

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

M. Paig

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

PRINTED: 01/03/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245290	B. WING		12	C 12/17/2021	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	•	71772021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	N SHOULD BE COMPLETION		
F 000	On 12/15/21 through abbreviated survey to conduct a comply was found to be IN 483, Requirements The following comply UNSUBSTANTIAT H5290033C (MN70 H5290038C (MN70 H5290038C (MN70 The following comply SUBSTANTIATED however NO deficing actions taken by the The facility is enrolly signature is not recognized to the CMS-2 correction is required.	gh 12/17/21, a standard was completed at your facility laint investigation. Your facility compliance with 42 CFR Part for Long Term Care Facilities. Colaint was found to be ED: H5290032C (MN70114); H5290034C (MN70618), 1024); H5290037C (MN70618), 1024); H5290039 (MN69942). Colaint was found to be H5290035C (MN75567), encies were cited due to be facility prior to the survey. Iled in ePOC and therefore a quired at the bottom of the first effect form. Although no plan of ed, the facility must pt of the electronic documents.	F				

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.

PRINTED: 01/03/2022 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/ IDENTIFICA	SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		00939		B. WING		12/1	7/2021	
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
OLIVIA F	RESTORATIVE CARE	CENTER	1003 WES OLIVIA, N	ST MAPLE IN 56277				
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2 000	Initial Comments			2 000				
	****ATTE	NTION*****						
	NH LICENSING	CORRECTIO	N 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 that may result from orders provided that the Department with notice of assessment.	n non-complia It a written req hin 15 days of	nce with these uest is made to receipt of a					
	INITIAL COMMENT On 12/15/21 throug survey was conduct surveyors from the Health (MDH). You compliance with the	ih 12/17/21, a ted at your fac Minnesota De r facility was fo MN State Lic	cility by epartment of ound IN censure.					
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Electronically Signed

Minnesota Department of Health

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Minnesota Department of Health STATE FORM