



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 25, 2025

Administrator
OLIVIA RESTORATIVE CARE CENTER

1003 WEST MAPLE AVENUE
OLIVIA, MN 56277

RE: CCN:245290

Cycle Start Date: July 10, 2025

Dear Administrator:

On July 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 10, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated.

This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 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	
E0000	Initial Comments On 7/07/25 through 7/10/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/08/2025	
F0000	INITIAL COMMENTS On 7/07/25 through 7/10/25, 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: H52908509C (MN113567), H52908510C (MN113705), H52908511C (MN113302), H52908512C (MN113789), and H52908528C (MN112893). 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.		F0000			08/08/2025	
F0678 SS = D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)		F0678	Immediate action(s) taken for the resident(s) found to have been affected include:		07/16/2025	

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0678 SS = D	Continued from page 1 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to update code status for 1 of 16 resident (R40) who requested to have his code status changed. Findings include: Document review on 7/7/25 at 4:51 p.m., R40 was identified to be a full code (Cardiopulmonary Resuscitation (CPR)) noted on his electronic medical record dashboard. Review of R40's Provider Orders for Life-Sustaining Treatment (POLST) signed by the resident and the physician identified he had changed his code status on 5/23/25 from CPR to Do not resuscitate (DNR). Interview on 7/8/25, at 2:00 p.m., with licensed practical nurse (LPN)-A identified if a resident's heart stops, they look at the dashboard to check code status, she explained the dashboard is at the top of a resident's main page in Point Click Care (PCC). PCC is the electronic system the facility uses for resident medical records. LPN-A opened R40's PCC main page and identified his code status is CPR. She identified when a resident is admitted they complete a Provider Orders for Life-Sustaining Treatment (POLST) form. A registered nurse updates the residents EMR in PCC and has the POLST reviewed and signed by the physician. LPN-A clicked a button next to the code status on the dashboard next to the code status to pull up R40's POLST. R40's most recent POLST identified he had requested to be DNR. LPN-A confirmed his code status listed on the dashboard in PCC was incorrect. Interview on 7/8/25 at 2:15 p.m., with the director of nursing identified if someone codes (heart stops beating) staff were to check the dashboard in PCC to check code status. Staff also have access to the POLST through the dashboard. She agreed R40's code status on the PCC dashboard was incorrect. At his last	F0678	Continued from page 1 All residents were audited for accuracy of code status on PCC to POLST in there documents and in the EMAR system. Identification of other residents having the potential to be affected was accomplished by: All residents could be affected by failing to update and change the code status. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing staff were educated on the importance of the code status by the DON. Licensed nurses were educated on how to change it in the computer and what to do when a POLST/Code status is received during an in-service on 7-16-25 by the DON. Nursing department staff are educated on their shift that have missed the meeting. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee is doing audits of new residents weekly to assure POLST is accurate. DON/designee picks 3 resident beyond the new admissions to assure the code status is accurate weekly. Review of code status will happen for 4 weeks, then monthly x3 and then PRN after. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F0678 SS = D	Continued from page 2 appointment, R40 requested to have his code status changed from CPR to DNR because he was "considering" hospice. Nursing should have put the new order in, "but it must have been missed". She identified she does audits on code status a couple times a year and the last one completed was about 2 days prior to R40's change. Review of the facility provided undated Residents' Rights Regarding Treatment and Advance Directives policy identified the facility would determine code status upon admission. Advance directive documents provided to the facility would be placed in the medical record. During the care planning process, the facility would identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. The policy made no mention how staff were to confirm code status should a resident require CPR if elected while living at the facility.	F0678		
F0725 SS = F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F0725	Immediate action(s) taken for the resident(s) found to have been affected include: Staffing was reviewed to ensure 24 hours of licensed nursing coverage continues. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents can be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Education will be given to nursing department to make sure they communicate with the DON if there is no nurse coming on and a licensed nurse must stay in the building until another licensed nurse is clocked in. DON/designee review schedule to ensure licensed staff are scheduled 24 hours a day. Education sent out via	08/13/2025

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F0725 SS = F	Continued from page 3 (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to have licensed nursing coverage on staff for 24 hours a day, based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed - Quarter 2, 2025, (January 1 to March 31st), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 39 residents living in the facility. Findings include: Review of the 2/09/25, Daily Assignment Sheet identified 1 charge nurse was assigned for the day and 1 charge nurse for the evening shift (minimum 12 hr. shifts). Licensed practical nurse (LPN)-E was listed as having worked the day shift. Registered nurse (RN)-C was listed as having worked the night shift. Review of 2/09/25, Individual Daily Staffing Casper Report 1702D identified the facility data submitted for Provider Based Journal (PBJ) noted of the floor staff working that day, there was noted to be 1 registered nurse (RN-C), and 1 contract LPN (LPN-E) captured for hours worked. Review of 2/09/25, staff timesheet punches provided by the facility identified only RN-C was clocked in as having worked. There was no way to verify LPN-E had worked the hours documented on the assignment sheet and as captured in the PBJ. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and			F0725	Continued from page 3 video and quiz to be completed by 8-13-25. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will review time sheets daily for 1 week, then weekly x4; then monthly x3; and then as needed after this. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		

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F0725 SS = F	Continued from page 4 communicated with the administrator. The DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently “overstaffs” their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of April 2025, facility assessment staffing plan portion identified it was based on the facility and community risk assessments, in addition to patient per day (PPD) methodology to determine the maximum number of hour available per day. Staffing assignments and variances was managed by moving staff, calling staff off, or calling in relief or extra staff, after staffing requirements was completed. Direct care staffing hours identified to be required were: 1 RN or LPN per day shift and 1 RN or LPN per evening/night shift. A copy of contract staff timesheets was requested but not received.			F0725			
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3]			F0727	Immediate action(s) taken for the resident(s) found to have been affected include: Staffing Reviewed. Reviewed with nursing department to ensure knowledge of needing RN coverage 8 hours consecutively in a 24 hour period is to be scheduled. The facility's assessment is reviewed to determine the required number of staff needed to meet resident needs on weekdays and weekends and adjusted accordingly. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include:		08/13/2025

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F0727 SS = F	Continued from page 5 §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) 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 record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day, 7 days per week, for 6 of 90 days reviewed. This had the potential to affect all 39 residents living in the facility. Findings include: Review of the facility schedule and timesheets for January 2025, February 2025, and March 2025 identified on: 1) January, there was no RN coverage for 2 of 31 days: 1/24/25 and 1/31/25. 2) February, there was no RN coverage for 3 of 28 days: 2/09/25, 2/14/25, 2/15/25. 3) March, there was no RN coverage for 1 of 31 days: 3/02/25. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units.			F0727	Continued from page 5 Education given to nursing department related to having an RN in the building 8 hours a day consecutively needs to happen. If this is not happening, DON needs to be notified. Reviewed the Nursing Staffing- RN and Facility assessment. Education sent out via video and quiz to be completed by 8-13-25. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will review the daily schedule to assure RN 8 hr coverage is scheduled r daily for 1 week, then weekly x4; then monthly x3; and then as needed after this. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		

