and care sheets. Nursing staff will be educated on any PROM programs that are handed off. Therapy staff and nursing staff have been reeducated on therapy handoffs, care planning, and program implementation. Nursing staff have been reeducated on performing PROM.

Random audits will be conducted by therapy director, RNAC, or interim DON.

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F 688	Continued From page 7	F 688		

two staff with all dressing, grooming, and bathing tasks, total assist with bed mobility and one assist to complete all of meal.

The current undated resident assignment sheet for R35 lacked identification of any ROM program.

Physician orders dated 8/7/17 revealed: Physical therapy evaluate and treat. R35, who was admitted on 8/30/17, had a physical therapy (PT) plan of care dated 9/1/17. The reason for referral documented: a 79 year old male who presents with multiple active medical conditions that have recently impacted function, including Lewy Body dementia and Alzheimer's left sided severe weakness, fainting starting in February 2016, and severe dementia following a syncopal attack. Due to weakness, this will require skilled physical therapy in order to regain standing and use of right hand. PT orders included therapy three times/week for 4 weeks for ultrasound, therapeutic exercise, neuromuscular re-education, and manual therapy. Goals identified: Patient and caregiver to be independent in range of motion and tone reducing techniques to back, neck, left extremity program. A 7 page form was attached and titled, Passive Range of Motion Exercises [PROM]- Caregiver education and had R35's name written on the document. In addition, a one page document dated 9/10/17, identified exercises for the neck and shoulder of R35.

During observation on 3/13/18, at 6:38 p.m. R35 had left hand clenched tightly, fingers pressing into the palm of hand. Family member (FM)-A was present and indicated staff attempt to give R35 objects to hold in his left hand. However,

the results will be forwarded to the administrator and then forwarded to QAPI for recommendations and review.

Therapy director and RNAC are responsible to monitor.

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F 688	Continued From page 8	F 688		

FM-A stated, "I don't know if he still gets exercises like he used to"; "The fingers press into his hand". FA also expressed concern about potential skin breakdown.

During a observation of cares on 3/14/18, at 9:20 a.m. it was noted R35's left fingers were clenched into the palm of hand. No PROM exercises were performed during cares.

When interviewed on 3/14/18, at 1:00 p.m., nursing assistant (NA)-C confirmed the hand seemed less flexible and increased difficulty when moved. Licensed practical nurse (LPN)-A also agreed it seemed more difficult to move R35's joints. NA-C confirmed the left hand required special hygiene care as it was difficult to perform and then demonstrated by gently opening the fingers; R35 became resistant and clenched teeth. The fingers with nails pressing into the palm of his hands could not be moved from the palm of his hand. NA-C, and LPN-A were not aware of a PROM program for R35.

On 3/14/18, at 1:00 p.m. NA-C and NA-D completed cares. They confirmed that R35's hands and legs were "more stiff and fingers are drawing more into the palm of his hand" and were unaware of any PROM program implemented for R35.

When interviewed on 3/14/18, at 9:00 a.m. the nurse manager (NM)-A confirmed there were no therapy notes in the electronic nor paper chart for R35. Therapy documentation was later submitted by the medical records staff at 10:43 a.m. During a follow-up interview on 3/14/18, at 11:11 a.m. NM-A confirmed the PROM program recommended by PT had never been placed into

