Electronically delivered
October 26, 2021

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

RE: CCN: 245290
Cycle Start Date: October 7, 2021

Dear Administrator:

On October 8, 2021, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 January 8, 2022 (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 April 8, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 10/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/7/21 through 10/8/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5290031C (MN76802), with a deficiency cited at F610. 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 that substantial compliance with the regulations has been attained.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610		11/12/21

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

Electronically Signed | 11/04/2021

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

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F 610	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident to resident sexual abuse allegations were thoroughly investigated to ensure protection for 2 of 3 residents (R1,R2) who resided on the locked memory care unit. Findings include: R1 R1's admission Minimal Data Set (MDS) dated 8/30/21, indicated R1 had diagnoses which included Alzheimer's and non-traumatic brain dysfunction. Further review of MDS, indicated R1 required supervision of one staff member for bed mobility, transfers and ambulation and extensive assist of one staff member for dressing and hygiene. In addition, MDS indicated R1 had severe cognitive impairments. R1's care plan printed 10/8/21, indicated R1 had periods of increased anxiety and restlessness which was displayed by looking for his wife and wanting to return home. R1's care plan revised on 9/22/21, indicated R1 had been physically inappropriate to female residents and verbally inappropriate to female staff and directed staff to de-escalate R1 with changing the subject to farming or offering food, intervene before agitation escalates, guide away from source of distress, offer a snack or offer an activity of interest.	F 610	On 10/14/21 an internal investigation was completed for the 9/16/21 investigation involving R1 and R2. To prevent further incident to other potential residents, on 11/4/21 all incidents for the past 6 months involving resident to resident concerns have been reviewed and investigation completed, as needed. To ensure systemic change has been made. the process for completing investigations has been reviewed and updated. Nurses will be educated on this new process by 11/12/21. Social Services was educated on this process on 11/4/21. The Administrator or designee will complete random audits on full completion of investigations weekly times 4 weeks. biweekly times 1 month, and monthly times 1 month, then randomly, as needed. Any immediate action will be identified and corrected. Results will be brought to the QAPI committee for further review and recommendations.	

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F 610	Continued From page 2	F 610		

Review of R1's progress notes included:
- On 9/13/21, R1 was making sexually inappropriate comments to a nursing assistant and was hard to redirect.
- On 9/15/21, R1 was noted "flirting with staff" and "moving closer to staff members wanting to touch them." Interventions were noted to be semi-effective "as he just keeps repeating his advanced towards staff." R1 was noted to do into another resident's room on this date.
- On 9/16/21, R1 "inappropriately touched another female resident in the hallway near dining room. [R1] touched the female resident on left abdomen and into groin. Female resident was immediately moved away from [R1]. [R1] was placed on 15-minute checks and stop signs were placed outside of female resident's door. Resident had been seen walking out of S9, approximately 20 minutes before incident in hallway. He was redirected to his room to evening meal by staff." On 9/16/21, VA report was filed.
- On 9/18/21, R1 approached R2 asking her, "Do you want to have sex with me?" and attempted to touch her hands.
- On 9/19/21, R1 displayed sexual inappropriate behavior every shift.
- On 9/20/21, R1 continued to display sexually inappropriate behavior and attempting to hug and kiss staff and hold hands and hug another female resident.

R2
R2's quarterly MDS dated 9/28/21, indicated R2 had diagnoses which included non-traumatic brain dysfunction, dementia and had severe cognitive impairments. Further review of MDS, indicated R1 required extensive assistance of two staff members for bed mobility, extensive assist of one staff member to dress, limited assistance

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transferring, and supervision while ambulating.

R2's care plan printed 10/8/21, indicated R2 was at risk for elopement related to disoriented to place, impaired safety awareness and aimlessly wanders. Further review of care plan indicated R1 had impaired communication related to dementia and shows difficulty with word finding and will often stay silent. In addition, care plan indicated R2 was at risk for safety and abuse due to cognitive level directing staff to ensure safety around others, keeping others away from R1 who may disturb her, and to redirect R1 if R1 appears to be confused or at risk to something that may have causes distress.

Review of R2's progress notes indicated on 9/16/21, R2 "was inappropriately touched in left abdomen and into groin on top of clothing in the hallway by another male resident. Inappropriate touch was reported to nurse by the CNA [certified nursing assistant]. [R2] and other resident both have severe cognitive declines. [R2] was immediately moved away from other resident to prevent further incident. Incident was reported to spouse, DON [director of nursing], and administrator."

Review of facility report dated 9/16/21, indicated R1 inappropriately touched R2 in left abdomen and groin area on top of R2's clothing at approximately 5:15 p.m. In addition, review of facility report dated 9/22/21, indicated the investigation summary included "writer spoke with [RN-A] who reported the incident. She interviewed staff who witnessed the incident. Staff stated [R1] touched [R2] inappropriately in the groin area. Writer spoke with other staff whom were present that evening to which witnessed

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nothing. Writer also interviewed each resident on the unit. No concerns noted."

Review of facility's internal investigation for incident that occurred on 9/16/21, between R1 and R2 included 15-minute checks for R1, stops signs on female resident's doors, and R1's updated care plan and interventions. Interviews with all resident's on memory care unit revealed no additional concerns. However, internal investigation lacked evidence of interviewing additional staff members who were assigned the care of R1 on the date of the incident to determine a root cause for the incident involving R1 and R2 and ensure appropriate interventions were implemented. In addition, the internal investigation lacked evidence of interview with spouse to complete a background history of resident's sexually inappropriate behaviors.