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F0727 SS = F	Continued from page 6 Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of March 2025 Nursing Services-Registered Nurse (RN) policy identified the facility was to utilize the services of an RN 8 consecutive hours per day, 7 days per week. The director of nursing (DON) may service as a charge nurse when the facility had a daily occupancy of 60 or fewer residents. In addition, the facility, was to submit timely and accurate staffing data through CMS payroll-based Journal (PBJ) system.	F0727		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control practices were maintained to ensure dietary staff were wearing a hair net and/or beard nets while in 1 of 1	F0812	Corrective action will be accomplished for identified affected individuals. It is the policy of the facility to ensure that all dietary staff must wear hair restraints (e.g. hairnet, hat and or beard restraint) to prevent hair from contacting food. It is the policy of he facility to ensure that food stored in the kitchen and kitchenettes are dated and not expired. It is the policy of the facility to ensure the chemical solution shall be maintained at the correct concentration, based on periodic testing. it is the responsibility of the dietary staff to check chemical test strip expiration dates prior to use. All residents have the potential to be affected. The dietary manager will promptly reeducate dietary staff regarding hair net requirement in the dietary department. Dietary manager will re-educate dietary staff on date marketing for food safety along with adding to check expiration dates for chlorine test strips to dish machine procedures. Systemic Changes will occur to ensure that the deficient practice will not occur: Dietary Manager will promptly re-educate dietary staff of Hair net Requirements in the Dietary Department. The dietary department will implement a checklist for auditing food storage in the kitchenettes to ensure	07/21/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0812 SS = F	Continued from page 7 kitchen and during meal services. The facility also failed to ensure 1 of 2 dining room refrigerators remained clean, and food was dated within the refrigerator to ensure it was not used beyond expiration. Additionally, the facility failed to ensure all Chlorine test strips for monitoring the dishwasher chemical level were not expired. Findings include: Observation and interview on 7/7/25 at 11:32 a.m., identified upon entrance to the kitchen for initial tour, dietary aide (DA)-A was preparing drinks for transportation to the dining rooms for the noon meal. DA-A had no hair net on. DA-A reported she was supposed to be wearing a hair net and there was no reason she did not have it on. Observation and interview on 7/7/25 at 11:40 a.m., cook (C)-A was standing behind the steam table outside of the north dining room and dishing up food for residents' noon meal. C-A had a hair net on but no beard net on. C-A had a mustache and beard. C-A reported he had never worn a beard net before; he was unaware he needed to wear one and was not even sure if the facility had any. Observation on 7/7/25 at 12:07 p.m., of the refrigerator in the central dining room which contained 2 large metal bins of individually wrapped ½ sandwiches that were undated. There was something pink spilled all over the bottom of the refrigerator and on the inside door of the refrigerator. The floor directly in front of the refrigerator was extremely sticky and dark brown/black in color. Observation on 7/7/25 at 5:24 p.m., C-A was standing behind the steam table in the central dining room dishing up food for the resident evening meal. C-A had a hair net on and no beard net on. Observation on 7/8/25 at 9:40 C-A just finished serving breakfast and had no beard net on. Observation and interview on 7/8/25 at 10:00 a.m., of the dishwasher cycle and DA-A testing the dishwasher chemical level with Hydrion Chlorine Test strips identified that the test strips had expired on 6/1/25.			F0812	Continued from page 7 items stored are dated and/or not expired. Checking the chlorine test strips expiration date will be add to the daily dish machine log. How the facility will monitor its corrective actions/ performance: Dietary Manager or other designee will complete audits 3x a week for 2 months to ensure that food stored in the kitchenettes are labeled and not expired. Dietary Manager or designee will complete daily audits x1 month to ensure all dietary employees are wearing proper hair nets/beard nets. Dietary manager or designee will audit weekly x2 months the documentation of Chlorine Test Strips Expiration Dates. Audits will be reviewed in QAPI until such time consistent with substantial compliance has been achieved as determined by the committee.		

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F0812 SS = F	Continued from page 8 DA-A was unaware the test strips had expired and discarded the testing strips and obtained a new packet. Observation on 7/9/25 at 8:36 a.m., of the refrigerator in the central dining room with DA-A and maintenance director who confirmed pink juice had been spilled all over the bottom of the refrigerator and the inside part of the refrigerator door. The floor area just in front of the refrigerator was dirty with dark brown/black sticky substance on the floor. C-A reported she believed that housekeeping was responsible for cleaning the refrigerator and floor. The maintenance director agreed that the floor was very sticky, and the refrigerator was dirty and needed to be cleaned. Observation and interview on 7/9/25 at 8:45 a.m. with dietary manager assistant (DMA)-A removed items from the bottom shelf of the refrigerator in the central dining room and agreed that the refrigerator was dirty with some sort of juice spilled all over the bottom of the refrigerator and the inside door of the refrigerator. She reported that it was dietary responsibility to clean the inside of the refrigerator and housekeeping responsibility to clean the outside and the floors in the dining room. She further confirmed that all dietary staff should be wearing hair nets and beard net if needed in the kitchen and when serving food. If there are no beard nets available staff can use a hair net to cover their beard. Staff should be checking the expiration date on the chemical test strips prior to checking the chemical level in the dishwasher. Interview on 7/9/25 at 9:02 a.m., with dietician identified all food in the refrigerators should be dated. The dietary staff should be monitoring the refrigerators for expired foods and cleaning on a regular basis. Her expectation was that staff would be wearing hair net and/or beard nets when in the kitchen and during food service. The chemical strips should be monitored for expiration and new ones ordered when needed. Review of undated, Dietary Employee Personal Hygiene policy identified all dietary staff must wear hair restraints including beard restraints to prevent hair from contacting food. Review of undated, Routine Cleaning and Disinfection		F0812				

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F0812 SS = F	Continued from page 9 policy identified routine cleaning, and disinfection was maintained to ensure safe, sanitary environment and to prevent transmission or development of infections to the extent possible. Cleaning of visible soil from objects and surfaced and frequently touched surfaces would be performed. Review of undated, Low Temperature Dish Machine Guidelines identified the wash and rinse cycle should be maintained between 120-145 Fahrenheit. The low temperature sanitizer level should be checked daily with the Chlorine test strip with an acceptable range from 50-100 ppm.	F0812		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;	F0838	Immediate action(s) taken for the resident(s) found to have been affected include: The facility assessment was reviewed to ensure the schedule going forward matched the assessment. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing department will receive education on the need to follow the nursing schedule to provide cares and services to residents. Will review staffing portion on the facility assessment with the nursing department. Education went out via video and quiz to be completed by 8-13-25. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will review the daily schedule to assure RN 8 hr coverage is scheduled daily for 1 week, then weekly x4; then monthly x3; and then as needed after this. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	08/13/2025

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F0838 SS = F	Continued from page 10 (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of		F0838				

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F0838 SS = F	Continued from page 11 nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement 1 of 1 facility assessment and ensure the required nursing staff were scheduled and working to provide care and services to residents. Findings include:		F0838				

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F0838 SS = F	Continued from page 12 Review of the 2/09/25, Daily Assignment Sheet identified 1 charge nurse was assigned for the day and 1 charge nurse for the evening shift (minimum 12 hr. shifts). Licensed practical nurse (LPN)-E was listed as having worked the day shift. Registered nurse (RN)-C was listed as having worked the night shift. Review of 2/09/25, Individual Daily Staffing Casper Report 1702D identified the facility data submitted for Provider Based Journal (PBJ) noted of the floor staff working that day, there was noted to be 1 registered nurse (RN-C), and 1 contract LPN (LPN-E) captured for hours worked. Review of 2/09/25, staff timesheet punches provided by the facility identified only RN-C was clocked in as having worked. There was no way to verify LPN-E had worked the hours documented on the assignment sheet and as captured in the PBJ. Review of the facility schedule and timesheets for January 2025, February 2025, and March 2025 identified on: 1) January, there was no RN coverage for 2 of 31 days: 1/24/25 and 1/31/25. 2) February, there was no RN coverage for 3 of 28 days: 2/09/25, 2/14/25, 2/15/25. 3) March, there was no RN coverage for 1 of 31 days: 3/02/25. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. The DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently “overstaffs” their employees on the units above the			F0838			

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F0838 SS = F	Continued from page 13 required allotted hours needed daily to ensure services and care needs for the resident population. Review of April 2025, facility assessment staffing plan portion identified it was based on the facility and community risk assessments, in addition to patient per day (PPD) methodology to determine the maximum number of hour available per day. Staffing assignments and variances was managed by moving staff, calling staff off, or calling in relief or extra staff, after staffing requirements was completed. Direct care staffing hours identified to be required were: 1 RN or LPN per day shift and 1 RN or LPN per evening/night shift. A copy of contract staff timesheets was requested but not received.	F0838		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care	F0851	Immediate action(s) taken for the resident(s) found to be affected include: No residents were affected by the inaccurate data that was submitted to CMS. Review if the schedules were completed and Nursing Coverage did occur on the dates stated as no Nurse on duty. Identification of other residents having the potential to be affected was accomplished by: All the residents had the potential to be affected if no Nurse coverage had happened. A new time tracking system had been put into place prior to survey with managers responsible to review all time sheets to ensure accuracy. Actions taken/systems put into place to reduce the risk of future occurrence include: Business office manager will review time sheets for missing punches or missing timecards and each department head will follow up to ensure that the employee has completed a missed punch form and the hours worked will be entered into the payroll-based journal to ensure accurate data is being reported per The New program is set up for all managers to review the prior days punches for all staff members to ensure that staff have punched in/out and if there are any missing punches the Manager is required to determine the time. Staff members were educated on how to complete a missed punch form that each manager is required to sign and give to the business office.	08/13/2025

