DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

January 3, 2022

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

RE: CCN: 245290
Survey Cycle Start Date: December 17, 2021

Dear Administrator:

On December 17, 2021 a survey was completed at your facility by the Minnesota Department of Health to investigate complaints 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. At the time of survey, the complaints were found to be both unsubstantiated and substantiated. However, the facility was found to be in compliance because corrective action was taken prior to the on-site investigation. Therefore, at the time of the investigation, the facility was found to meet federal requirements. A plan of correction is not required.

Also at the time of this survey, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute § 144.653 and/or Minnesota Statute § 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to federal deficiencies only.

Electronically attached is your copy of the Federal CMS-2567 Form and State Form.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 12/17/2021 |

| 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<br><br>On 12/15/21 through 12/17/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be UNSUBSTANTIATED: H5290032C (MN70114); H5290033C (MN78175); H5290034C (MN78373); H5290036C (MN71024); H5290037C (MN70618), H5290038C (MN70052); H5290039 (MN69942).<br><br>The following complaint was found to be SUBSTANTIATED: H5290035C (MN75567), however NO deficiencies were cited due to actions taken by the facility prior to the survey.<br><br>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, the facility must acknowledge receipt of the electronic documents. | F 000 | | |

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

Electronically Signed

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00939 | A. BUILDING: _____ B. WING _____ | C 12/17/2021 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 12/15/21 through 12/17/21, 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.<br><br>The following complaint was found to be | 2 000 | | |

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|---|---|---|---|---|
| 2 000 | Continued From page 1<br><br>UNSUBSTANTIATED: H5290032C (MN70114); H5290033C (MN78175); H5290034C (MN78373); H5290036C (MN71024); H5290037C (MN70618), H5290038C (MN70052); H5290039 (MN69942).<br><br>The following complaint was found to be SUBSTANTIATED: H5290035C (MN75567), however NO licensing orders were issued.<br><br>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>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 | | |