On 10/07/21, at 2:49 p.m. nursing assistant (NA)-A indicated R1 has shown an increase in sexual aggression. NA-A indicated R1 had made sexual comments towards NA-A stating "I want to [explicit word] you" and was also known to focus on female staff. On 9/16/21, NA-A stated she witnessed R1 attempting to hold R2's hand on a few different occasions and NA-A immediately separated the two residents prior to the incident of R1 inappropriately touching R2.
On 10/7/21, 3:22 p.m. NA-B indicated R1 had made sexual comments and "will flirt with caregivers and want to lay in bed with him." NA-B indicated she did not witness R1 touch R2 on 9/16/21, however NA-C approached NA-B and stated "I just had to stop R1 from touching R2. [R1] touched [R2] and started rubbing [R2]'s stomach" so NA-C went "in there and told them to stop."

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On 10/8/21, at 8:34 a.m. family member (FM)-A indicated R1 had been in another facility prior to admitting to Olivia Restorative Care Center for short term rehab and FM-A stated R1 had been "inappropriate there. I don't know if he touched them or just verbally saying things and then they started using a male nurse after that." In addition, FM-A stated, "this is not a new behavior." Further, FM-A indicated R1's sexual aggression while at current facility began about "10 days or so after admission" when he became "flirtatious" however, stated "I don't think he crossed the line until recently. They were telling me he was being inappropriate at times and then they called me and said he touched this resident and was getting a little more sexual with staff. So, I called his psychiatrist."

On 10/8/21, at 10:03 a.m. social services (SS) indicated she completed the investigation involving the incident between R1 and R2. SS indicated on 9/16/21, she spoke with registered nurse (RN)-A and was provided that neither R1 nor R2 could recall the incident happening. Further, SS indicated on 9/20/21, R1 and R2 were interviewed, and neither could recall the incident and other residents on the memory care unit were interviewed as well. In addition, SS stated "I don't think any other staff were interviewed other than [NA-C], who was the nursing assistant on north center [a different unit than the memory care] because the other two nursing assistants on were in rooms feeding at that moment."

On 10/8/21, at 10:12 a.m. NA-D indicated R1 had made sexual comments towards staff, residents, and himself. NA-D indicated NA-C approached

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him on 9/16/21, to report NA-C had witnessed R1 touch R2. Further NA-D denied it was reported to him on 9/16/21, when R1 and R2 were noted to be holding hands prior to the incident. In addition, NA-D stated "I have caught them [R1 and R2] holding hands and sitting in the dinning room [R1] asked [R2] to have sex with him. I want to say that was last week. It was after the incident where they were touching each other." NA-D then stated "I was not spoken to about the incident on 9/16/21, and no one spoke to me about the other incident either. I was told to keep an eye out and keep them away and redirect to the rooms. I know the nurse told me that, and [SS] told us if we have a problem to give her a call."

On 10/8/21, at 11:48 a.m. during an interview with SS and RN-A, the facility was not aware of R1's behaviors on admission. Further, SS stated "we just became aware last week that he had been seeing psych prior to admitting here." SS indicated R1's sexual behaviors began "the second week into him being here and was able to be redirected by talking with wife. The sexual comments were just with staff at first." When asked about the investigation for the incident reported 9/16/21, RN-A stated "the only thing I can tell you about it is [NA-C] was sitting at the desk charting. They [R1 and R2] were behind the meal cart and [R1] touched her in the left groin area on top of [R2]'s clothes. [NA-C] immediately got up and separated those two and walked [R2] back to her room and [R1] went back to the dining room and no other residents were in there. Then [NA-C] came out and told me about it and I contacted everybody." In addition, SS stated "I was on medical leave and came back and visited with RN-A and Administrator. I went and interviewed R1 and R2 and they did not recall

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anything. Then I talked with other residents on the unit. The other residents didn't report anything. They said they feel safe. They didn't have any issues. Some of them have good cognition but majority do not. They are in memory care. I didn't talk to any staff that day. I don't know if anyone else did. I talk with them [staff] on how things are going and I call here on weekends to see how things are going. I just didn't interview the other staff because [NA-C] was the only one that seen it and I was on leave so when I returned I just interviewed the residents." Further, SS stated "I guess we wouldn't know of any behaviors without interviewing other than the behaviors that are in the charting." SS and RN-A indicated there have been no other incidents with R1 and R2 and confirmed that were not aware of R1 and R2 holding hands and R1 asking R1 to have sex.

On 10/8/21, at 1:03 p.m. when asked what the facility's process was for completing a thorough investigation after an abuse allegation, Administrator indicated staff were expected to "interview all staff involved with the resident or when the situation happened you would interview residents that could have witnessed or been involved or affected by it that is for both resident to resident or staff to resident. We would expect any education that is supposed to be provided and to suspend the alleged staff member. Social worker takes the lead with the interview and talking with the nurses on what happened. I [Administrator] will review before things are submitted." Further, Administrator confirmed she was not aware no other staff were interviewed during the investigation.

Review of facility policy titled Accidents and Incidents-Investigating and Reporting updated on

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F 610	Continued From page 8 2/11/21, indicates "all accidents or incident involving resident, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Director of Nursing Services and Administrator." Further review of facility policy indicated "other pertinent date as necessary or required" should be included in the incident report and "the Staff Nurse and or Nurse Manager shall complete a Risk Management Incident for review. The Director of Nursing and Administrator review the Risk Management Incident form for each occurrence."	F 610		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/7/21 through 10/8/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5290031C (MN76802), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	2 000		