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F0851 SS = F	Continued from page 14 staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit accurate staffing data based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed - Quarter 2, 2025, (January 1 to March 31st), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 39 residents living in the facility. Findings include: JANUARY Review of the 1/24/25, Daily Assignment Sheet identified 1 charge nurse as noted to be on the day shift, 1 charge nurse on the evening shift, and 1 nurse	F0851	Continued from page 14 Each morning in the department managers meeting, missed punches will also be reported. The business office manager will complete an audit form indicating how many employees have missed punches or missed punch forms. PBJ resubmission is completed to provide compliance of corrected reportable hours. How the corrective action(s) will be monitored to ensure the practice will not occur: Each morning in department managers meeting, missed punches will also be reported. The business office manager will complete an audit form indicating how many employees have missed punches or missed punch forms. Missed punch counts will be calculated on a monthly basis and presented to the QAA committee to ensure all information has been entered and is accurate prior to submission according to CMS guidelines for three months or until compliance has been met.	

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F0851 SS = F	Continued from page 15 for RN coverage. Review of 1/24/25, staff timesheets identified: 1) Licensed practical nurse (LPN)-B had worked 06:59 a.m. to 11:36 a.m. and 11:59 a.m. to 9:06 p.m., for a total of 13.62 hours. 2) LPN-C had worked 06:00 a.m. to 7:40 p.m., for a total of 12.67 hours. 3) RN-C had worked 06:03 p.m. to 06:30 a.m., the next day for a total of 11.45 hours. Review of the 1/24/25, Individual Daily Staffing- 1702D Casper Report identified 1 LPN with 13.62 captured hours, and 1RN with 13.0 captured hours. FEBRUARY Review of the 2/21/25, Daily Assignment Sheet identified 1 charge nurse on the day shift and 1 nurse for RN coverage. The sheet lacked evidence a charge nurse was assigned on the evening shift. Review of 2/21/25, staff time sheets identified: 1) The director of nursing (DON) had worked 8:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 2) RN-B had worked from 8:09 a.m. to 12:42 a.m., the next day for a total of 16.05 hours. 3) RN-C had worked from 6:05 p.m., to 7:33 a.m., the next day for a total of 12.97 hours. Review of the 2/21/25, Individual Daily Staffing- 1702D Casper Report identified only 1 LPN with 14.23 captured hours, the director of nursing for 8 hours, and 1 registered nurse with 12.35 captured hours. Review of the 2/28/25, Daily Assignment Sheet identified 1 RN was assigned to the day shift (RN-B) who was the Minimum Data Set (MDS nurse) and 1 RN was assigned to the evening/night shift. Review of 2/28/25, staff time sheets identified:		F0851				

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F0851 SS = F	Continued from page 16 1) The DON had worked 08:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 2) RN-C had worked 08:08 a.m. to 7:43 p.m., for a total of 11.08 hours. 3) LPN-B had worked from 6:13 a.m. to 11:53 a.m. and again from 11:53 a.m. to 7:58 p.m., for a total of 13.23 hours captured. 4) LPN-D had worked 5:59 p.m. to 06:57 a.m., for a total of 12.47 hours. Review of 2/28/25, Individual Daily Staffing- 1702D Casper Report identified 1 RN with administrative duties only worked for 11.08 hours. No other floor RN staff were noted. 3 LPN's were submitted. 1 LPN with 13.23 hours, 1 LPN with 12.43, and 1 contracted LPN with 14.38 hours. The DON had 8 hours captured. MARCH Review of the 3/21/25, Facility Daily assignment sheet identified 1 LPN (LPN-E) worked the day shift, and also on days was RN-B (the MDS nurse), who was assigned as RN coverage. There was no nurse listed for the evening/night shift. Review of 3/21/25, staff timesheets identified: 1) LPN-B had worked from 7:59 a.m. to 09:55 a.m. and again from 10:38 a.m. to 7:16 p.m., for a total of 10.57 hours. 2) The DON had worked from 8:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 3) RN-B classified as RN with administrative duties, worked from 8:53 a.m. to 12:16 p.m., for a total of 3.38 hours. 4) RN-C had worked 7:13 p.m. to 06:29 a.m., for a total of 10.77 hours. Review of 3/21/25, 1702D Casper report identified 1 RN with administrative duties worked 3.38 hours, the DON hours captured were 8.0, 1 RN hours were captured as 10.85, and 2 LPN's (1 contract and 1 exempt) were			F0851			

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F0851 SS = F	Continued from page 17 captured with 10.57 and 13.72 hours respectively. There was no additional RN with any captured hours submitted. There was no indication the above-mentioned data submitted had been checked for accuracy prior to their respective submissions. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs and reviewed PBJ hours weekly before submission. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of the July 2024, Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Frequently Asked Questions, located at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/pbj-policy-manual-faq-11-19-2018.pdf, identified reporting shall be based on the employee's primary role. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out when needed). Facilities shall still report just the total hours of that employee based on their primary role. However, CMS recognizes that staff may completely shift their primary role in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). Review of March 2025 Payroll Based Journal policy identified the facility was to submit timely and		F0851				

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F0851 SS = F	Continued from page 18 accurate direct care staffing information according to specifications established by CMS. In the addition, the facility was to ensure staffing data was auditable and able to verify through either payroll, invoices, and/or tied back to contract staff.	F0851		
F0880 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 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 §483.71 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:	F0880	Immediate action(s) taken for the resident(s) found to have been affected include: Glucometer use and disinfection education was given to the licensed nurses and trained medication assistants inthe facility on 7-16-25. Staff continue to be educated upon there return to work. Policy of Glucometer disinfection reviewed. Review of the facilities Infection Surveillance Policy was completed. Updated line listing for information related to return-to-work date, and symptoms start/end date. Updated Illness form for the floor staff to utilize to communicate illnesses to managers. Identification of other residents having the potential to be affected was accomplished by: The facility has determined all residents in the facility are at risk due to checking blood sugars can be a nursing judgement. Main residents affected are residents who are diabetics and residents utilizing psychotic medications. The facility has determined all residents have the ability to be affected by ill staff members. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed nurses and trained medication assistants will be retrained on glucometer disinfection via review of the policy and competency completion. Licensed nurses and trained medication assistants will be educated prior to there next shift on the floor. Education will be provided via video and quiz to be completed by 8-13-25. Staff who do not have it completed will be expected to complete prior to their next shift. Education reviewed with the DON and Staffing scheduler about the process of illness forms and documentation. DON/designee to review all illness forms, contact ill	08/13/2025

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F0880 SS = F	Continued from page 19 (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 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 and interview the facility failed to disinfect 1of 2 glucometers (capillary blood glucose sampling device) after use to prevent transmission of blood borne diseases. Additionally, the facility failed to complete accurate staff illness surveillance for 2 of 2 staff. Findings include: Observation on 7/9/25 at 7:43 a.m., with registered nurse (RN)-A identified RN-A gathered the glucometer from the treatment cart to check R15's blood sugar. RN-A used a lancet to prick R15's finger to obtain a blood sample to test R15's blood sugar with the glucometer. RN-A exited R15's room and walked back to the treatment cart where she placed the used lancet in the sharp's container and the glucometer back in the drawer next to another resident's glucometer without	F0880	Continued from page 19 staff member, and log into the spread sheet. Education on Illness forms and documentation of when return to work criteria completed with staff members via video and quiz to be completed by 8-13-25. Staff who do not have it completed will be expected to complete prior to their next shift. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete random weekly audits for compliance with disinfection of glucometers for 4 weeks and then monthly x3 months and then as needed after. Audit records will be reviewed by the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. The DON/designee will review call-in log related to staff illness daily x1 week; weekly x4; monthly x3 and as needed after for compliance with completion of the spreadsheet to assure documentation is completed such as but not limited to illness type, start end of symptoms, and return to work date is communicated and completed.	