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F 688	Continued From page 9 the resident chart for staff to review nor had it been added to the care plan. NM-A confirmed it had not been implemented and verified the quarterly MDS dated 2/28/18, did not identify the functional limitation of the left upper and lower extremity. During an interview on 3/14/18, at 11:55 a.m. with the nursing consultant (NC) and the administrator, it was confirmed they planned to conduct another screening by the therapist to evaluate R35's current status. The administrator stated, "we will do what we need to do moving forward". During an interview with the registered occupational therapist (OTR) on 3/15/18, at 1:20 p.m. it was verified there was a current plan developed for nursing staff to exercise R35's left lower extremity but was unable to confirm whether nursing staff implemented the PROM plan. After a screening was conducted, the OTR stated he was unable to verify whether the left hand, arm and/or shoulder had declined in ROM as no measurements were available to compare with the previous therapy assessment. The OTR indicated a plan would be implemented that R35 could tolerate. Review of the OTR evaluation dated 3/15-2/19/18, identified that R35 required passive PROM to left upper extremities and application of a splint to the left hand during sleeping hours. Document review of: Evaluation and plan and treatment, included a certification of occupational therapy for 3/15/18-3/29/18.	F 688		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 727	Continued From page 10 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week since December 2017. This had the potential to affect all 36 residents who reside in the facility. Findings include: During an interview with the administrator on 3/15/18, at 10:48 a.m. the registered nurse (RN) total hours per day were reviewed and confirmed for the period of December 2017 through March 11, 2018 as noted: 12/3/17-5 hours(hrs) 79 minutes; 12/10/17-5 hrs 38 minutes; 12/23/17-6 hrs 41 minutes; 12/24/17- 6 hrs 41 minutes; 12/30/17 6 hrs 47 minutes; 12/31/17-6 hrs 8 minutes; 1/6/18-4 hrs 30 minutes;	F 727	The facility schedules 7 day / week RN coverage; however, 8-hour consecutive coverage was not provided. The schedule has been amended and designates an RN facility charge for 8 consecutive hours / 7 days a week. Random audits will be conducted by the business office manager and administrator to ensure 8 hour RN coverage. The audit results will be forwarded to the administrator and then forwarded to QAPI for recommendation and review. The administrator is responsible for monitoring.	

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F 727	Continued From page 11 1/28/18-6 hrs 36 minutes; 2/10/18-6 hrs 54 minutes; 2/17/18-4 hrs 43 minutes; 2/18/18- 4 hrs 54 minutes; 2/24/18-7 hrs 25 minutes; 3/3/18-zero (0) no hours; 3/4/18-2 hrs 53 minutes; and 3/11/18- 5 hrs 25 minutes. When interviewed on 3/15/18, at 11:01 a.m. the administrator indicated her expectation was for 8 hours/24 hours of RN coverage. When further questioned, the administrator indicated the lack of RN coverage had been an issue since the end of November 2017. A request for a policy related to RN coverage but none was provided.	F 727		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the dietary kitchen in good condition, including the linoleum floor and functioning cupboards/back door. This had the potential to affect the staff and the 36 residents who reside in the facility. Findings include: During a tour of the dietary kitchen with the cook on 3/14/18, at 10:51 a.m. it was noted the	F 921	Housekeeping has completed deep cleaning, buffing, and waxing the kitchen floor. Maintenance director has replaced some tile and completed repair work. The baseboard located on the South wall has been repaired. Cupboard door enclosures have been installed. The backdoor threshold has been lowered. Random kitchen audits will be conducted	4/20/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 12 linoleum floor covering throughout appeared in poor repair; the linoleum was gouged, scratched, stained and without any wax finish. Approximately half of the floor was sheet linoleum and the remainder linoleum tiles; some of the seams were separating between the two floor coverings. The edges of the linoleum were grimey, with a build up of wax and debris around the perimeter of the room. The linoleum located beneath the dishwasher appeared a rusty color and was soiled; the linoleum was separating from the underlayment and appeared to bubble up from the floor. The baseboard located on the south wall of the kitchen was peeling away from the wall; the cupboard doors would not always remain closed when shut, but would swing open upon closing. The back door of the dietary kitchen where supplies were delivered, had an apparent gap between the bottom of the door and the door threshold; outside light shone beneath the door frame as it lacked weather stripping . When interviewed on 3/14/18, at 11:06 a.m. the dietary manager (DM) agreed with the noted observations and the poor condition of floor. In addition, the DM indicated she had trouble keeping the cupboard doors closed and was not sure whether it was a problem with the door hinges. When discussed with the administrator and 3/15/18, at 3:30 p.m. no further information was communicated related to the condition of the items noted.	F 921	by the dietary manager and the administrator. The results will be forwarded to the administrator, then onto QAPI for recommendations and review. The dietary manager is responsible to monitor.	

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

F5290026

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	245290	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**03/13/2018**

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OLIVIA REHABILITATION & HEALTHCARE CEI	**1003 WEST MAPLE** **OLIVIA, MN 56277**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 13, 2018. At the time of this survey, Olivia Rehab and Healthcare was found to be 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 Occupancies. Olivia Rehab and Healthcare 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 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 55 beds and had a census of 35 at time of the survey.	K 000		

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

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.

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

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 ______	03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA REHABILITATION & HEALTHCARE CEI	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 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		