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F0880 SS = F	Continued from page 20 first disinfecting it. She walked back to the nurse's station to chart the blood sugar and check to see if R15 required any sliding scale insulin. Interview on 7/9/25 at 7:55 a.m., RN-A stated she had meant to disinfect the glucometer, but she had gotten "nervous and forgot". RN-A then opened the treatment cart and pulled both glucometers out of the drawer. She used purple top Sani-cloth disinfecting wipes and briefly wiped off both glucometers and then returned the glucometers to the drawer. RN-A did not allow any "wet" contact time per the Sani-cloth instructions prior to returning glucometers to the treatment cart drawer. The General Guidelines for Use undated, (purple top) Super Sani-cloth germicidal disposable wipes instructions identified: 1) to unfold the wipe and thoroughly wet the surface 2) allow treated surface to remain wet for two minutes. Let air dry. 3) Do not reuse towelette. Dispose of used towelette in trash. Interview on 7/9/25 at 9:37 a.m., with director of nursing (DON) identified the glucometer should be cleaned after each use with an alcohol wipe for 60 seconds and thought the purple top sanitizer was to remain wet for 3 minutes. She was unsure of the exact time and stated she would check on that. She would expect the glucometer would be disinfected after each use, prior to placing in the co-mingled medication cart. She identified there was a high potential for cross contamination without appropriate disinfection having been performed. Review of the undated, Glucometer Disinfection policy identified cleaning was the removal of visible soil from the objects and surfaces and disinfection was the process that eliminate many or all pathogenic microorganisms, except bacterial spores on objects. Staff were to clean and disinfect glucometers after each use. Staff were to obtain 2 disinfectant wipes and clean the surface of the glucometer with the first wipe and then use the second wipe to disinfect the glucometer thoroughly and allow to air dry. EMPLOYEE SURVEILLANCE Review of the facilities staff illness logs from 2/21/25 through 6/30/25 noted the following categories:		F0880				

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F0880 SS = F	Continued from page 21 Department, First/Last name, absent date, type, reason, number of unexcused absences, illness testing/type, results, and number of days off. The illness logs identified the following: 1.) Activity Aid (AA)-A called off sick on 4/16/25, with influenza. The staff illness log did not identify what day AA-A returned to work, how they were cleared to return, or how many days she was out. 2.) Nursing assistant (NA)-A called off sick on 6/23/25, the type of call in was “personal”, and the reason was “unknown”. The log did not identify a return-to-work date, how they were cleared to return to work, or number of days off. Interview on 7/7/25 at 3:40 p.m., with the facilities infection preventionist identified she keeps a staff illness log for surveillance and in addition they use a form called Staff Call-In/Illness Report. The form is filled out by the charge nurse when a staff calls off. Review of the facility staff call in/illness reports identified the following: 1.) AA-A called off on 4/16/25, the reason for her absence was influenza, the report did not identify a return-to-work date, how they were cleared to return to work, or number of days absent. 2.) (NA)-A called off on 6/23/25 at 4:00 a.m., the reason was “feeling sick”. The report did not indicate symptoms, how they were cleared to return to work, or a return-to-work date. Interview on 7/9/25 at 10:46 a.m., with the director of nursing identified she agreed with the above finding. The facility has had a major turn over in staff and they are working on improving their staff surveillance program. She was unable to provide documentation of any additional training she had completed with the infection preventionist or other staff regarding staff surveillance. Review of the facilities undated Infection Surveillance policy identified the facility would collect data to properly identify possible communicable diseases or infections among residents and staff before the spread by identifying infections, signs and symptoms, location, number of residents or staff who developed			F0880			

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F0880 SS = F	Continued from page 22 infections, observation of staff, trends, and patterns. The policy made no mention that staff would document the return-to-work date in the staff illness surveillance.			F0880			

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/08/2025	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/08/2025. 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/07/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 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;			K0000			

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K0000	Continued from page 2 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 60 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			K0324	Corrective Action: 1. The residential stove in the Therapy Room had the electrical cord physically removed from the appliance so that it cannot function but serves only for demonstration purposes. 2. The residential stove from the North Dining room was physically removed from the dining room and is no longer on the premises. Measures and monitoring to ensure deficiencies do not recur: 1. No operational stoves or ranges will be placed in residential seating areas. If any would be installed in the future, they will be equipped with a shut-off timer that does not exceed 120 minute capacity that would automatically deactivate the cook top or range, independent of staff action. Those stoves and ranges used for demonstration purposes only in Restorative Therapy Room, shall have the electrical cords removed from the appliances to render them inoperable.		07/09/2025

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K0324 SS = F	Continued from page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/08/2025 at 10:35 AM, it was revealed by observation that the residential stove located in the Therapy Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. 2. On 07/08/2025 at 11:01 AM, it was revealed by observation that the residential stove located in the North Dining Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0324	Continued from page 3 Ongoing compliance monitoring: 1. The Maintenance Director will be responsible to ensure that no operational stoves or cooking ranges or cooking appliances will be placed in the North Resident Dining Room or in the Restorative Therapy room. Date of Correction: 07/09/2025		
K0355 SS = E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by:			K0355	Corrective Action: 1. The 3 portable Fire Extinguishers in the Maintenance Office and the 1 Fire Extinguisher in the Storage Room have been secured to the wall to prevent hazard from accidental tipping and accidental discharge. 2. The Fire Extinguisher in the Boiler Room was initialed after re-inspection to verify the monthly inspection had been completed. Measures and Monitoring to ensure deficiencies do not recur:		07/10/2025

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K0355 SS = E	Continued from page 4 Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/08/2025, at 10:18 AM, it was revealed by observation, that there were three fire extinguishers in the Maintenance Office that were not properly secured. 2. On 07/08/2025, at 10:23 AM, it was revealed by observation, that the fire extinguisher located in the Boiler Room had not inspected monthly. 3. On 07/08/2025, at 10:26 AM, it was revealed by observation, that there was a fire extinguisher in the Storage Room that was not properly secured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0355	Continued from page 4 1. Monthly Fire Extinguisher checks will be added to the TELS Maintenance monitoring system list to ensure continued compliance and that the deficiencies do not recur. Ongoing compliance monitoring: 1. The Maintenance Director will be responsible to ensure continued compliance through monitoring accomplished through audits by the TELS electronic Maintenance checklist monitoring system.			
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.		K0761	Corrective Action: 1. The residential stove in the Therapy Room had the electrical cord physically removed from the appliance so that it cannot function but serves only for demonstration purposes. 2. The residential stove from the North Dining room was physically removed from the dining room and is no longer on the premises. Measures and monitoring to ensure deficiencies do not recur: 1. No operational stoves or ranges will be placed in residential seating areas. If any would be installed in the future, they will be equipped with a shut-off timer that does not exceed 120 minute capacity that would automatically deactivate the cook top or range, independent of staff action. Those stoves and ranges used for demonstration purposes only in Restorative		07/09/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/08/2025	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 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
K0761 SS = F Bldg. 01	Continued from page 5 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/08/2025 at 10:32 AM, it was revealed by observation that the fire doors between the South wing and Nurse's Station did not shut completely when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	Continued from page 5 Therapy Room, shall have the electrical cords removed from the appliances to render them inoperable. Ongoing compliance monitoring: 1. The Maintenance Director will be responsible to ensure that no operational stoves or cooking ranges or cooking appliances will be placed in the North Resident Dining Room or in the Restorative Therapy room.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 25, 2025

Administrator
OLIVIA RESTORATIVE CARE CENTER

1003 WEST MAPLE AVENUE
OLIVIA, MN 56277

RE: CCN:245290

Cycle Start Date: July 10, 2025

Dear Administrator:

On July 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 10, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated.

This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 56277			
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E0000	Initial Comments On 7/07/25 through 7/10/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/08/2025	
F0000	INITIAL COMMENTS On 7/07/25 through 7/10/25, 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: H52908509C (MN113567), H52908510C (MN113705), H52908511C (MN113302), H52908512C (MN113789), and H52908528C (MN112893). 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.		F0000			08/08/2025	
F0678 SS = D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)		F0678	Immediate action(s) taken for the resident(s) found to have been affected include:		07/16/2025	

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0678 SS = D	Continued from page 1 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to update code status for 1 of 16 resident (R40) who requested to have his code status changed. Findings include: Document review on 7/7/25 at 4:51 p.m., R40 was identified to be a full code (Cardiopulmonary Resuscitation (CPR)) noted on his electronic medical record dashboard. Review of R40's Provider Orders for Life-Sustaining Treatment (POLST) signed by the resident and the physician identified he had changed his code status on 5/23/25 from CPR to Do not resuscitate (DNR). Interview on 7/8/25, at 2:00 p.m., with licensed practical nurse (LPN)-A identified if a resident's heart stops, they look at the dashboard to check code status, she explained the dashboard is at the top of a resident's main page in Point Click Care (PCC). PCC is the electronic system the facility uses for resident medical records. LPN-A opened R40's PCC main page and identified his code status is CPR. She identified when a resident is admitted they complete a Provider Orders for Life-Sustaining Treatment (POLST) form. A registered nurse updates the residents EMR in PCC and has the POLST reviewed and signed by the physician. LPN-A clicked a button next to the code status on the dashboard next to the code status to pull up R40's POLST. R40's most recent POLST identified he had requested to be DNR. LPN-A confirmed his code status listed on the dashboard in PCC was incorrect. Interview on 7/8/25 at 2:15 p.m., with the director of nursing identified if someone codes (heart stops beating) staff were to check the dashboard in PCC to check code status. Staff also have access to the POLST through the dashboard. She agreed R40's code status on the PCC dashboard was incorrect. At his last		F0678	Continued from page 1 All residents were audited for accuracy of code status on PCC to POLST in there documents and in the EMAR system. Identification of other residents having the potential to be affected was accomplished by: All residents could be affected by failing to update and change the code status. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing staff were educated on the importance of the code status by the DON. Licensed nurses were educated on how to change it in the computer and what to do when a POLST/Code status is received during an in-service on 7-16-25 by the DON. Nursing department staff are educated on their shift that have missed the meeting. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee is doing audits of new residents weekly to assure POLST is accurate. DON/designee picks 3 resident beyond the new admissions to assure the code status is accurate weekly. Review of code status will happen for 4 weeks, then monthly x3 and then PRN after. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.			

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F0678 SS = D	Continued from page 2 appointment, R40 requested to have his code status changed from CPR to DNR because he was "considering" hospice. Nursing should have put the new order in, "but it must have been missed". She identified she does audits on code status a couple times a year and the last one completed was about 2 days prior to R40's change. Review of the facility provided undated Residents' Rights Regarding Treatment and Advance Directives policy identified the facility would determine code status upon admission. Advance directive documents provided to the facility would be placed in the medical record. During the care planning process, the facility would identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. The policy made no mention how staff were to confirm code status should a resident require CPR if elected while living at the facility.	F0678		
F0725 SS = F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F0725	Immediate action(s) taken for the resident(s) found to have been affected include: Staffing was reviewed to ensure 24 hours of licensed nursing coverage continues. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents can be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Education will be given to nursing department to make sure they communicate with the DON if there is no nurse coming on and a licensed nurse must stay in the building until another licensed nurse is clocked in. DON/designee review schedule to ensure licensed staff are scheduled 24 hours a day. Education sent out via	08/13/2025

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F0725 SS = F	Continued from page 3 (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to have licensed nursing coverage on staff for 24 hours a day, based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed - Quarter 2, 2025, (January 1 to March 31st), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 39 residents living in the facility. Findings include: Review of the 2/09/25, Daily Assignment Sheet identified 1 charge nurse was assigned for the day and 1 charge nurse for the evening shift (minimum 12 hr. shifts). Licensed practical nurse (LPN)-E was listed as having worked the day shift. Registered nurse (RN)-C was listed as having worked the night shift. Review of 2/09/25, Individual Daily Staffing Casper Report 1702D identified the facility data submitted for Provider Based Journal (PBJ) noted of the floor staff working that day, there was noted to be 1 registered nurse (RN-C), and 1 contract LPN (LPN-E) captured for hours worked. Review of 2/09/25, staff timesheet punches provided by the facility identified only RN-C was clocked in as having worked. There was no way to verify LPN-E had worked the hours documented on the assignment sheet and as captured in the PBJ. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and			F0725	Continued from page 3 video and quiz to be completed by 8-13-25. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will review time sheets daily for 1 week, then weekly x4; then monthly x3; and then as needed after this. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		

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F0725 SS = F	Continued from page 4 communicated with the administrator. The DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently “overstaffs” their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of April 2025, facility assessment staffing plan portion identified it was based on the facility and community risk assessments, in addition to patient per day (PPD) methodology to determine the maximum number of hour available per day. Staffing assignments and variances was managed by moving staff, calling staff off, or calling in relief or extra staff, after staffing requirements was completed. Direct care staffing hours identified to be required were: 1 RN or LPN per day shift and 1 RN or LPN per evening/night shift. A copy of contract staff timesheets was requested but not received.		F0725				
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3]		F0727	Immediate action(s) taken for the resident(s) found to have been affected include: Staffing Reviewed. Reviewed with nursing department to ensure knowledge of needing RN coverage 8 hours consecutively in a 24 hour period is to be scheduled. The facility's assessment is reviewed to determine the required number of staff needed to meet resident needs on weekdays and weekends and adjusted accordingly. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include:		08/13/2025	

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F0727 SS = F	Continued from page 5 §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) 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 record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day, 7 days per week, for 6 of 90 days reviewed. This had the potential to affect all 39 residents living in the facility. Findings include: Review of the facility schedule and timesheets for January 2025, February 2025, and March 2025 identified on: 1) January, there was no RN coverage for 2 of 31 days: 1/24/25 and 1/31/25. 2) February, there was no RN coverage for 3 of 28 days: 2/09/25, 2/14/25, 2/15/25. 3) March, there was no RN coverage for 1 of 31 days: 3/02/25. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units.			F0727	Continued from page 5 Education given to nursing department related to having an RN in the building 8 hours a day consecutively needs to happen. If this is not happening, DON needs to be notified. Reviewed the Nursing Staffing- RN and Facility assessment. Education sent out via video and quiz to be completed by 8-13-25. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will review the daily schedule to assure RN 8 hr coverage is scheduled r daily for 1 week, then weekly x4; then monthly x3; and then as needed after this. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		

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F0727 SS = F	Continued from page 6 Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population.	F0727		
F0812 SS = F	Review of March 2025 Nursing Services-Registered Nurse (RN) policy identified the facility was to utilize the services of an RN 8 consecutive hours per day, 7 days per week. The director of nursing (DON) may service as a charge nurse when the facility had a daily occupancy of 60 or fewer residents. In addition, the facility, was to submit timely and accurate staffing data through CMS payroll-based Journal (PBJ) system.			
	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control practices were maintained to ensure dietary staff were wearing a hair net and/or beard nets while in 1 of 1	F0812	Corrective action will be accomplished for identified affected individuals. It is the policy of the facility to ensure that all dietary staff must wear hair restraints (e.g. hairnet, hat and or beard restraint) to prevent hair from contacting food. It is the policy of he facility to ensure that food stored in the kitchen and kitchenettes are dated and not expired. It is the policy of the facility to ensure the chemical solution shall be maintained at the correct concentration, based on periodic testing. it is the responsibility of the dietary staff to check chemical test strip expiration dates prior to use. All residents have the potential to be affected. The dietary manager will promptly reeducate dietary staff regarding hair net requirement in the dietary department. Dietary manager will re-educate dietary staff on date marketing for food safety along with adding to check expiration dates for chlorine test strips to dish machine procedures. Systemic Changes will occur to ensure that the deficient practice will not occur: Dietary Manager will promptly re-educate dietary staff of Hair net Requirements in the Dietary Department. The dietary department will implement a checklist for auditing food storage in the kitchenettes to ensure	07/21/2025

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F0812 SS = F	Continued from page 7 kitchen and during meal services. The facility also failed to ensure 1 of 2 dining room refrigerators remained clean, and food was dated within the refrigerator to ensure it was not used beyond expiration. Additionally, the facility failed to ensure all Chlorine test strips for monitoring the dishwasher chemical level were not expired. Findings include: Observation and interview on 7/7/25 at 11:32 a.m., identified upon entrance to the kitchen for initial tour, dietary aide (DA)-A was preparing drinks for transportation to the dining rooms for the noon meal. DA-A had no hair net on. DA-A reported she was supposed to be wearing a hair net and there was no reason she did not have it on. Observation and interview on 7/7/25 at 11:40 a.m., cook (C)-A was standing behind the steam table outside of the north dining room and dishing up food for residents' noon meal. C-A had a hair net on but no beard net on. C-A had a mustache and beard. C-A reported he had never worn a beard net before; he was unaware he needed to wear one and was not even sure if the facility had any. Observation on 7/7/25 at 12:07 p.m., of the refrigerator in the central dining room which contained 2 large metal bins of individually wrapped ½ sandwiches that were undated. There was something pink spilled all over the bottom of the refrigerator and on the inside door of the refrigerator. The floor directly in front of the refrigerator was extremely sticky and dark brown/black in color. Observation on 7/7/25 at 5:24 p.m., C-A was standing behind the steam table in the central dining room dishing up food for the resident evening meal. C-A had a hair net on and no beard net on. Observation on 7/8/25 at 9:40 C-A just finished serving breakfast and had no beard net on. Observation and interview on 7/8/25 at 10:00 a.m., of the dishwasher cycle and DA-A testing the dishwasher chemical level with Hydrion Chlorine Test strips identified that the test strips had expired on 6/1/25.			F0812	Continued from page 7 items stored are dated and/or not expired. Checking the chlorine test strips expiration date will be add to the daily dish machine log. How the facility will monitor its corrective actions/ performance: Dietary Manager or other designee will complete audits 3x a week for 2 months to ensure that food stored in the kitchenettes are labeled and not expired. Dietary Manager or designee will complete daily audits x1 month to ensure all dietary employees are wearing proper hair nets/beard nets. Dietary manager or designee will audit weekly x2 months the documentation of Chlorine Test Strips Expiration Dates. Audits will be reviewed in QAPI until such time consistent with substantial compliance has been achieved as determined by the committee.		

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F0812 SS = F	Continued from page 8 DA-A was unaware the test strips had expired and discarded the testing strips and obtained a new packet. Observation on 7/9/25 at 8:36 a.m., of the refrigerator in the central dining room with DA-A and maintenance director who confirmed pink juice had been spilled all over the bottom of the refrigerator and the inside part of the refrigerator door. The floor area just in front of the refrigerator was dirty with dark brown/black sticky substance on the floor. C-A reported she believed that housekeeping was responsible for cleaning the refrigerator and floor. The maintenance director agreed that the floor was very sticky, and the refrigerator was dirty and needed to be cleaned. Observation and interview on 7/9/25 at 8:45 a.m. with dietary manager assistant (DMA)-A removed items from the bottom shelf of the refrigerator in the central dining room and agreed that the refrigerator was dirty with some sort of juice spilled all over the bottom of the refrigerator and the inside door of the refrigerator. She reported that it was dietary responsibility to clean the inside of the refrigerator and housekeeping responsibility to clean the outside and the floors in the dining room. She further confirmed that all dietary staff should be wearing hair nets and beard net if needed in the kitchen and when serving food. If there are no beard nets available staff can use a hair net to cover their beard. Staff should be checking the expiration date on the chemical test strips prior to checking the chemical level in the dishwasher. Interview on 7/9/25 at 9:02 a.m., with dietician identified all food in the refrigerators should be dated. The dietary staff should be monitoring the refrigerators for expired foods and cleaning on a regular basis. Her expectation was that staff would be wearing hair net and/or beard nets when in the kitchen and during food service. The chemical strips should be monitored for expiration and new ones ordered when needed. Review of undated, Dietary Employee Personal Hygiene policy identified all dietary staff must wear hair restraints including beard restraints to prevent hair from contacting food. Review of undated, Routine Cleaning and Disinfection		F0812				

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F0812 SS = F	Continued from page 9 policy identified routine cleaning, and disinfection was maintained to ensure safe, sanitary environment and to prevent transmission or development of infections to the extent possible. Cleaning of visible soil from objects and surfaced and frequently touched surfaces would be performed. Review of undated, Low Temperature Dish Machine Guidelines identified the wash and rinse cycle should be maintained between 120-145 Fahrenheit. The low temperature sanitizer level should be checked daily with the Chlorine test strip with an acceptable range from 50-100 ppm.	F0812		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;	F0838	Immediate action(s) taken for the resident(s) found to have been affected include: The facility assessment was reviewed to ensure the schedule going forward matched the assessment. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing department will receive education on the need to follow the nursing schedule to provide cares and services to residents. Will review staffing portion on the facility assessment with the nursing department. Education went out via video and quiz to be completed by 8-13-25. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will review the daily schedule to assure RN 8 hr coverage is scheduled daily for 1 week, then weekly x4; then monthly x3; and then as needed after this. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	08/13/2025

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F0838 SS = F	Continued from page 10 (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of			F0838			

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F0838 SS = F	Continued from page 11 nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement 1 of 1 facility assessment and ensure the required nursing staff were scheduled and working to provide care and services to residents. Findings include:		F0838				

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F0838 SS = F	Continued from page 12 Review of the 2/09/25, Daily Assignment Sheet identified 1 charge nurse was assigned for the day and 1 charge nurse for the evening shift (minimum 12 hr. shifts). Licensed practical nurse (LPN)-E was listed as having worked the day shift. Registered nurse (RN)-C was listed as having worked the night shift. Review of 2/09/25, Individual Daily Staffing Casper Report 1702D identified the facility data submitted for Provider Based Journal (PBJ) noted of the floor staff working that day, there was noted to be 1 registered nurse (RN-C), and 1 contract LPN (LPN-E) captured for hours worked. Review of 2/09/25, staff timesheet punches provided by the facility identified only RN-C was clocked in as having worked. There was no way to verify LPN-E had worked the hours documented on the assignment sheet and as captured in the PBJ. Review of the facility schedule and timesheets for January 2025, February 2025, and March 2025 identified on: 1) January, there was no RN coverage for 2 of 31 days: 1/24/25 and 1/31/25. 2) February, there was no RN coverage for 3 of 28 days: 2/09/25, 2/14/25, 2/15/25. 3) March, there was no RN coverage for 1 of 31 days: 3/02/25. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. The DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently “overstaffs” their employees on the units above the		F0838				

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F0838 SS = F	Continued from page 13 required allotted hours needed daily to ensure services and care needs for the resident population. Review of April 2025, facility assessment staffing plan portion identified it was based on the facility and community risk assessments, in addition to patient per day (PPD) methodology to determine the maximum number of hour available per day. Staffing assignments and variances was managed by moving staff, calling staff off, or calling in relief or extra staff, after staffing requirements was completed. Direct care staffing hours identified to be required were: 1 RN or LPN per day shift and 1 RN or LPN per evening/night shift. A copy of contract staff timesheets was requested but not received.	F0838		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care	F0851	Immediate action(s) taken for the resident(s) found to be affected include: No residents were affected by the inaccurate data that was submitted to CMS. Review if the schedules were completed and Nursing Coverage did occur on the dates stated as no Nurse on duty. Identification of other residents having the potential to be affected was accomplished by: All the residents had the potential to be affected if no Nurse coverage had happened. A new time tracking system had been put into place prior to survey with managers responsible to review all time sheets to ensure accuracy. Actions taken/systems put into place to reduce the risk of future occurrence include: Business office manager will review time sheets for missing punches or missing timecards and each department head will follow up to ensure that the employee has completed a missed punch form and the hours worked will be entered into the payroll-based journal to ensure accurate data is being reported per The New program is set up for all managers to review the prior days punches for all staff members to ensure that staff have punched in/out and if there are any missing punches the Manager is required to determine the time. Staff members were educated on how to complete a missed punch form that each manager is required to sign and give to the business office.	08/13/2025

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F0851 SS = F	Continued from page 14 staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit accurate staffing data based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed - Quarter 2, 2025, (January 1 to March 31st), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 39 residents living in the facility. Findings include: JANUARY Review of the 1/24/25, Daily Assignment Sheet identified 1 charge nurse as noted to be on the day shift, 1 charge nurse on the evening shift, and 1 nurse	F0851	Continued from page 14 Each morning in the department managers meeting, missed punches will also be reported. The business office manager will complete an audit form indicating how many employees have missed punches or missed punch forms. PBJ resubmission is completed to provide compliance of corrected reportable hours. How the corrective action(s) will be monitored to ensure the practice will not occur: Each morning in department managers meeting, missed punches will also be reported. The business office manager will complete an audit form indicating how many employees have missed punches or missed punch forms. Missed punch counts will be calculated on a monthly basis and presented to the QAA committee to ensure all information has been entered and is accurate prior to submission according to CMS guidelines for three months or until compliance has been met.	

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F0851 SS = F	Continued from page 15 for RN coverage. Review of 1/24/25, staff timesheets identified: 1) Licensed practical nurse (LPN)-B had worked 06:59 a.m. to 11:36 a.m. and 11:59 a.m. to 9:06 p.m., for a total of 13.62 hours. 2) LPN-C had worked 06:00 a.m. to 7:40 p.m., for a total of 12.67 hours. 3) RN-C had worked 06:03 p.m. to 06:30 a.m., the next day for a total of 11.45 hours. Review of the 1/24/25, Individual Daily Staffing- 1702D Casper Report identified 1 LPN with 13.62 captured hours, and 1RN with 13.0 captured hours. FEBRUARY Review of the 2/21/25, Daily Assignment Sheet identified 1 charge nurse on the day shift and 1 nurse for RN coverage. The sheet lacked evidence a charge nurse was assigned on the evening shift. Review of 2/21/25, staff time sheets identified: 1) The director of nursing (DON) had worked 8:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 2) RN-B had worked from 8:09 a.m. to 12:42 a.m., the next day for a total of 16.05 hours. 3) RN-C had worked from 6:05 p.m., to 7:33 a.m., the next day for a total of 12.97 hours. Review of the 2/21/25, Individual Daily Staffing- 1702D Casper Report identified only 1 LPN with 14.23 captured hours, the director of nursing for 8 hours, and 1 registered nurse with 12.35 captured hours. Review of the 2/28/25, Daily Assignment Sheet identified 1 RN was assigned to the day shift (RN-B) who was the Minimum Data Set (MDS nurse) and 1 RN was assigned to the evening/night shift. Review of 2/28/25, staff time sheets identified:		F0851				

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NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 56277			
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F0851 SS = F	Continued from page 16 1) The DON had worked 08:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 2) RN-C had worked 08:08 a.m. to 7:43 p.m., for a total of 11.08 hours. 3) LPN-B had worked from 6:13 a.m. to 11:53 a.m. and again from 11:53 a.m. to 7:58 p.m., for a total of 13.23 hours captured. 4) LPN-D had worked 5:59 p.m. to 06:57 a.m., for a total of 12.47 hours. Review of 2/28/25, Individual Daily Staffing- 1702D Casper Report identified 1 RN with administrative duties only worked for 11.08 hours. No other floor RN staff were noted. 3 LPN's were submitted. 1 LPN with 13.23 hours, 1 LPN with 12.43, and 1 contracted LPN with 14.38 hours. The DON had 8 hours captured. MARCH Review of the 3/21/25, Facility Daily assignment sheet identified 1 LPN (LPN-E) worked the day shift, and also on days was RN-B (the MDS nurse), who was assigned as RN coverage. There was no nurse listed for the evening/night shift. Review of 3/21/25, staff timesheets identified: 1) LPN-B had worked from 7:59 a.m. to 09:55 a.m. and again from 10:38 a.m. to 7:16 p.m., for a total of 10.57 hours. 2) The DON had worked from 8:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 3) RN-B classified as RN with administrative duties, worked from 8:53 a.m. to 12:16 p.m., for a total of 3.38 hours. 4) RN-C had worked 7:13 p.m. to 06:29 a.m., for a total of 10.77 hours. Review of 3/21/25, 1702D Casper report identified 1 RN with administrative duties worked 3.38 hours, the DON hours captured were 8.0, 1 RN hours were captured as 10.85, and 2 LPN's (1 contract and 1 exempt) were			F0851			

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F0851 SS = F	Continued from page 17 captured with 10.57 and 13.72 hours respectively. There was no additional RN with any captured hours submitted. There was no indication the above-mentioned data submitted had been checked for accuracy prior to their respective submissions. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs and reviewed PBJ hours weekly before submission. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of the July 2024, Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Frequently Asked Questions, located at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/pbj-policy-manual-faq-11-19-2018.pdf, identified reporting shall be based on the employee's primary role. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out when needed). Facilities shall still report just the total hours of that employee based on their primary role. However, CMS recognizes that staff may completely shift their primary role in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). Review of March 2025 Payroll Based Journal policy identified the facility was to submit timely and			F0851			

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F0851 SS = F	Continued from page 18 accurate direct care staffing information according to specifications established by CMS. In the addition, the facility was to ensure staffing data was auditable and able to verify through either payroll, invoices, and/or tied back to contract staff.	F0851		
F0880 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 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 §483.71 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:	F0880	Immediate action(s) taken for the resident(s) found to have been affected include: Glucometer use and disinfection education was given to the licensed nurses and trained medication assistants inthe facility on 7-16-25. Staff continue to be educated upon there return to work. Policy of Glucometer disinfection reviewed. Review of the facilities Infection Surveillance Policy was completed. Updated line listing for information related to return-to-work date, and symptoms start/end date. Updated Illness form for the floor staff to utilize to communicate illnesses to managers. Identification of other residents having the potential to be affected was accomplished by: The facility has determined all residents in the facility are at risk due to checking blood sugars can be a nursing judgement. Main residents affected are residents who are diabetics and residents utilizing psychotic medications. The facility has determined all residents have the ability to be affected by ill staff members. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed nurses and trained medication assistants will be retrained on glucometer disinfection via review of the policy and competency completion. Licensed nurses and trained medication assistants will be educated prior to there next shift on the floor. Education will be provided via video and quiz to be completed by 8-13-25. Staff who do not have it completed will be expected to complete prior to their next shift. Education reviewed with the DON and Staffing scheduler about the process of illness forms and documentation. DON/designee to review all illness forms, contact ill	08/13/2025

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F0880 SS = F	Continued from page 19 (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 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 and interview the facility failed to disinfect 1of 2 glucometers (capillary blood glucose sampling device) after use to prevent transmission of blood borne diseases. Additionally, the facility failed to complete accurate staff illness surveillance for 2 of 2 staff. Findings include: Observation on 7/9/25 at 7:43 a.m., with registered nurse (RN)-A identified RN-A gathered the glucometer from the treatment cart to check R15's blood sugar. RN-A used a lancet to prick R15's finger to obtain a blood sample to test R15's blood sugar with the glucometer. RN-A exited R15's room and walked back to the treatment cart where she placed the used lancet in the sharp's container and the glucometer back in the drawer next to another resident's glucometer without	F0880	Continued from page 19 staff member, and log into the spread sheet. Education on Illness forms and documentation of when return to work criteria completed with staff members via video and quiz to be completed by 8-13-25. Staff who do not have it completed will be expected to complete prior to their next shift. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete random weekly audits for compliance with disinfection of glucometers for 4 weeks and then monthly x3 months and then as needed after. Audit records will be reviewed by the QAA committee until such time consistent substantial compliance has been achieved as determined by the committee. The DON/designee will review call-in log related to staff illness daily x1 week; weekly x4; monthly x3 and as needed after for compliance with completion of the spreadsheet to assure documentation is completed such as but not limited to illness type, start end of symptoms, and return to work date is communicated and completed.	

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F0880 SS = F	Continued from page 20 first disinfecting it. She walked back to the nurse's station to chart the blood sugar and check to see if R15 required any sliding scale insulin. Interview on 7/9/25 at 7:55 a.m., RN-A stated she had meant to disinfect the glucometer, but she had gotten "nervous and forgot". RN-A then opened the treatment cart and pulled both glucometers out of the drawer. She used purple top Sani-cloth disinfecting wipes and briefly wiped off both glucometers and then returned the glucometers to the drawer. RN-A did not allow any "wet" contact time per the Sani-cloth instructions prior to returning glucometers to the treatment cart drawer. The General Guidelines for Use undated, (purple top) Super Sani-cloth germicidal disposable wipes instructions identified: 1) to unfold the wipe and thoroughly wet the surface 2) allow treated surface to remain wet for two minutes. Let air dry. 3) Do not reuse towelette. Dispose of used towelette in trash. Interview on 7/9/25 at 9:37 a.m., with director of nursing (DON) identified the glucometer should be cleaned after each use with an alcohol wipe for 60 seconds and thought the purple top sanitizer was to remain wet for 3 minutes. She was unsure of the exact time and stated she would check on that. She would expect the glucometer would be disinfected after each use, prior to placing in the co-mingled medication cart. She identified there was a high potential for cross contamination without appropriate disinfection having been performed. Review of the undated, Glucometer Disinfection policy identified cleaning was the removal of visible soil from the objects and surfaces and disinfection was the process that eliminate many or all pathogenic microorganisms, except bacterial spores on objects. Staff were to clean and disinfect glucometers after each use. Staff were to obtain 2 disinfectant wipes and clean the surface of the glucometer with the first wipe and then use the second wipe to disinfect the glucometer thoroughly and allow to air dry. EMPLOYEE SURVEILLANCE Review of the facilities staff illness logs from 2/21/25 through 6/30/25 noted the following categories:		F0880				

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F0880 SS = F	Continued from page 21 Department, First/Last name, absent date, type, reason, number of unexcused absences, illness testing/type, results, and number of days off. The illness logs identified the following: 1.) Activity Aid (AA)-A called off sick on 4/16/25, with influenza. The staff illness log did not identify what day AA-A returned to work, how they were cleared to return, or how many days she was out. 2.) Nursing assistant (NA)-A called off sick on 6/23/25, the type of call in was “personal”, and the reason was “unknown”. The log did not identify a return-to-work date, how they were cleared to return to work, or number of days off. Interview on 7/7/25 at 3:40 p.m., with the facilities infection preventionist identified she keeps a staff illness log for surveillance and in addition they use a form called Staff Call-In/Illness Report. The form is filled out by the charge nurse when a staff calls off. Review of the facility staff call in/illness reports identified the following: 1.) AA-A called off on 4/16/25, the reason for her absence was influenza, the report did not identify a return-to-work date, how they were cleared to return to work, or number of days absent. 2.) (NA)-A called off on 6/23/25 at 4:00 a.m., the reason was “feeling sick”. The report did not indicate symptoms, how they were cleared to return to work, or a return-to-work date. Interview on 7/9/25 at 10:46 a.m., with the director of nursing identified she agreed with the above finding. The facility has had a major turn over in staff and they are working on improving their staff surveillance program. She was unable to provide documentation of any additional training she had completed with the infection preventionist or other staff regarding staff surveillance. Review of the facilities undated Infection Surveillance policy identified the facility would collect data to properly identify possible communicable diseases or infections among residents and staff before the spread by identifying infections, signs and symptoms, location, number of residents or staff who developed			F0880			

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

FORM APPROVED
OMB NO. 0938-0391

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F0880 SS = F	Continued from page 22 infections, observation of staff, trends, and patterns. The policy made no mention that staff would document the return-to-work date in the staff illness surveillance.			F0880			

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/08/2025. 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/07/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 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;			K0000			

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K0000	Continued from page 2 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 60 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			K0324	Corrective Action: 1. The residential stove in the Therapy Room had the electrical cord physically removed from the appliance so that it cannot function but serves only for demonstration purposes. 2. The residential stove from the North Dining room was physically removed from the dining room and is no longer on the premises. Measures and monitoring to ensure deficiencies do not recur: 1. No operational stoves or ranges will be placed in residential seating areas. If any would be installed in the future, they will be equipped with a shut-off timer that does not exceed 120 minute capacity that would automatically deactivate the cook top or range, independent of staff action. Those stoves and ranges used for demonstration purposes only in Restorative Therapy Room, shall have the electrical cords removed from the appliances to render them inoperable.		07/09/2025

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NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 56277			
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K0324 SS = F	Continued from page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/08/2025 at 10:35 AM, it was revealed by observation that the residential stove located in the Therapy Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. 2. On 07/08/2025 at 11:01 AM, it was revealed by observation that the residential stove located in the North Dining Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0324	Continued from page 3 Ongoing compliance monitoring: 1. The Maintenance Director will be responsible to ensure that no operational stoves or cooking ranges or cooking appliances will be placed in the North Resident Dining Room or in the Restorative Therapy room. Date of Correction: 07/09/2025			
K0355 SS = E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by:		K0355	Corrective Action: 1. The 3 portable Fire Extinguishers in the Maintenance Office and the 1 Fire Extinguisher in the Storage Room have been secured to the wall to prevent hazard from accidental tipping and accidental discharge. 2. The Fire Extinguisher in the Boiler Room was initialed after re-inspection to verify the monthly inspection had been completed. Measures and Monitoring to ensure deficiencies do not recur:		07/10/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/08/2025	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 56277			
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K0355 SS = E	Continued from page 4 Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/08/2025, at 10:18 AM, it was revealed by observation, that there were three fire extinguishers in the Maintenance Office that were not properly secured. 2. On 07/08/2025, at 10:23 AM, it was revealed by observation, that the fire extinguisher located in the Boiler Room had not inspected monthly. 3. On 07/08/2025, at 10:26 AM, it was revealed by observation, that there was a fire extinguisher in the Storage Room that was not properly secured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0355	Continued from page 4 1. Monthly Fire Extinguisher checks will be added to the TELS Maintenance monitoring system list to ensure continued compliance and that the deficiencies do not recur. Ongoing compliance monitoring: 1. The Maintenance Director will be responsible to ensure continued compliance through monitoring accomplished through audits by the TELS electronic Maintenance checklist monitoring system.		
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.			K0761	Corrective Action: 1. The residential stove in the Therapy Room had the electrical cord physically removed from the appliance so that it cannot function but serves only for demonstration purposes. 2. The residential stove from the North Dining room was physically removed from the dining room and is no longer on the premises. Measures and monitoring to ensure deficiencies do not recur: 1. No operational stoves or ranges will be placed in residential seating areas. If any would be installed in the future, they will be equipped with a shut-off timer that does not exceed 120 minute capacity that would automatically deactivate the cook top or range, independent of staff action. Those stoves and ranges used for demonstration purposes only in Restorative		07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/08/2025	
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K0761 SS = F Bldg. 01	Continued from page 5 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/08/2025 at 10:32 AM, it was revealed by observation that the fire doors between the South wing and Nurse's Station did not shut completely when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	Continued from page 5 Therapy Room, shall have the electrical cords removed from the appliances to render them inoperable. Ongoing compliance monitoring: 1. The Maintenance Director will be responsible to ensure that no operational stoves or cooking ranges or cooking appliances will be placed in the North Resident Dining Room or in the Restorative Therapy room.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 2, 2025

Administrator
OLIVIA RESTORATIVE CARE CENTER
1003 WEST MAPLE AVENUE
OLIVIA, MN 56277

RE: CCN: 245290

Cycle Start Date: July 10, 2025

Dear Administrator:

On August 26, 2025, we notified you a remedy was imposed. The Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 5, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 9, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 26, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 9, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 5, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



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